Blackberry Hill Limited

St Anne's Nursing Home

Inspection report

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London
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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

St Anne's Nursing Home provides nursing and residential care to a maximum of 50 men and women who are elderly or have physical care needs. The service is provided by Blackberry Hill Limited and there were 47 people in residence at the time of our inspection.

This inspection took place on 10 and 11 May 2017 and was unannounced. At our previous comprehensive inspection in March 2015 we found that, although risks were identified and reviewed, there was a lack of consistency among the staff team about how to respond to all potential risks. We also made two recommendations regarding activities and recommended a wider variety and inclusion of activities aimed to promote people's mobility. At our focused inspection on 23 February 2016, we found that the breach of regulation 9, regarding risk assessments, and the recommendations regarding activities had both been resolved and all the areas of the service were rated as good.

At the time of our inspection, a manager was employed at the service. This person had applied to register with CQC. 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.

There were a mixture of views from people about the choice and diversity of food provided and menu options. The provider acknowledged that improvements to people's dining experience could be achieved and was taking action to do so. The policy of protected mealtimes lacked clarity, which was acknowledged by the provider and changes were made to explain this more clearly to visitors and staff.

The provider had a policy and guidance available for staff about keeping people safe from abuse and staff had training about this. The members of staff we spoke with had a good understanding of how to keep people safe and what they should do if they had any concerns.

Risks to people using the service were considered and common risks such as the risk of falls and those associated with people's healthcare needs were included. Any risks associated with people's individual circumstances were also given attention and responded to.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] to ensure that people who could not make decisions for themselves were protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People were supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home each week, but would also attend if needed outside of these times. A GP was visiting and

spoke with us during this inspection and told us of how well the home co-operated in response to people's known and emerging healthcare needs.

Eight people we spoke with that either used the service, or were relatives, specifically commented about caring attitudes of staff and gave examples. The care plans we looked at showed that attention was given to how staff could ascertain each person's wishes. There had been significant improvement to the efforts that were made to engage people in varied and interesting activities. This received praise from people living at the home and activities were offered to people whether they were able to participate in a group or to do so individually.

Communication between people using the service, relatives and staff were respectful. Although some people said they felt some staff could be more communicative. Staff we spoke with talked about the people they cared for with dignity and respect and we observed compassionate interactions between people using the service and the staff caring for them.

The provider listened to and responded to complaints and acknowledged that further changes could be made to ensure the continued effectiveness of complaint responses. People's views were sought, as too were the views of relatives, visitors, health and social care professionals and staff. The feedback that people gave was taken seriously and the provider took action to monitor and improve the quality of the service.

There was regular and effective communication between staff and management of the home and the service provider. There were ample opportunities to raise anything of concern and to discuss care practices and improvements to the service. The views of staff were respected as was evident from feedback we received from staff.

At this inspection we found that the service met all of the regulations we looked at.

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's safety and any risks to their safety were identified and reviewed. Any concerns about people's safety or well-being arose these were responded to appropriately.

There were sufficient staff to care for people at different times of the. A staff recruitment programme had resulted in almost all permanent posts now being filled.

Medicines were stored and administered safely by nursing staff that were trained to do this.

The service was clean and well maintained.

Is the service effective?

Good

The service was effective. Staff were well trained and supported.

The home complied with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were able to choose from a varied menu. However, culturally diverse food options were not included on the menu as regularly as the manager had stated they would be at a resident and relative meeting. The provider was currently reviewing the dining experience for people and staff supported anyone who needed help to eat and drink to do this.

People's healthcare needs were monitored and any action that was needed to respond to healthcare concerns was taken.

Is the service caring?

Good

The service was caring. Staff communicated with people in calm and friendly tones, demonstrating compassion and warmth towards people using the service. Staff demonstrated knowledge of people's characters and personalities.

People were involved with planning and making decisions about care when they were able to be. This was done in liaison with families, if involved, or other health and social care professionals.

The service sought consent and had used advocacy services for people who did not have relatives or friends who could fulfil this role.

Is the service responsive?

Good

The service was responsive.

Complaints were responded to. The provider had learnt from complaints and complaint responses and kept these under review.

There were a range of opportunities for people to be involved in activities in groups as well as individually.

Care planning was undergoing changes to make recording more efficient and less time consuming. Care plans and care needs were regularly updated and any changes required resulted in appropriate action being taken.

Is the service well-led?

Good

The service was well led. Views of people using the service, relatives, stakeholders and staff were obtained although there was no written survey of people living at the home.

A common theme from people who spoke with us had been that there was concern about the home last year but in the last six months people had seen improvements and felt more confident about how care and support was managed.

The service had a clear management structure in place. Oversight and governance of the service had improved. The provider had achieved the action that had been required by the local authority commissioning team in 2016.

St Anne's Nursing Home

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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 10 and 11 May 2017. The inspection team comprised of an inspector, and inspection manager, and assistant inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.

Before the inspection, we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams and local NHS healthcare professionals.

During our inspection we spoke with eleven people using the service and five relatives. We spoke with a visiting GP, palliative care nurse specialist from the local NHS trust and a community psychiatric nurse. We also spoke with the manager, deputy manager, two provider operations managers, the chef, four nurses and ten care staff.

Prior to this inspection we had received written feedback from a local authority which places most of the people using the service.

As a part of this inspection we reviewed nine people's care plans. We looked at the medicines management for eight people, staff induction, training, appraisal and supervision programme for staff. We reviewed other records such as complaints information, feedback to the service from visitors, maintenance, safety and fire records.

Good

Is the service safe?

Our findings

A person using the service told us about numbers of staff, "Sometimes enough. Sometimes not, it's a lot of work." Someone else told us "I think there are enough staff and they do their job well. I feel safe being here, nurses are here if you are bothered. I can ring my buzzer; it might take a few minutes but does not take long. Staff are nice."

A visiting relative told us, "I feel [my relative] is safe here, not like when they were at home." Another relative told us they were unhappy about some aspects of care, thinking staff were busy and sometimes not able to take their relative to the toilet, and they thought their relative's mobility had decreased. The person's care plan records did not confirm their concerns but they were none the less important so we referred these comments onto the manager for attention.

Some people using the service and relatives thought there was not enough staff, while others thought there were a suitable number. We looked at the staffing rota for the last six months. A staffing level of two registered nurse and ten care assistants was maintained during the day for the entire home. At night a staffing level of one nurse and two care assistants on each of the two floors was being maintained. The provider carried out monthly dependency needs assessments in order to keep staffing levels under review. This demonstrated that the provider did monitor the staffing levels required and based this on people's needs. Temporary staff were being replaced by newly recruited care and nursing staff and almost all vacant posts had now been filled.

The provider operated safe recruitment practices and undertook all of the necessary background checks. Two new staff we spoke with described the process they went through to have checks carried out, provide references and attend an interview.

The provider's policy and procedure for safeguarding people from abuse was available to staff. This policy was comprehensive and gave clear definitions about what constituted abuse or neglect as well as the expectation that staff respond and report any concerns. Staff were able to describe the action they would take if a concern arose. The entire staff team, with the exception of a member of staff who had started working at the home and was on their induction programme, had undertaken the required safeguarding training and this was refreshed yearly.

The service worked in cooperation with the local authority to examine and respond to safeguarding concerns. This included liaison with people that may be potentially at risk and their families. The home responded and addressed concerns appropriately.

Risk assessments, for example, due to medical conditions such as diabetes, the risk of falls and the use of bed rails were in place. The instructions for staff about minimising risks were clear. Evaluations were updated in people's care plans. The provider's risk assessment policy stated that everyone should have their full risk assessments re-assessed at least annually but sooner if someone was at higher risk or any change of need had occurred. This was being carried out.

The risk some people faced of developing pressure ulcers was taken seriously. There was detailed and clear information provided to staff about minimising this risk. The provider employed a specialist tissue viability nurse. This person was visiting at least once a week at present and often more than this to review any concerns and action needed for people who had, or may be developing, pressure ulcers. Pressure ulcer care was well managed and there were good links with the local NHS pressure ulcer tissue viability service. Action taken to reduce the risk of people developing pressure ulcers included provision of air mattresses and instructions concerning the monitoring of these. Additionally, people's weight, their need for fluids and a balanced diet, checks on skin integrity, application of barrier cream and turning were also used. This was monitored by the tissue viability nurse who reviewed these records.

People were supported to take their medicines in a safe way and medicines were also stored safely. On the first day of our inspection we observed medicines being administered by a nurse on the first floor. Before this took place the nurse that had been in charge the previous night went through a check of the medicines records with the nurse coming on duty for the day. They looked at whether all medicines required had been given and checked the amounts of controlled drugs [These are drugs that are strictly controlled under the Miss Use of Drugs Act 1971]. Each nurse counted and then signed the register of these medicines.

We looked at eight people's medicines administration records [MAR] and counted up a sample of medicines for each person against the record of medicines that should be in stock. People had received all their medicines as prescribed. Nursing staff were responsible for administering all medicines. There was clear guidance about this, including administration to people who required medicines due to using a Percutaneous Endoscopic Gastrostomy (PEG) tube [This is a tube used by people that is surgically implanted through their abdomen to their stomach to receive foods and fluids if they had swallowing difficulties]. The needs of people that required PEG tubes were well managed.

During our visits we checked the communal areas of the service which were all clean and well maintained. Domestic staff were employed and there were detailed infection control procedures. The most recent internal infection control audit that was carried out in March 2017 rated the service at meeting all required infection control practices and procedures.

Good

Is the service effective?

Our findings

People had mixed views on the food at the home. One person told us, "The food is sometimes good, sometimes not. I get a choice. One day I said I wanted a sausage and it was not on the menu but they got one. If you want a cup of tea they make you one."

Other people told us "I'm satisfied with it. If you don't fancy it they change it for something else." However, they also said that "Food not bad. Today the porridge was cold." One person had a mixture of views about food in general and said, "I don't have food here, my family bring food. I have sandwiches in the evening and have breakfast. They give you tea any time of the day." We were told that this was an agreement with the person's family and was their preference.

A relative told us "[My relative] does not like the food. Our family brings in food." Another relative told us they brought in food sometimes, as they knew their relative had particular favourites that they liked.

There were some people living at the home whose cultural heritage was different to most people who were living there. A resident and relatives meeting in March 2017 had raised the matter of culturally diverse foods being made available and the manager had informed the meeting that two options per week would be added to the menu if people required this. This was not included in the current four week rotating spring menu, the manager stated this menu was being changed to a summer menu shortly and at least two standard culturally diverse meal options would be included each week. The menu did state that "Alternative meal choices are always available, please ask for today's selection." However, it was not clear what range of possible alternatives were on offer each day as this was not advertised on the menu. The provider was carrying out a review of the people's dining experience at the time of the inspection.

The home operated a protected mealtimes policy. The manager told us that visiting professionals were asked not to make appointments to see people during mealtimes. However, one relative told us that although they were allowed to be present at mealtimes they were not allowed to sit with their relative at the dining table. When we spoke with staff, some were not clear about protected mealtimes and what these meant. The manager stated that this was not a restriction on relatives or friends. The information displayed about protected mealtimes could lead people to think that the visiting restriction applied to everybody rather than visiting professionals. We were informed shortly after this inspection that staff had been reminded about this and the posters on display about protected mealtimes had been changed to make this clear.

At lunchtime on the first day of our inspection, we observed nobody was rushed to finish their meal. Staff noticed when people were not eating and encouraged them to do so. People were offered drinks regularly. Specialised diets, such as diabetic meals or mashed and pureed foods, were prepared when required. The chef knew which people needed specialised meals. Complaints had been made about night time snacks being available. The action being taken included making sure that snacks and drinks were always stocked in the kitchenettes on each floor and that night staff were provided with guidance and clear expectations of what they should do to respond to people at night.

Staff induction was detailed and a mentor was assigned to new members of staff during their induction. This was a more senior or experienced member of staff. We spoke with four newly recruited staff and were told that they felt they were receiving support and guidance about how to work with people and how the service operated. They told us they were shadowing colleagues for two weeks as a part of their induction in order to learn about how people preferred to be supported.

Staff told us they had good training opportunities both through on line e learning and face-to-face group training sessions. Records of staff training demonstrated a high degree of staff compliance with required training, with almost a 100 per cent achievement rate at the time of this inspection. The frequency of updates for staff training and refresher courses was yearly, for example safeguarding, manual handling and infection control, or two yearly for equality and diversity, dementia and end of life care.

Staff participated in regular supervision, which staff confirmed to us. This formed a part of an on going performance and appraisal process, which the provider referred to as practical supervision. Each member of staff had these sessions usually at two monthly intervals. The provider had introduced a "Reaching the star" programme. This was designed to encourage staff to drive positive changes at the service. It was further designed to recognise what staff needed to do to offer safe and effective support to people and to strive to be local champions. Areas for staff to become champions for included such things as nutrition and hydration, staffing [including involvement of people using the service in staff selection] and health.

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 authorisation 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.

Clear evidence of obtaining people's signed consent, or their relative on their behalf, to their care and treatment was available. In one case we found no consent form signed but were told this was awaiting signature of a social care professional who was arranging a review of the person in question. Most people were able to give consent themselves, or for those who could not, this was obtained from a member of their family. If no family were involved the consent was obtained from health or social care professionals that had responsibility for the person. People that were subject to DoLS had these agreements up to date and in place.

People were supported to maintain their health. Nurses were on duty at the service 24 hours a day and a local GP visited the home twice each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met effectively, which a visiting GP confirmed with us and said that positive changes were being made at the service.

Good

Is the service caring?

Our findings

A person told us, "Some days are good and some days are bad. When you are nice to people they are nice to you." We were introduced to another person in their room by a male care assistant, they greeted each other warmly and there was clearly an affectionate interaction between them. The person they introduced us to said, "Nice boy. Looks after me very well, he's like my son. All staff are very nice." They also said, "They ask you if you are hungry. Everything is lovely, very nice staff. My children said they would have me home but I said no, very happy here."

A relative who visited frequently told us they had some concerns around six months ago about the attentiveness of staff and had given clear guidance to them about their relative's preferences. They said things had improved although they then showed us their relative's wardrobe in their bedroom where some clothes had been left in the bottom of it and had not been put away properly. We informed the deputy manager about this for their attention.

A relative told us "Staff are lovely, really nice." Another relative told us "Staff are compassionate. [My relative] had a chest infection and was not them self. They [staff] sent [my relative] to hospital. I am made welcome, offered a cup of tea but they don't keep me informed. Today I was told about the manager's surgery, I did not know before today. They want a date to look at the care plan."

We saw that a member of staff responded and spoke kindly to a person who was crying, they stroked the person's arm and helped dry their eyes. After lunch people, visitors and staff were sitting round the table, listening to music and having tea. Initially the person who had been upset earlier was sitting in their wheelchair a little away from the table. A member of staff noticed this and helped the person to join other people at the table.

In the afternoon of the first day of our inspection, on one floor of the home, most people were either in their rooms or at the day centre. There were three people in a smaller dayroom where a staff member sat with them and offered them fruit and drinks. A staff member was seen sitting with someone and held their hand for as long as the person wanted.

When people could be meaningfully involved in making decisions about their care plan they were able to do so. At times some people were not able to and, if relatives were involved with the person, we saw examples of their involvement. Health and social care professionals were contacted if there was no family involvement and we saw two examples where different people had been supported by a local advocacy service that the home had made contact with to discuss particular matters.

Staff demonstrated a good understanding of equality and diversity issues. Staff were trained and they had detailed information about respecting human rights, equality and the provider's commitment to the service being inclusive. A person we met who lived at the home did not speak English as a first language. However, it was evident that the staff and the person had found ways to communicate. The person spoke, rather than English, two other languages and staff had compiled a phrase book with words that the person mostly used.

There was a clear understanding by staff, which we observed, about how the person communicated.

Staff spoke with people in a calm and friendly manner. They demonstrated a good knowledge of people's characters and personalities.

We spoke with a palliative care specialist nurse who was visiting. This person told us they believed the service attended to end of life planning and palliative care treatment very well and listened to the advice and guidance that was provided.

Good

Is the service responsive?

Our findings

One person told us "I have complained about the night staff." The person did not tell us why they had done so. The manager had carried out a night time visit in February 2017. The manager stated they would be carrying out further night time spot checks. They also said that as a result of their visit they had further thoughts about changes that could be beneficial. Staff who worked permanently at night were going to be required to also work at least one day each month. They told us this was being done to provide permanent night time staff with the opportunity to see and engage with people during the day. This was being introduced on the next month's staff rota which demonstrated the provider was reviewing night time care and thinking about any changes that could be beneficial to people using the service and staff.

Someone told us that "They choose what you wear. Sometimes it matches, sometimes it does not." The person then said that a member of staff had said been unkind to them but could not recall who this was or when. We saw two separate occasions where the person was upset and staff responded with care and empathy when comforting them. The care plan for this person provided staff with guidance about why the person became upset and ways to comfort them. Staff were responding appropriately to the person's distress and we did not think that the person was uncared for. No one else told us that staff were unkind to them.
Another person using the service told us told us about what they thought about the home and said "I like it, it's just nice. I have no complaints."

There was a corporate complaints policy. The policy referred to the complaints procedure and how to manage verbal, serious and written complaints. There were details of where complainants could also complain to the local government ombudsman if they were not satisfied with the provider's handling of a complaint. Complaints were responded to well, although the provider accepted that a reply letter to one complaint should have been better and should have offered an apology. The person who had made the complaint told us that they had not been satisfied at the time they complained but in the months since they had seen improvements and had not felt any need to make a further complaint. The other recorded complaints had been responded to appropriately and the full details of the complaint and the outcomes had all been clearly recorded, along with the written responses to the people who had complained. The provider evaluated complaints at senior management level and shortly after this inspection we were informed that the provider was going to seek further feedback about people's current view of complaints handling at the next residents and relatives meeting.

People's individual care plans were accessible and clearly written. They described care needs, action to be taken and an evaluation of each person's progress. The nine people's care records we looked at included information about people's life history, when this information had been shared, how they communicated and guidance about how personal care should be provided. The provider was trialling a new online remote care plan recording system on one of the floors. A staff member showed us how they could immediately record care needs using a handheld device and that this made it far quicker to record at the times of the day they had carried out care tasks. They could also record interactions and events for people. Although this system was in its early stages of use there was a good degree of confidence from both staff and the provider

that this would make the recording of care more efficient. Care provided to people could also be clearly linked to the member of staff providing the care as each had their own log in to the handheld devises that they had to use before the care records could be accessed. The records that were generated on this system were held on computer. We looked at updated information for people whose written care plans we had viewed and found the information was available.
A visitor told us "They treat [my relative] with respect and definitely ask before they do things. [Relative] used to spend a lot of time sleeping but now there is a new activities coordinator and its working well."

People could take part in an increasingly wide range of activities. A wellbeing coordinator and an activity coordinator were both employed by the provider and both worked exclusively at St Anne's Nursing Home. The wellbeing coordinator was enthusiastic about what they were developing in terms of activities and links with the local community, including schools and performing arts groups. As an example, a play had been created and performed at the home by an arts group that had based the play on a topic that people had chosen. The play was about the South Pacific and incorporated people's ideas about what they imagined or thought that may be like.

We were shown examples of the 'People Like Me' project where staff's hobbies and interests are matched with those of people living at the home to create meaningful and fun interactions between them. Arts, creative and tactile therapy sessions took place and everyone at the home was being included in a personal activity plan. These were still being developed and we saw three examples of these. A birthday party was taking place on the first afternoon of our inspection and other activities were taking place at different points each day. There was a lot of focus about providing opportunities for stimulating engagement with people which, even for some who may have not originally been interested in becoming involved, was having a good deal of success.

Good

Is the service well-led?

Our findings

The service engaged with people and was open about communication and in seeking people's views about the quality of the service. The manager told us that the service received feedback from people using the service regularly and that resident and relatives meetings were held. The minutes of the meetings outlined action being taken in response to comments that people had made and also aspects of the day to day operation and developments at the home. Relatives and staff surveys, most recently in January 2017, showed that there was usually satisfaction with the service. It was evident that people's views were sought in a variety of ways. As most people using the service were able to give their views verbally there were no written surveys gathered from people living at the home.

A person using the service told us, "Management are very efficient." A visitor told us that staff "Make you feel welcome." However, they also said "[I have] Not spoken to the manager. I do not know who the manager is. Nobody talks to me. I would like whoever he is to come and talk to me." We informed the manager of this and they said they would speak with the person when they next visited. Another relative told us "If I was worried about care I would speak to them downstairs. Really well run." A third visitor said, "They listen when I raise an issue. They are getting there. No manager for a while but now [deputy manager and the manager] on board. They are going to have personalised one to one work with residents. It will come up pretty quickly."

Staff felt there was open communication between management, the provider and staff team. They commented on the number of changes that had been made and staff were enthusiastic about the changes being positive for people using the service and themselves.

Prior to this inspection we had received written feedback from a local authority which mostly placed people at the service. This described issues that had been raised in March 2016 about elements of staffing, handovers, the environment and the experience of people using the service. There had also been improvements required from a visit in December 2016 about a need to re-organise aspects of medicines management and a staffing matter. We were shown confirmation from the local authority that the necessary improvements had been made and all actions had been fully complied with. A common theme from people who spoke with us had been that there was concern about the home last year but in the last six months people had seen improvements and felt more confident about care and support.

The views of staff about the service were respected as was evident from conversations that we had with staff and that we observed. Staff told us that there were regular team meetings, which we confirmed, where staff had the opportunity to discuss care at the service and other topics.

The provider had developed a programme for staff achievement which they called the Forest of Stars. Information was displayed for staff on a poster advertising the programme and staff were provided with information about what steps to take to achieve this. This programme outlined what steps staff could take to meet the goals, for example, in areas such as safeguarding, diversity, dementia care, staff skills, and supporting people with nutrition and hydration. This was an on going programme for the whole of the staff

team and provided staff with detailed guidance on how they could achieve these aims and be recognised for their achievement.

The provider also informed us that they had become a founder member of the Centre for Creativity and Innovation in Care. This was designed as a new movement to model outstanding practices and to increase the levels of creativity and creative leadership within care services. We were shown an agenda for a coaching session that included aims, commitment to those taking part and learning objectives. This initiative was recently introduced at St Anne's by the provider.

The provider had in place a system for monitoring the quality of care. The provider had identified that there had been shortfalls in monitoring the service in the latter half of 2016, but this had improved since then. The provider and manager undertook regular audits and reviews of a wide range of aspects of the service. We looked at audits for medicine's management, care planning, pressure ulcers, risk reduction measures and health and safety. These were mostly completed electronically and the provider was monitoring the performance of the service and responded to any action needed.

The necessary safety certificates and records were in place for example, gas, electrical and fire warning systems. Hoists and slings used to support people with transfers were regularly checked to ensure people's safety. The provider had an emergency contingency plan for the service which gave clear instructions to staff about responding to emergency situations.