Ashgables House Limited

Ashgables House

Inspection report

Oak Lodge Close
Chippenham
Wiltshire
SN15 1NG

Tel: 01249658498
Website: www.alliedcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 and 7 July 2017 and was unannounced on the first day.

Ashgables is a residential home providing care, rehabilitation and support for up to 26 people with mental health needs and learning disabilities.

At this inspection there were 24 people living at the service.

At the last inspection, the service was rated Requires Improvement. We found improvement had been made at this inspection.

The service had a new manager in post. They were going through the registration process to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of the inspection staff were relaxed, and there was a calm, quiet atmosphere. Staff had a clear roles within the service. Information we requested was supplied promptly, records were organised, clear, easy to follow and comprehensive.

People's medicines were not always managed safely. People received their medicines as prescribed, received them on time and understood what they were for however, the service's policy did not reflect practice at the service and audits were not robust and in line with best practice. Records relating to skin cream required improvement. We also found the systems in place to monitor the use of medicines which require additional storage needed to be more robust. The service acted promptly to make changes to ensure medicine management was in line with best practice. We issued a recommendation in this area.

People were supported by staff that were knowledgeable about the Mental Capacity Act (2005), which ensured they were involved in decisions about their care and their rights were respected. The service followed their processes which protected people's human rights and liberty. However, records required clarity. The records shown showed the staff had not followed the principles of the MCA and made appropriate applications to restrict people's liberty from the assessments of capacity."

People were comfortable with staff supporting them and we observed positive interactions. Care records were in date and personalised. Staff responded quickly when they noted changes to people's mental or physical well-being contacting the appropriate health professionals for example people's mental health nurses. People or where appropriate those who mattered to them, were involved in discussions of care needs and how they would like to be supported. People's preferences for care and treatment were identified and respected.

Staff exhibited a kind and compassionate attitude towards people. Positive, caring relationships had been developed and practice was person focused and not task led. Staff had appreciation of how to respect people's individual needs around their privacy and dignity.

People's risks were managed well and monitored. People were promoted and encouraged to live full and active lives. Staff were thoughtful in finding ways to overcome obstacles that restricted people's independence.

People were supported to maintain good health through regular access to health and social care professionals, such as GPs, mental health nurses, social workers, occupational therapists and physiotherapists.

People we observed were safe and told us they felt safe living at Ashgables. The environment was uncluttered and clear for people to move freely around the home. All staff had undertaken training on safeguarding vulnerable adults from abuse, they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Regular fire tests and checks occurred and personal evacuation plans were in place.

People were protected by the service's safe recruitment practices. Staff underwent the necessary checks which determined they were suitable to work with vulnerable adults, before they started their employment. People were supported by a staff team that had received a comprehensive induction programme, training for mental health conditions and ongoing support from the management team. Supervision and staff meetings were in place. Staff told us they felt listened too. Staff were aware of the whistleblowing policy should they require this.

The service had a policy and procedure in place for dealing with any concerns or complaints. The management team had responded to minor concerns in a timely way.

People described the management to be supportive and approachable. Staff talked positively about their jobs. The manager was supported by an assistant manager, deputy manager and an operations manager for the company.

There were effective quality assurance systems in place. New auditing processes for medicines were implemented during the inspection period. Incidents were appropriately recorded and analysed from trends. Learning from incidents and concerns raised was used to help drive improvements. The management team took inspection feedback seriously and acted upon our recommendations and findings to further enhance the quality of care.

We made recommendations that the service review their medicine practice in line with best practice and review their policies and procedures in line with the Mental Capacity Act Code of Practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were supported with their medicines in a safe way by staff who had appropriate training. However, robust policies, audits and checks were not in place at the time of the inspection to ensure all aspects of medicine management were safe.

People benefitted from support from enough skilled staff, who knew their needs well and who met their needs in a timely way.

People benefitted from well maintained and equipped accommodation in a homely environment.

People were protected from the risk of harm or abuse whilst independence was promoted in a balanced way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People and/or their representatives were involved in their care and people were cared for in accordance with their preferences and choices. However, people's capacity to consent was not always well documented and the Mental Capacity Code of practice well understood by the staff. Records showed some people had deprivation of liberty applications made but we were advised they had capacity to consent to their care.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining

people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which was responsive to their changing needs and met people's social and leisure needs.

People made choices about aspects of their day to day lives.

People and/or their representatives were involved in planning and reviewing their care.

People and/or their representatives shared their views on the care they received and on the home more generally.

People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Good

The service was well led.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

The service took account of inspection feedback and sought timely advice from relevant health professionals and used various resources to improve care.

There was an honest and open culture within the staff team who felt well supported by management and the provider.

People benefitted from a well organised home with clear lines of accountability and responsibility within the management team.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Ashgables 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.

The inspection took place on the 6 and 7 July 2017. The first day of the inspection was unannounced and undertaken by one adult social care inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

Prior to the inspection, we asked the provider to complete a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information as part of the inspection.
During the inspection we spoke with we spoke with 13 people at the service, eight staff members including the assistant manager and operations manager. Following the inspection we spoke with the manager.

We looked at seven records related to people's individual care needs and discussed the care and support other people at the service received. These included support plans and risk assessments. We also looked at records related to the administration of medicine, training records, four staff recruitment files and policies and procedures. We reviewed the quality assurances processes in place at the service and feedback people had provided.

We left details for other people, relatives or staff to contact us if they wished during the inspection period. No staff made further contact.

Requires Improvement

Is the service safe?

Our findings

We found a number of minor areas where medicine management could be improved. The medicine policy required updating to reflect the current procedures being followed by the staff. The record of staff who were able to administer medicines was not current as it included the name of the previous registered manager and two other staff who had left. The deputy manager told us "I need to update that." Regular audits of daily medicines took place by staff but this did not include medicines which required additional security. We found the clinical room to be warmer than recommended but it was an unusually hot day. The clinical room temperature on one unit (known as unit one and two) was 26.5 degrees. Later in the day this had risen to 27.5. The clinical room at the second unit (unit three)was at the acceptable temperature of 25 degrees. This over a prolonged period could affect the efficiency of some medicines. Some people were prescribed skin creams. We found there were no body maps on the location of the body where the topical creams were to be applied within MAR file or in people's rooms. The service took action following our feedback and skin cream charts and body maps were put in place immediately. Audits were commenced to include all medicines following the inspection.

We recommend the service reviews their medicine management processes in line with NICE (National Institute for clinical Excellence) guidelines.

Apart from the minor issues above, medicines were administered consistently and safely. People were not on medicines administered without their knowledge covert. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines.

Annual staff competency checks were conducted and the deputy manager told us "I won't let them do medicines till they're competent to do it." We observed the deputy manager administering medicines at lunchtime. This was carried out safely and proficiently. We looked at medicines administration records (MAR) and, we noted all had been correctly completed. We saw that when required (PRN) protocols were in place to provide guidance on the administration of 'as required' medicines. For example, a person's protocol for Paracetamol 500mg was one to two tablets PRN and stated "[the person] is able to tell staff when she is unwell or has a headache. She will always ask staff". We saw that people had individual PRN medicines. Medicines were ordered on a 28 day cycle via a local pharmacy. Individual prescription medicines were provided in personal colour coded 'biodose' system containers. These were organised in individual trays according to time of administration and included liquids as well as solid oral medicines. We saw that, when people were prescribed medicines that required special precautions such as insulin, lithium carbonate and clozapine, these were monitored by health professionals. We saw that the service recorded the disposal (returned/ destroyed) of medicines via the pharmacy. MAR charts included a photograph and administration times for medicines. We saw that a person's allergy was noted on their MAR chart.

Accidents and incidents were recorded and reviewed for trends by the manager. We noted that body maps were not always completed when there had been an injury or bruise. The operations manager told us these had previously been in place and they would ensure they were completed following the inspection.

People were supported by sufficient numbers of staff to keep them safe. The manager regularly reviewed the staffing levels, so that people received reliable and consistent care, and to help ensure staff could be flexible around people's needs, appointments and activities. During the inspection in addition to support staff, there were two cooks, housekeeping staff and a maintenance staff. Staff appeared unhurried and relaxed in their work.

Some staff told us there had been staff shortages in recent months due to staff sickness and vacancies. Staff had worked together at these times to meet people's needs. The assistant manager advised recruitment was ongoing to ensure people's needs were met. In the event of staff sickness agency staff were used and the new manager was working on developing a "bank" of regular staff to call upon as needed.

Some staff raised some concerns with us about their safety and ability to call for help if there were an incident with some people. Staff felt there were some people who posed a risk at times and could be unpredictable. Staff told us if they required support they would need to use people's call bells in their rooms to summon assistance. Some staff said they had alarms but did not use them and they were worried they would not be heard in the other units or if they were in secluded areas of the service. During the inspection feedback we spoke with the operations manager about the staffing skill mix across two units at the service. This was because the staffing levels on a unit for eight people was two staff on duty and it was documented that some people at times exhibited behaviours which meant female staff should not be left alone with some people. During the inspection we noted when one staff was busy providing support or personal care to others in this unit, female staff were left alone. We raised these points with the operations manager for discussion with the manager on their return from annual leave. Following the inspection the manager contacted us and advised staff safety was on her action plan."

People we spoke with confirmed they were safe and well treated, "Yes, I feel safe here; if anyone was unkind I'd tell the staff; everyone is kind though." People were kept safe by staff who understood what keeping safe meant and how to support people to remain safe at Ashgables and within the community.

Staff we spoke with were aware of people's vulnerabilities, they told us they closely observed people and monitored for signs of financial exploitation and bullying and harassment within the service. Staff had completed safeguarding training and were clear on the internal and external reporting procedures. Staff told us they had undertaken safeguarding of vulnerable adults from abuse training and this was updated regularly. One staff member commented, "Usually we refresh after one year". Staff told us the different types of abuse, and their responsibility to report and record any concerns promptly. A member of staff said "It can be physical abuse, emotional abuse."

People had their own bank accounts or were supported with their finances through the Court of Protection. The staff also helped people to manage their money if they wished. People told us this helped them manage money for tobacco and outings. Safe procedures were in place to ensure incoming and outgoing money was recorded.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. Staff we spoke with confirmed these checks had been completed before they were able to start work.

People were supported by staff who understood and managed risk effectively. Risk management plans

recorded concerns and noted actions required to address risk and maintain people's independence. For example some people needed staff support when visiting the local shops due to poor road safety awareness, other people's mental health needs meant they could be vulnerable to other's when out. These people were supported by staff to ensure their safety. Staff ensured the environment was safe to enable people's safety, for example many people smoked. Fire risk assessments were in place for these people and everyone was encouraged to smoke outside the building.

Risk assessments highlighted where people were at risk of behaviours associated to their mental health needs. Staff knew the plans in place for each person to mitigate these risks and when to involve people's health and social care professionals. For example staff were aware of those who might have verbal outbursts when unsettled and who could be aggressive. Staff knew people well, their potential triggers and were skilled at de-escalation and distraction skills. Where people's health deteriorated some people were at risk of falls and the staff were proactive and considered equipment such as walking aids to reduce the likelihood of falls.

The equipment in the service was well maintained. Regular, weekly fire alarm checks took place. People had personal evacuation plans in place in the event of an emergency. Information to staff and emergencies about people on safe evacuation which might be required in an emergency was kept by the manager. 80% of staff had received fire training and an external fire visit had occurred in June 2017. Further fire training was booked for November 2017.

All areas of the home were clean. Although people were encouraged to keep their own rooms clean, staff supported them when they found this difficult. There was ample personal protective equipment around the service for staff to help prevent cross infection and staff knew the precautions to take in the event of a sickness bug at the service.

Requires Improvement

Is the service effective?

Our findings

Most people had capacity to make their own decisions at Ashgables House. Staff involved people in their care decisions and enabled them to make their own choices about their care. However, we found there was confusion amongst staff about people's capacity and there was not always clear, written evidence of consent to areas such as bed rails which could be seen as restrictive. When people's mental health deteriorated and affected their capacity to make decisions, staff contacted health care professionals in order for an assessment under the Mental Capacity Act or Mental Health Act 1983.

The Mental Capacity Act (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. We saw a good example about how one person's mental health meant there were periods where they required staff to care for them in their best interests as they lacked capacity to make specific decisions during these periods. This person with the support of the staff and mental health team had developed a comprehensive care plan on how they were to be supported when there was deterioration in their mental health.

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 were concerned staff were not sure who was subject to a DoLS in the absence of the manager. This meant staff would not know what restrictions were in place for people. We also noted many people had an application submitted to the supervisory body by the previous manager but staff told us they felt they had capacity. DoLS are only applicable to people who do not have capacity to consent to their care and treatment. We spoke to the new manager about this who was reviewing people's care needs.

We recommend the service sources Mental Capacity Act training for staff and reviews their policies and procedures in line with the Mental Capacity Act Code of Practice.

People were supported by well trained staff who met their health and social care needs. The provider (Ashgables House Limited) had an essential training programme which staff were required to complete. Additional training was provided for staff to enable them to support people's complex mental health needs. The management team and provider closely monitored staff training to ensure it remained in date. Staff told us they had completed a range of training including, "Mental health awareness, health and safety, food hygiene, nutrition and hydration, lone working, mental capacity and first aid." Other staff said, "I've done loads of training." Staff confirmed mandatory training was set by the provider and was monitored by the management. Following the last inspection staff had also undertaken training in person centred choice and care and dignity. Staff had received training in areas to meet people's specific needs for example stoma training and epilepsy.

Staff received a thorough induction programme, which included shadowing experienced staff when they started with the provider. The manager monitored staff progress through regular supervision (one to one meetings) to ensure they were confident in their role. Newly appointed staff where necessary, completed the Care Certificate recommended following the 'Cavendish Review'. The outcome of the review was to improve consistency in the training health care assistants and support workers received in social care settings.

Formal and informal supervision with their line manager took place to support good practice and support staff. The manager observed care and interactions between staff and people regularly and was quick to discuss any shortfalls with staff promptly.

People where appropriate, were supported to have sufficient amounts to eat and drink. During the inspection there was a heat wave. People were frequently offered drinks to help them avoid dehydration and stay cool. People told us the food was good and there were choices available if people didn't like the main meal. Although staff encouraged people to join in with cooking to develop their culinary skills if they wished, the kitchen staff did the majority of the cooking.

Some people were prone to weight gain due to the prescribed medicines and staff educated and prompted people to follow healthy diets whilst respectful that some people chose otherwise. "Some people required a special diet due to their health needs, these needs were clearly recorded in people's care plans and staff knew the diets people should be following and which food people needed to avoid.

Records showed how staff either made a referral or advised people to seek relevant healthcare services when changes to health or wellbeing had been identified. Care records evidenced where health and social care professionals had been contacted. People told us they had seen their doctor when physically unwell and when they had contact with mental health nurses. The staff supported people to attend appointments if this was required. Several people had regular intramuscular injections of long acting antipsychotic medication. These were given at a local health centre or at the home by the community mental health nurse, who visited during our inspection.

Good

Is the service caring?

Our findings

At the last inspection in May 2016 we found people were not always treated with dignity and respect. The provider sent us an action plan advising us how they would address these concerns. We found improvement had been made.

Following the previous inspection staff had received training in "person centred care and choice". Dignity and person centred care had been discussed in staff meetings and with staff during one to one supervisions. Care plans had been updated so they were more person centred and reflected people's choices, likes and dislikes. The new manager had signed up to be a "Dignity champion" (A Dignity Champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate, person centred, as well as efficient, and are willing to try to do something to achieve this) and was keen to embed dignity and respect into the culture at Ashgables.

People were well cared for by staff that had a caring attitude and treated them with kindness. People told us, "I do like living here, I get on with staff, they help me"; "They let me know when I need a shower and need to change my clothes – I don't like showers"; "I like it here, the staff are nice and compliant." Another person said, "Staff are caring; they help us do breakfast, check how we are doing, remembered my birthday."

A mental health nurse told us, "I have always found the staff to be caring, friendly and work well with a difficult group of clients. They appear to respond to client's needs. The clients who I have dealings with have always appeared happy and content with their care."

Equality and diversity was understood by staff and people's strengths and abilities valued. People who lived at Ashgables had a variety of different backgrounds, experiences and health needs. Staff worked with people in a non-judgmental manner, with respect and with great understanding of their complexities.

Staff had genuine concern for people's wellbeing, they worked together to ensure people received good outcomes and had the best quality of life possible. Staff commented that they cared about the support they gave, and explained the importance of adopting a caring approach and making people feel they mattered. Staff spoke of people with fondness wanting them to receive care like one of their family members.

Staff took time to get to know people by reading their care records, talking to their family, health and social care professionals and discussing people with the team. Therapeutic relationships with people were fostered because staff invested time in people. They nurtured and paid attention to people. Staff knew people well and their particular mannerisms which might mean they were distressed, anxious or unwell. They took prompt action to address what might be causing someone's anxiety for example, by providing one to one time with people.

People's privacy and dignity were respected; people were encouraged to be as independent as possible. People told us staff knocked on their doors before entering and they were able to lock their rooms.

People's independence was valued and encouraged. Staff encouraged people to develop and maintain skills to enhance their abilities to self-care. For example some people did their own tidying of their bedroom and helped with household chores. This helped people's confidence and self-esteem.

People were proactively supported to express their views as far as possible. Staff gave people time, and were skilled at giving people explanations and the information they needed to make decisions. Once decisions had been made, staff acted upon them to help ensure people's views were listened too and respected.

Advocacy support services were available for people if needed, for example when considering moving on to different services. Staff at the service also advocated for people ensuring their views and wishes were listened too.

People's birthdays and special occasions were celebrated. During the inspection a birthday party was held for one person.

Good

Is the service responsive?

Our findings

At the previous inspection in May 2016 we found care plans lacked detail and guidance on how to support people with specific conditions. At this inspection we found care plans were more detailed and gave staff clear guidance on how to care for people with specific needs such as epilepsy. We also noted the new manager was reviewing people's care plans.

People received consistent personalised care, treatment and support. Once the service agreed to support a person, an initial assessment took place. Staff made every effort to empower the person to be actively involved in the whole process. Information was gathered about the person's medical history and life. People were supported to move to Ashgables at a pace which was right for them.

People and health professionals where possible, were involved in planning their ongoing care and making regular daily decisions about how their needs were met. Each person had individualised care plans that reflected their needs, choices and preferences, and gave detailed guidance to staff on how to make sure personalised care was provided. For example one care plan we reviewed said, "(X) loves to read books, write letters, listen to music and enjoys going out for meals." They shared with us these were some of their hobbies when we spoke with them. The family, professionals and other people who mattered to people were known and people's goals/aspirations and interests were considered. We spoke to the operations manager about developing this area further to evidence the outcomes people achieved.

People's changes in care needs were identified promptly and with the involvement of the individual, family and professionals as required. Plans were then updated, monitored regularly and put into practice by staff and regularly monitored. Regular staff handovers and staff discussions shared important changes to people's care. This meant staff knew what had changed and how to support people as they required.

People were protected from the risk of social isolation and staff recognised the importance of companionship and keeping relationships with those who mattered to them. People were supported to see their family and some had made friendships in the service. People were encouraged to maintain hobbies and interests but some people had symptoms which meant they lacked motivation to see plans through.

The service employed activity co-ordinators and there was an activity hut in the grounds of Ashgables, this was called "Creative Corner". During the inspection a group of people were enjoying painting and chatting. We were also shown a new vegetable garden and plans for a gardening club were being discussed. Staff told us they hoped people could make their own chutneys. A variety of events were on offer for people including a cooking club, a special Olympics day, trips out to the park and local attractions and we saw some people had holidays planned. During the inspection many people were enjoying the outside areas in the warm weather. We saw staff throughout the inspection checking if people wanted a fan, had sun cream on and being asked if they wanted an ice lolly to help them stay cool.

The service had a policy and procedure in place for dealing with any concerns or complaints. People's behaviour was monitored through observation for any changes which might mean they had concerns.

People told us they would feel comfortable talking to staff about any complaints. Complaints made to the service had been appropriately investigated by the manager and feedback received by the complainant.

Good

Is the service well-led?

Our findings

Since the previous inspection a new manager had started work at the service. They had been in post a few months and were going through the Commission's registered person process. The manager was supported by the operations manager for the provider, an assistant manager, a deputy manager and team leaders. People and staff, without exception, all described the new manager of the service to be approachable. We observed that they knew people well and were happy to work alongside staff with in the service.

There was a positive culture within the service. Ashgables was warm, welcoming and friendly whilst providing clear boundaries to ensure the service was safe for everyone. The website said, "The key objective is to assist residents in building the self-confidence that will enable them to live an enjoyable and satisfying life."

Feedback was sought from people where possible and those who mattered to them, and staff, in order to enhance the service. Questionnaires had been distributed that encouraged people to be involved and raise ideas that could be implemented into practice. Resident meetings occurred to seek people's views of the service and keep them updated on changes.

The management team told us they and the staff were continually looking to find ways to enhance the service they provided. Management and staff meetings were held where staff were updated on information within the house such as maintenance, repair and decoration.

The service worked in partnership with key organisations to support care provision particularly mental health services and people's funding authorities. Good working relationships had been fostered with local doctors, the local community mental health teams and social workers.

The manager and provider created an open, honest culture. They were aware of what they could and could not do, where improvement was needed and learned from feedback and situations they had experienced. This reflected on the Duty of Candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The manager and provider encouraged staff to provide a quality service. Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a high standard of care.

The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff received this at the start of their employment with the company.

There was an effective quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised.