Isand Limited

Hawkstone House

Inspection report

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Date of inspection visit:
24 August 2016

Date of publication:
18 November 2016

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

This was an unannounced inspection which we carried out on 24 August 2016.

We last inspected Hawkstone House in July 2014. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Hawkstone House is a care home that provides accommodation and personal care for up to 10 people with learning disabilities. Nursing care is not provided. Ten people were using the service at the time of inspection.

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

People and staff told us they felt safe and there were enough staff on duty at all times to provide safe and individual care to people. There was an emphasis on providing person centred care to ensure people received safe care and support in the way they wanted and at times they chose. Risk assessments were in place and they accurately identified current risks to the person.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed. Menus were varied and staff were aware of people's likes and dislikes and special diets that were required.

Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. We have made a recommendation about medicines management where medicines were given in a person's best interest. People received their medicines in a safe and timely way.

People were supported to go on holiday and to be part of the local community. They were provided with opportunities to follow their interests and hobbies and were introduced to new activities. They were supported to maintain some control in their lives. They were given information in a format that helped them to understand and encourage their involvement in every day decision making. A complaints procedure was available and written in a way to help people understand if they did not read.

People had the opportunity to give their views about the service. There was regular consultation with people

and/ or family members and their views were used to improve the service. The home had a quality assurance programme to check the quality of care provided.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Regular checks were carried out to ensure the building was safe and fit for purpose. Appropriate checks were carried out before staff began work with people.

Staffing levels were sufficient to meet people's needs safely. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Is the service effective?

Good

The service was effective.

Staff had received training to ensure people's needs were met effectively. Staff were given regular supervision and support.

Best interest decisions were mostly made appropriately on behalf of people, when they were unable to give consent to their care and treatment. However, where people without mental capacity received medicine without their knowledge not all the necessary people were involved in the decision making process. We have made a recommendation about the management of medicines and best interest decision making.

People received appropriate support to meet their healthcare needs. Staff liaised with GPs and other professionals to make sure people's care and treatment needs were met.

People received a varied diet.

Is the service caring?

Good

The service was caring.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

The staff team were caring and patient as they provided care and support. Staff spent time interacting with people and they were all were encouraged and supported to be involved in daily decision making.

There was a system for people to use if they needed the support of an advocate.

Is the service responsive?

Good

The service was responsive.

People were encouraged by staff to be independent and to maintain some awareness and control in their lives.

People received support in the way they wanted and needed because staff had detailed guidance about how to deliver people's care. Care plans were in place to meet people's care and support requirements.

People were provided with a range of opportunities to access the local community. They were supported to follow their hobbies and interests and were introduced to new experiences.

People had information in a format they may understand to help them complain.

Is the service well-led?

Good

The service was well-led.

The registered manager encouraged an ethos of involvement amongst staff and people who used the service.

Staff were well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

The registered manager monitored the quality of the service provided and introduced improvements to ensure people received safe care that met their needs.

Hawkstone House

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 24 August 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with four people who lived at Hawkstone House, the registered manager, the deputy manager, five support workers, one relative and a visiting social care professional. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for four people, the recruitment, training and induction records for four staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the manager had completed.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people told us they felt safe and staff were around when they needed them. One person commented, "I feel safe living here."

We considered sufficient staff were on duty to provide safe and person centred care to people who used the service. At the time of our inspection there were 10 people living at the home. Ten people required one to one or two to one staffing to support them safely because of their physical health or behavioural needs. The registered manager told us staffing levels were kept under review as people's needs changed. Staffing rosters showed during the day there were nine support staff and one team leader to support 10 people. The numbers increased to 10 support workers and a team leader in the afternoon until evening. These numbers did not include the registered manager and deputy manager who were also on duty during the day. Overnight two waking night staff were on duty to provide support to people.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. These included environmental risks and any risks due to the health and support needs of the person such as epilepsy and distressed behaviour. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time they gave guidance for staff to support people to take risks to help increase their independence. Staff told us people were supported to become more independent and the need for one to one staff decreased as the level of risk reduced and they became more independent.

Care plans were in place to show peoples' care and support requirements when they became distressed. For example, one care plan stated, "If I am sad and become nervous and start biting my tee-shirt. I want you to reassure me and say everything is okay." This was to supplement the behaviour management guidelines that were in place for people to help staff support them. Staff therefore had information to help them recognise triggers and help de-escalate situations if people became distressed and challenging. Care plans also provided detail and guidance when physical intervention was required with some people. This was used as a last resort and it was used to keep people safe.

Staff told us they had received training about the management of actual and potential aggression (MAPA) before they began to support people. This training helped to prepare staff and ensure they had the knowledge to support people with distressed behaviour and recognise signs to de- escalate any potentially unsafe situations. Staff told us they felt safe supporting people.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to psychologists or the department of psychiatry. Staff told us they followed the instructions and guidance of the psychologists for example, to complete behavioural charts when a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person. Staff meeting minutes showed a psychologist attended some team meetings to educate staff about people's behavioural care and support needs. This was to ensure staff

had more insight and understanding as to why people may become distressed and challenging.

Information and guidance was available for each person to help staff support them if they were agitated or distressed. We were told this guidance was followed to try to calm people before any sedative medicine was administered, which was used as a last resort. Guidance was in place to advise staff 'when required' medicines should be used for agitation and distress to ensure a consistent approach.

People received their medicines in a safe way. We observed medicines as they were administered to people. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

A personal emergency evacuation plan (PEEP) giving guidance if the home needed to be evacuated in an emergency was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed regularly to ensure they were up to date.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. One staff member said, "If I had any concerns about anyone's care I'd report it to the manager straight away." Staff told us, and records confirmed they had completed safeguarding training. They were able to tell us about different types of abuse and were aware of potential warning signs. They described when a safeguarding incident needed to be reported.

The registered manager was aware of potential safeguarding incidents that should be reported. A log book was in place to record minor safeguarding issues which could be dealt with by the provider. Eight safeguarding referrals to the local authority safeguarding adult's team had been raised since the last inspection and had been investigated and resolved.

Staff were aware of the reporting process for any accidents or incidents that occurred. We were told incidents were analysed by the registered manager at the home to make sure any learning from incidents took place. We were told all incidents were also audited at head office to check action was taken as required to help protect people. A staff member told us, "After an incident the team leader will check people. The incident is talked about at the staff meeting and we discuss how to handle the incident next time."

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with.

Staff we spoke with and staff records confirmed staff had been recruited correctly. The necessary checks to ensure people's safety had been carried out before people began work in the service. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had also been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable

to work with vulnerable people.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "There is plenty of training," "There are professional development courses," "I've just done autism and safeguarding training and I've three work books to get signed off," and, "We get opportunities for training."

Staff said they received supervision from the management team, to discuss their work performance and training needs. Staff comments included, "I've paperwork to complete for supervision. I'm due a supervision now," and, "We have supervisions every three months." Staff told us they were well supported to carry out their caring role. They said they could also approach the registered manager and deputy manager in the service at any time to discuss any issues. They also said they received an annual appraisal to review their work performance.

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of face to face and practical training. Some new staff told us, "There are always staff around to ask advice," and, "There are experienced staff here to support us." The staff training matrix showed new staff completed an induction and studied for the Care Certificate in health and social care as part of their induction training. The staff training matrix showed existing staff members also studied for the Care Certificate.

The staff training records showed staff received training in safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that gave them some knowledge and insight into people's needs and this included a range of courses such as, epilepsy, person centred support, equality and diversity, mental health awareness, bereavement, nutrition, and a range of courses about distressed behaviour management.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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). The deputy manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us seven applications had been authorised and three applications were being processed. Several people received one to one or two to one staff support in order to keep them safe.

People who used the service were involved in developing their care and support plan and identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. The registered manager told us they worked with the local authority to ensure appropriate capacity assessments were carried out where there were concerns regarding a person's ability to make a decision. People's care records contained details about people's mental health and the correct 'best interest' decision making process. Care records showed when other 'best interest' decisions may need to be made. For example, with regard to a person's ability to cross the road safely.

Some medicines were administered covertly (covert medicine refers to medicine which is hidden in food or drink). Records showed that where people lacked mental capacity to be involved in their own decision making a meeting had taken place but the correct process had not been used. We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) as NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests." A meeting had taken place with a local authority representative but other relevant people such as a family member, health care professional and pharmacist had not been involved.

We recommend the service considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes with regard to the use of 'covert medicine.'

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and wellbeing of people. All staff were involved in the handover. Staff comments included, "The team leader uses a written handover sheet to inform us," "Handover is informative. You need a handover to find out what's happening," "There are no problems with communication," and," You find out people's needs."

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. A four week menu was in place that included people's suggestions. People's care records included nutritional care plans and these identified requirements such as the need for a weight reducing or modified diet. For example, "To support [Name] to maintain a healthy weight [Name] has a snack box in the morning and afternoon which consists of three healthy snacks and two pieces of fruit." Care plans indicated if people had the need of a specialist diet for example, due to diabetes. Food was prepared and made available for people with different cultural requirements. For example, Halal meat. Some people were involved in meal preparation and required different levels of support. They received support from staff to help prepare or make a meal and drinks. People's records showed the support people required. For example, a care plan stated, "[Name] can help to make simple snacks for themselves and cut up vegetables for meals."

People who used the service were supported by staff to have their healthcare needs met. Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. Records showed people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from GPs, opticians, dentists, speech and language therapists, nurses and other personnel. The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. Care plans recorded the advice and guidance received. For example, one care plan recorded, "In order to support [Name] to drink in line with the dentist's

recommendations staff must encourage them to drink water as well as orange juice. Offer a drink of orange juice and then water alternatively throughout the day."

Good

Is the service caring?

Our findings

People who used the service were supported by staff who were caring and respectful. They appeared comfortable with the staff who supported them. People who were able to talk to us about their experiences said they were happy with the care and support they received. One person told us, "Staff are kind."

During the inspection there was a happy, relaxed and tranquil atmosphere in the home. Staff interacted well with all people, engaging and joking with them and spending time with them. People who needed one to one support received it in an unobtrusive way that respected the person's dignity. Staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff interventions were appropriate and caring. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff.

Staff engaged with people in a calm and quiet way. We observed the lunch time meal served in the dining room. The atmosphere was pleasant and unhurried and staff provided people with assistance as necessary. We saw a staff member who assisted a person to eat explained what they were doing and reassured them as they supported them and provided words of encouragement.

Not all of the people were able to fully express their views verbally. Support plans provided detailed information to inform staff how a person communicated. For example, "When I'm happy I smile and clap my hands," "Say good morning whilst using Makaton (sign language) [Name] will communicate good morning back to you in their own way," and, "When [Name] is ready to get up in the mornings we are likely to hear them whistling." This meant staff had information to inform them what the person was communicating to them. People were encouraged to make choices about their day to day lives and staff used pictures, signs and symbols to help people make choices and express their views. Care records detailed how people could be supported to make decisions. For example, one person's communication support plan stated, "Since my last review I have got better at understanding clear instructions from my picture cards."

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, two items of clothing. This encouraged the person to maintain some involvement and control in their life. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. People's care records also provided written information to guide staff if a person was unable to express they were unwell or experiencing pain. For example, one record stated, "When I'm unwell I frown and lie on the bed more than usual. I look pale and tired."

Records showed people were able to make other choices such as what to wear and when to get up and go to bed. For example, one support plan recorded, "I can choose my own tee shirt and put it on," and, a person told us, "I can go to bed when I want."

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. We saw staff knocked on a person's door and waited for permission before they went into their room. Records provided guidance for staff about how people communicated and to respect their privacy. For example, one care plan recorded, "Never ignore me. Always respect my privacy and wait until I leave the room or take you by the arm to enter my bedroom."

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. The registered manager told us advocates where used as required. An advocacy group visited the service three times a year to listen to people and advocate on their behalf if necessary. One person had used an Independent Mental Capacity advocate (IMCA) to discuss arrangements about the person's care. Advocates can represent the views of people who are not able to express their wishes

Good

Is the service responsive?

Our findings

All people were supported to access the community and try out new activities as well as continue with previous interests. We were told the service had two minibuses and people were also supported to use the bus to get out and about. People enjoyed meals out and trips to the coast and countryside. Staff said there were always enough staff on duty so people had the choice to go out or to remain at the service. People's comments included, "I go out for meals", "I'd like to go to London," and, "I go out shopping." Records also showed people interests and showed they had the opportunity to go out on day trips and for holidays. For example, "It is important to me to go to a theme park and to visit Blackpool," and, "I like going to the bank, going shopping and going out for a meal." Some people were also supported to go to work, attend college or day placements such as horticulture and bakery full or part time

Written information was available that showed people of importance in a person's life. Examples included, "I see my Mum on Tuesday," "[Name] sees their Dad at weekends," and, "My Mum is important to me. I like sitting on the sofa with my Mum and watching television." Staff told us people were supported to keep in touch and spend time with family members and friends. Some people had visitors and some people went to spend time at their family home for a day or overnight stay.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs. Examples in care plans included, "[Name] is capable of dressing and undressing but will need verbal prompts to carry this through," and, "When [Name] does not chew their food enough, they can cough. [Name] will eat very quickly so staff have to prompt them to slow down."

The registered manager told us a new care planning system was being introduced to make them more individual. People's care plans were being rewritten and a system to update them more regularly was in place to ensure they accurately reflected people's care and support needs. Care plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. Examples in people's care plans included, "It is important that [Name] maintains and builds up their life skills. Staff should be aware not to do everything for [Name] as this will lead to them being de-skilled and becoming dependent on others," and, "I help clean my room. If you give my dirty basket and say [Name] put dirty clothes in there I understand and will do it."

People's care records were person centred and contained information about people's likes, dislikes and preferred routines. Examples, included, "I like listening to Smooth and Magic radio. This helps me to relax," "I love swimming and playing in the water," "I enjoy my Saturday pub lunch," and, "[Name] enjoys both showers and baths. They particularly like baths where they enjoy soaking and relaxing in an evening." Staff were knowledgeable about the people they supported. They were aware of their preferences and interests,

as well as their health and support needs, which enabled them to provide a personalised service.

Monthly meetings were held with people who used the service. The registered manager said meetings provided feedback from people about the running of the home. Meeting minutes were produced in an accessible way for people who did not read. They showed people were asked about menus, activities, health and safety and the action taken to any areas highlighted. For example, August meeting minutes recorded, "[Name] doesn't like sandwiches but likes bagels and toasties," "Would like to go on a rollercoaster and a picnic at Ilkley or Blackpool. We noted action from the meeting was for a picnic to be organised and completed by 30 September 2016. Meeting minutes showed they were an opportunity for people to give feedback about the care they received. For example, "I'm happy with my staff support," "I'm happy with staff and the food," and, "Games nights very month with snacks."

People we spoke with said they knew how to complain. A complaints log was available and we saw six complaints had been received that had been investigated and resolved. Resident meeting minutes also showed the complaint's procedure was discussed with people to remind them of how to complain. A copy of the complaints procedure was available and was written in a way to help people understand if they did not read.

Good

Is the service well-led?

Our findings

A registered manager was in post and they had registered with the Care Quality Commission in May 2016. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The registered manager had recently begun employment with the organisation. They said they had introduced changes to the service to help its' smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns that may be raised. The atmosphere in the home was friendly and lively. Staff said they felt well-supported. They were very positive about the management team and it was observed how enthusiastic they were. Comments included, "Both managers are approachable," "It's good working here," "The new manager is very good," "We are a strong staff team," and, "Management are definitely approachable, you can go straight to them."

The culture of the service promoted person centred care, for each individual to receive care in the way they wanted and to be helped to maximise their potential. Staff were made aware of the rights of people with learning disabilities and their right to live an 'ordinary life.' Information was available to help staff provide care the way the person may have wanted, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

Staff told us and meeting minutes showed monthly general staff meetings and team leader meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed service issues, health and safety, resident meetings, staffing, training and the needs of people who used the service. Staff told us meeting minutes were made available for staff who were unable to attend meetings. Staff comments included, "We have monthly team leader meetings," "We had a staff meeting last week," and, "Staff meetings happen every month."

A monthly service user forum was run by head office with representatives from people who used each of the provider's services on the forum. Recent minutes showed policies and procedures were discussed and put into an accessible format such as pictures so people who did not read would have the information to keep them informed. For example, the personal care policy and fire policy were made pictorial. Other topics included respecting people's privacy and dignity, pictorial menus and person centred care. Subjects discussed at the meeting and any changes and suggestions were then introduced across the services.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a range of weekly, monthly, quarterly and annual checks. They included health and safety, infection control, training, care provision, medicines and information governance. Audits identified actions that needed to be taken. The annual audit was carried out to monitor the safety and quality of the service provided. Records showed regular audits were carried out by a representative from head office and the registered manager to check on the quality of service provision. An annual peer audit was carried out by a registered manager of another service to speak to people and the

staff with regard to the standards in the service. They also audited a sample of records, such as care plans and staff files. These visits were carried out to provide an external monitoring of the service. They were to check on service provision to ensure any areas of need were identified and timely action taken to improve the care experience for people who used the service.

The registered manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service. Surveys had been completed by people who used the service, professionals and relatives in Autumn 2015. Comments from surveys included, "[Name] is clearly very happy in their home and interacts well with support workers. This has been a joy to see," "Reviews and support plans completed were very thorough and well presented," and, "[Name] likes all the staff and [Name] loves their job."