The Wilf Ward Family Trust

Fell Close

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 16 February 2017 and was announced.

At our last inspection on 24 November 2014 we rated the service 'Good'. We found the service remained 'Good' at this inspection.

Fell close is registered to provide long-term accommodation to four adults who have a learning disability and/or a physical disability. The service is situated in Newby, on the outskirts of Scarborough. There is limited car parking available to the front of the service and disabled access into the building. People have access to a garden area to the rear of the building and a selection of communal spaces within the service. These included a dining area and a lounge. Both floors of the service have communal bathrooms and toilet facilities. The bedrooms are all single occupancy. At the time of this inspection, four people were using the service.

The registered provider is required to have a registered manager, but at the time of our inspection the manager in post was not registered with the Care Quality Commission (CQC). For this report, we have referred to this person as 'the manager' throughout the text. 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.

We found that the care staff had a good knowledge of how to keep people safe from harm and the staff had been employed following robust recruitment and selection processes. We found that the management of medication was safely carried out.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

People that used the service were cared for and supported by qualified and competent staff that were regularly supervised. 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 received adequate nutrition and hydration to maintain their levels of health and wellbeing. People had been included in planning menus and their feedback about the meals in the service had been listened to and acted on.

People were able to see their families when they wanted to. There were no restrictions on when people could visit the service. We saw that staff were caring and people were happy with the care they received. People had access to community facilities and most participated in the activities provided in the service.

We observed good interactions between people who lived in the service and staff on the day of the inspection. We found that people received compassionate care from kind staff and that staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook support tasks.

People's comments and niggles/grumbles were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that the manager met with people on a regular basis to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible.

The staff told us that the service was well managed. The manager monitored the quality of the service, supported the members of staff and ensured that there were effective communication and response systems in place for people who used 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 remains good.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents.

There were sufficient numbers of staff on duty to meet people's needs and medicines were managed safely so that people received them as prescribed by their doctor.

Is the service effective?

Good

The service remains good.

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people. Staff were aware and worked within the requirements of the Mental Capacity Act 2005.

People had a choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

People received appropriate health-care support from specialists and health-care professionals where needed.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the service to be meeting the requirements of DoLS.

Is the service caring?

Good

The service remains good.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when

supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Good

The service remains good.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs, their interests and preferences and this enabled them to provide a personalised service.

Staff supported people to maintain their independence and to build their confidence in all areas.

People who used the service were able to make suggestions and raise concerns or complaints about the service they received.

Is the service well-led?

Good

The service remains good.

The service was without a registered manager. However, a registered manager's application was sent to CQC immediately following this inspection.

People were at the heart of the service and staff continually strived to improve. Staff were supported by the manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the manager.

The manager and registered provider carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff and to ensure the safety and well-being of people who lived and worked there.

Fell Close

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 registered 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 16 February 2017 and was announced. We gave the registered provider 48 hours' notice of the inspection because it is small service. People using the service and the manager are often out of the service and we needed to be sure that they would be in.

The inspection team consisted of one adult social care inspector.

Before our inspection, we looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams. We asked the registered provider to submit a provider information return (PIR) and this was returned within the agreed timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection, we spoke with the manager and two members of staff. We met all four of the people using the service, but they were not able to speak with us directly so we also recorded observations during the inspection.

We spent time in the office looking at records, which included the care records for two people who used the service, the recruitment, induction, training and supervision records for two members of staff and other records relating to the management of the service.

Good

Is the service safe?

Our findings

The service was safe. Observations showed that there were sufficient staff on duty to meet people's needs and have time to carry out activities, housework and sit and talk with people who used the service. We saw that people trusted the staff and followed their guidance and direction during day to day tasks. The duty rotas showed that there was always someone in charge of the service in the form of the manager or assistant manager and, on the day of this inspection, there were three care staff on duty. We observed one person being escorted to a dental appointment in the morning and two people went out shopping in the afternoon. This showed us that staffing was flexible enough to enable outings and social activities to take place.

We looked at the recruitment files of two members of staff and saw that safe recruitment practices had been followed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them.

The registered provider had policies and procedures in place to guide staff in safeguarding adults. The manager described the local authority safeguarding procedures and our checks of the safeguarding file showed that there had been one alert raised by the manager in the last twelve months. This had been resolved by working with the local authority and the family concerned. We received feedback from the local authority safeguarding team that they had no on-going concerns about the service and the information we hold about the service showed that CQC had been notified of the alert. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

The manager and the staff had completed safeguarding adults training in the last year and this was evidenced in the staff training files we looked at. The staff said they were confident about raising any issues with the manager.

There were care notes and risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; these risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe, but also ensured they were able to make choices about aspects of their lives.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. Where people were assessed as at risk of falling out of bed, the manager had ensured the person had been referred to the appropriate health-care professional. For example, one person had been assessed by a physiotherapist and now had a fold out mattress in their room to act as a 'crash' mat at night. We saw that there were no accidents within the service in the last year. This indicated that the safety measures within the service were effective.

There were no lifts, hoists or slings used at the time of inspection; although there was an overhead tracking hoist in place if it should be needed. Everyone within the service was mobile and had wheelchairs, where they were assessed as being needed, for longer distances. There was written evidence that wheelchairs were checked and maintained by the wheelchair services. We looked at documents relating to the servicing of equipment used in the service. These records showed us that service contracts were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems for fire safety, portable electrical items, electrical wiring and the gas system. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the manager and staff. These environmental checks helped to ensure the safety of people who used the service.

We saw that the fire risk assessment for the service was up to date and reviewed yearly. The people who used the service had personal emergency evacuation plans (PEEPs) in place. A PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency. Fire drills were part of the service's emergency plans and were held three times a year. We saw the last recorded drill was in December 2016. These safety measures meant the risk of harm for people and staff was monitored and reduced as much as possible.

We looked at the registered provider's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis. This ensured people would be kept safe, warm and have their care, treatment and support needs met. It had been reviewed in the last year.

We looked at how medicines were managed within the service and checked people's medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. The care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training files. There were no controlled medicines kept within the service and no refrigerated items. However, there were appropriate storage facilities for both types of medicine if needed. There had been three medicine errors in the last year with no adverse effects on people who used the service. The pharmacy supplier carried out an audit of the medicines and stock checks were completed by the staff to ensure safe practices were being followed.

Good

Is the service effective?

Our findings

The service was effective. Observations showed that people got on well with the staff and there were some very positive interactions with a lot of laughter and good humour. People who used the service were interested in what we were doing in the service and we saw staff communicate effectively with them using Makaton signs and gestures.

The manager told us that good communication was a key part of being an effective service. We looked at two care files and saw that the people used communication books devised by the Speech and Language Therapy (SALT) team. These communication aids used pictures and large clear print to help people express their wishes and choices to the staff and others. We saw information in the kitchen area that was both pictorial and easy to read. Other documents such as 'hospital passports were written in a format that people who used the service could understand. Hospital passports were taken with people to hospital or medical appointments. They gave clear information to other health-care professionals about how people wished to be supported with their care, in case they had some difficulty communicating with others.

We were not able to speak with any health-care professionals prior to this inspection. However, we saw evidence of their feedback to the service in recent satisfaction questionnaires. Comments included, "Good discussion with the multi-disciplinary team regarding equipment and best interest meetings" and "Staff are responsive to people's changing needs and wishes."

We looked at induction and training records for two members of staff. These indicated that new staff completed the Care Certificate Induction from Skills for Care and received appropriate training and practice monitoring to ensure they could provide safe care and support. Skills for Care is a nationally recognised training resource. We saw documentation which showed new staff shadowed more senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork.

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff had access to a range of training deemed by the registered provider as 'essential'. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling, Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

Training on specialist subjects linked to people's medical conditions was also completed by staff to ensure they had the knowledge and skills to meet people's needs. Records showed staff participated in training on topics including learning disability, mental health, epilepsy, autism, and Down's Syndrome.

The manager monitored the staff training programme and the development needs of each member of staff. This was discussed during supervision and at staff meetings, so staff had the opportunity to say if they required any additional support. The staff we spoke with said they were very happy with the level of training and support they received.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. We looked at three staff supervision records, which showed that care staff were being supervised by the manager. The staff we spoke with were positive about their supervisions saying, "We have staff supervision about how we work or where we can improve. We get both positive and negative feedback from the manager and this helps us develop as individuals." Staff appraisals were not carried out although the manager said this was being developed. The manager spoke about their progress towards implementing appraisals and how they would take this work further to ensure all staff practice was monitored and reviewed. This would make sure people who used the service received a good standard of care.

The staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and decisions. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans. Observations of people who used the service showed how and when staff used their knowledge to make people's lives better. For example, one person acted in a particular way when anxious or distressed, but staff had found using a distraction technique reassured them and they stopped these behaviours and focused on the object they were given. We saw them happily engaging with staff during our inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Records showed that four people who used the service had a DoLS in place around restricting their freedom of movement. These were kept under review and new applications had been submitted where needed. People who used the service had a voice through the appointment of an advocate who visited regularly. An advocate is someone who supports a person so their views are heard and their rights are upheld.

Information in the care files indicated people who used the service received input from health-care professionals such as their GP, dentist, optician and podiatrist. We saw in care files that care plans were in place for oral mouth care and dental care. People received regular check-ups and staff provided people with support to attend their appointments. Best interest meetings took place when informed choice could not be made by the individual, and included the views of all those involved in the individual's care, including family and health and social care professionals.

Input from specialists such as SALT, dieticians, district nurses, continence nurses, physiotherapists and the community learning disability team was used to develop the person's care plans and any changes to care were updated immediately. Within people's files we found detailed care plans relating to nutrition. These included information about people's likes and dislikes, level of understanding and methods used to encourage independence. There were risk assessments relating to nutrition, choking and swallowing and where appropriate referrals had been made to the dietician or SALT team where necessary.

Discussion with the manager indicated that concerns had been raised about one person's weight in recent

weeks. The staff had recorded a steady weight loss even though the person was eating and drinking regularly. We noted that they had been referred to their GP and were waiting for a hospital appointment for further tests. This showed us people's health and wellbeing was monitored so they remained well and received appropriate care and support.

We saw that people were able to tell staff what they wanted for their meals each day. A menu was developed with them each month and people pointed out their favourite meals. Information on people's likes and dislikes was on display in the kitchen and staff demonstrated a good understanding of any allergies that people had. On the day of our inspection, people had chosen sandwiches and crisps at lunch time and they were having lasagne for their evening meal. People's activity sheets also indicated that they enjoyed going out for a coffee or a meal in the local town and we observed two people going shopping with the staff. We saw that one end of the kitchen had been adapted for wheelchair use so that people could take part in meal preparation if they wanted to; although the people we observed preferred just to watch staff prepare the meal and chat to them as part of their social activities.

Within the service there was promotion of a healthy diet and lifestyle, with visual aids to support people's recognition of different foods. People had access to nutritional specialists including a dietician and healthy eating groups through their GP. Families had commented in a recent satisfaction survey, "Staff have improved [Name's] health through good diet, including them in choice and doing cooking" and "We are pleased with the way that staff have managed [Name's] weight loss through dieting."

Good

Is the service caring?

Our findings

The service was caring and we found the service to be calm and relaxed. We asked people if they enjoyed living at the service and they responded by smiling and nodding their heads. One relative had commented in a recent survey that, "The support workers know [Name] really well and they are obviously happy with the staff."

Observations of the interactions between people and staff showed there was a good level of trust and friendship between them. People were at ease in the service and the conversations being held between them and staff were friendly and relevant to the person's interests. The care being provided was person-centred and focused on providing each person with practical support and motivational prompts to help them maintain their independence. We saw staff explain to people what was going to happen during the day, using appropriate language and giving time for people to process what was being said. Relatives had commented in a recent satisfaction survey, "A regular routine helps [Name] in their daily life. This includes regular activities and trips out."

The manager told us that staff were responsible for the housekeeping tasks within the service as the majority of people who used the service need support to do cleaning or laundry tasks. We saw people were encouraged to help out if they wished and we saw one person helping a member of staff with the hoovering. We could see from the good natured banter and glee on the face of the person who used the service that they thoroughly enjoyed participating.

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. We saw that staff treated people on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in some of the care files. One relative commented in a recent satisfaction survey, "Staff are always caring and put [Name] at the centre of their work."

The four people who used the service had their own bedrooms, which were individually decorated in colours and styles to match each person's choices and preferences. For example, one room reflected the person's taste in music and another reflected the person's love of colour. Relatives had written in the recent survey, "Service is pleasant, clean and [Name's] room has recently been redecorated and has new furniture." We saw that one bedroom window had half frosted panes of glass and staff told us, "[Name] does not like the curtains closed so the frosted glass protects their privacy and modesty."

Care plans included information about the person's lifestyle, including their hobbies and interests and the people who were important to them. We saw that where necessary information was provided in accessible formats, to involve the person in planning their care, using alternative ways of communicating and encouraging choice. This showed that the person and their relatives had been involved in assessments and plans of care. We saw evidence that staff supported people to remain in contact with their families through telephone calls, even those who had difficulty communicating. For one person, the staff rang their family at

an arranged time each week and updated the family member on what their relative had been doing. They then put the person onto the telephone and their family spoke with them about their activities and outings. This family responded in the recent survey saying, "Staff keep us fully in the picture through weekly telephone calls."

Staff respected people's privacy and dignity. We observed how staff promoted people's privacy and dignity during the day by knocking on their bedroom door before entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. People had their own private bedroom and staff respected their wishes to be alone at times during the day and night. We noted that staff addressed people by their preferred name, made eye contact when conversing with them and were always polite and respectful when completing care tasks.

We found that people who used the service were dressed in clean, smart, co-ordinating clothes. Their hair was brushed, finger nails and hands were clean and well cared for and gentlemen were clean shaven (if that was their choice). We were told by staff that people could have a bath or shower whenever they wished and information in the care files and bathing records showed that these usually took place on a daily basis.

There was no-one requiring end of life care at the time of our inspection. However, we saw evidence that work had gone into discussing end of life wishes and choices for people who used the service. The manager told us, "End of life plans ensure care and support in the place the person feels most comfortable and with people who know them well. Supporting best interest decisions, health professionals and families ensure the individual does not have to be admitted to hospital unnecessarily, and reduces stress and anxiety for all, including supporting staff."

Good

Is the service responsive?

Our findings

The service was responsive. People's care plans were extremely detailed and person-centred. Staff used communication books with people to help them express their wishes and choices and these were documented in their care files. Families were also encouraged to input to the care files where people were unable to contribute. Each of the care plans included details of the person's care needs, their wishes and aspirations in the area and any risks related to the need. This meant that people's care profiles included a wide range of information designed to assist staff to support them effectively. When people's needs changed this was clearly recorded.

We were not able to talk with people who used the service about their care plans. However, the staff were knowledgeable about the people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care. People were invited to attend reviews of their care each year with the funding authority and other people involved in their care. Families and advocates were also invited.

We saw that the care plans reflected the care being given to people. For example, moving and handling information documented where a person was independent or used a wheelchair for longer distances. We found that wheelchairs had been obtained, following appropriate assessment, where people had been identified as needing this equipment. Observation of the environment showed that this had been adapted, to reduce risk to people. For example, some doorways had 'finger guards' fitted to prevent fingers becoming trapped when doors shut. This was in response to one person's habit of putting their hands on the door jambs when standing in the doorways. They had a care plan and risk assessment relating to this in their care file.

People were encouraged to maintain their links with families and friends. Care plans were very detailed and descriptive about how communication between individuals could be promoted and strengthened. For one person whose family lived some distance from the service this contact was helped by their having family photographs in their bedroom and staff taking time to speak with them about their family. Families were invited to celebrate special occasions with people who used the service, such as at birthdays and Christmas. Staff also supported people to visit their families using the service's minibus.

People who used the service each had their own personal timetable of activities and outings written for them by the staff and based on each person's preferences, interests and hobbies. We saw that people enjoyed swimming, horse riding, arts and crafts, and going shopping or for meals. Some people attended social clubs each week and we saw that the manager used flexible staffing hours to enable these activities to take place.

We saw that activities took place as recorded in the timetables for the day of our inspection. Those people who stayed at home, enjoyed listening to music, watching television, playing cards and chatting with staff. Everyone was engaged in an activity, but had the opportunity to just sit and relax in the comfort of their own home. One relative had commented in the recent survey, "There is a person-centred programme of

activities" and "[Name] is happy and settled."

People had access to a copy of the registered provider's complaints policy and procedure in a format suitable for them to read and understand. We looked at the complaints folder and saw that no complaints had been made in the last year, but four compliments had been received from families of people who used the service.

We saw evidence during our inspection that the manager was in daily contact with people who used the service and was available to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

Good

Is the service well-led?

Our findings

There was no registered manager for the service, but the day after our inspection CQC received a registered manager application from the registered provider. The manager of the service had worked there since November 2014 and had taken over the role of manager in 2016.

We found the service had a welcoming and friendly atmosphere. Staff said the culture of the service was open, transparent and the manager sought ideas and suggestions on how care and practice could be improved. The manager was described as being open and friendly and there was an open door policy as far as they were concerned.

Our observation of the service was that it was well run and that people who used the service were treated with respect and in a professional manner. We asked the manager what their view was on the culture of the service. They told us, "It is about enabling [people who used the service] to develop their independence and skills. It is my role to see that they achieve their goals and ambitions by offering them the right support and care."

We sent the registered provider a provider information return (PIR) that required completion and return to CQC by December 2016. This was completed and returned with the given timescales.

Staff spoke positively of the manager and told us they felt well supported. Comments included, "I get on well with the manager, they are really approachable." Another said, "I can go to the manager and assistant manager with anything, they are really supportive."

Staff said that they were not asked to do tasks they were not confident about completing. The staff training plan showed that all care staff completed essential training and then went on to undertake more specialist training and vocational training courses such as diplomas in health and social care to further develop their knowledge. This demonstrated that people were looked after by well trained and knowledgeable staff, who were confident and capable of meeting their needs.

Feedback from people who used the service, relatives, health-care professionals and staff was usually obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. The most recent survey took place in September 2016 and relatives had commented, "The management is very good" and "The service provides effective support for everyone." Four families had responded to the survey and all had rated the service as 'good' or 'outstanding'. The most recent staff meetings took place in February 2017 and January 2017. Subjects discussed included training, health and safety issues, quality assurance and feedback from previous meetings. This demonstrated that staff were able to talk about practices within the service and looked at where these could improve to make the service more effective and safe for the people living there.

We saw that the manager monitored and analysed risks within the service and reported on these to the

registered provider. The manager carried out audits of the systems and practices to assess the quality of the service, which were then used to make improvements. The manager told us that changes to how audits were undertaken was in progress. Moving forward in 2017 the registered provider wanted all managers to visit different services and carry out the quality assurance checks to make sure all the services were complying with the regulations.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.