Interserve Healthcare Limited

Interserve Healthcare Liverpool

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 9 and 11 October 2018. The inspection was announced.

Interserve Healthcare Liverpool is a domiciliary care agency providing nursing and personal care to adults and children in their own homes. At the time of the inspection the service was directly managing the provision of care to 12 adults and 14 children.

The service had a registered manager. A registered manager is a person who has registered with CQC 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.

The service had since our last inspection merged with another branch and now also provided care services to people in the Lancashire and Fylde area.

During the previous inspection we found the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were placed at risk of receiving unsafe care as some care plans were lacking in detail.

During this inspection we found the service had made the necessary improvements. Staff had added more detail to care plans. The branch had introduced a review of care plans as a team, to ensure the information was clear to all readers. We discussed with the branch nurse and registered manager that aspects of people's 'as required' medicines would benefit from a similar review to ensure clarity.

During the inspection we were given access to the electronic records relating to the service which included evidence of quality audits.

As part of our inspection we checked three people's medication administration records (MAR). We found that staff had sent completed MAR for review by nurses. However, two people's MAR we checked had not been reviewed until several months after completion. An audit had identified some outstanding records, but actions had not been completed when we inspected.

We have made a recommendation regarding the service's keeping and auditing of records.

People and relatives we spoke with told us they overall had no concerns and had confidence in the staff providing care. A person and a relative we spoke to were concerned about arrangements, if their current staff should become unavailable. The registered manager was able to tell us about their contingency plans.

Staff we spoke with had no concerns about the service. Staff explained to us their role and responsibilities regarding safeguarding people who used the service. Staff were confident that any concerns they had would

be dealt with by branch staff and the registered manager. The registered manager managed accidents and incidents appropriately.

The service had two dedicated care coordinators ensuring the safe recruitment of staff. Branch staff planned who would provide care to people months in advance, to help identify gaps. This identified vacancies which the provider was recruiting for when we inspected. The provider had effective recruitment, supervision and training processes in place to ensure the staff were safely able to support people using the service.

Care plans showed the service always sought people's consent before providing support. Staff were knowledgeable about the Mental Capacity Act. The registered manager had written to social workers where a person using the service had transitioned from child to adult services, to ensure the appropriate authorisations were sought.

The service worked with other health professionals to provide effective care for people. We saw that professionals from hospitals had been involved in writing specific care plans for people.

Staff we spoke with talked about people who used the service in a caring way, showing understanding and knowledge of things important to people. People and relatives we spoke with told us about the caring, engaging nature of the regular staff teams.

Relatives told us they were involved in the planning of their loved one's care. Branch nurses regularly visited people to review and reassess their needs. Spot checks focused on the interactions staff had with people, to ensure staff provided kind, quality care.

People and relatives told us they knew how to make a complaint. The service carried out quarterly surveys. The registered manager had responded to people's comments to let them know how they would improve.

We saw that the service recorded complaints, but also conversations about improvement needs, to ensure they were followed up.

The registered manager was supported by a management team with responsibility for assessment, development of care plans, staff coordination and contact with people who used the service. The provider's quality specialists completed regular audits and provided additional oversight of the service.

Staff we spoke with told us that they were happy in their jobs and that managerial staff based at the branch quickly helped them with any problems. The registered manager was introducing teleconferences for staff to dial into, to include more staff in team meetings.

Care plans promoted a culture of care that was dignified and respectful. Staff were knowledgeable about people's different communication needs and the service used an interpreter for example to make information accessible for relatives.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding the service.
Ratings from the last comprehensive inspection were on display as required.

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.

Staff were clear about their responsibilities to safeguard people and protect them from preventable risk.

People we spoke with had no concerns about the service except for some uncertainty about staffing. The service was addressing this.

Staff recruitment was robust. The service planned care for people well in advance and was recruiting additional staff to fill any gaps.

Records we viewed showed staff managed people's medicines safely. 'As required' medicine instructions and processes around MAR reviews needed reconsideration.

Is the service effective?

Good

The service was effective

Staff had the skills and knowledge to care for people with complex health needs effectively.

Care staff felt well supported by staff in the office. Branch staff had focused on building a good rapport with field staff.

The service worked in line with principles of the Mental Capacity Act 2005. The registered manager was working with the local authority to apply for appropriate authorisations.

Staff supported people to eat and drink well. The service was working effectively with other health professionals to plan care for people's complex needs.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly about their staff teams and their caring approach.

Staff spoke warmly about people who used the service and were knowledgeable about what was important to people they cared for.

Care plans evidenced a focus on dignified approaches that respected people's privacy and independence.

People and their relatives were involved in decisions over their care.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and linked to ongoing assessments to remain up-to-date and were regularly reviewed.

The service conducted quarterly surveys and findings led to improvements.

People and relatives told us they knew how to complain. The service encouraged people to speak to any branch staff member about their concerns.

Staff were knowledgeable about people's different communication needs and their responsibility to make information accessible.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Record checks to identify potential issues were at times delayed. Audits took place but did not always lead to timely corrective actions.

A registered manager was in post. The registered manager was exploring creative ways to involve staff in team meetings, to increase attendance.

People were involved in the development of the service. The service communicated consistently with people. Branch nurses met with people regularly to discuss any concerns.

Staff supported people's diverse needs respectfully, to promote the open and inclusive culture of the service.

Interserve Healthcare Liverpool

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 9 and 11 October and was announced. The registered provider was given 48 hours' notice because we needed to be sure that someone would be available at the office. The inspection was conducted by one adult social care inspector.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

The provider had submitted a provider information return (PIR) with information about the service and feedback from CQC' questionnaires. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, a client manager, a branch nurse, a care coordinator, a care assistant and a renal technician who had worked for the provider for a long time in different roles.

We also spoke with three people who used the service and two relatives. In the report we talk about "branch staff" and "field staff". "Branch staff" were based at the service's central office in Liverpool. They reached out from there to provide support to people who used the service, relatives and staff, by phone, email or in person. "Field staff" were care professionals and nurses who directly provided personal and nursing care to

people in their own homes.

We looked at the care records of four people receiving support from the service, four staff recruitment records, medicine administration records (MAR) and other records relevant to the quality monitoring of the service.

Good

Is the service safe?

Our findings

People using the service and relatives we spoke with told us that they had no concerns about the regular staff that came to provide care. Comments we received included, "Everything is fine at the moment, I have no worries" and "I feel a lot safer when [staff member] is here".

A relative and a person using the service told us their only concern was about the service's back-up plans for staff support. We heard from a relative that service had not always been able to cover some shifts when staff became unavailable at short notice. However, the relative also told us that the service tried to accommodate their requests for care at short notice whenever possible.

Staff providing care for people with complex health needs required specific training and competency assessments. This meant a back-up plan was needed if the regular and competent staff became unavailable at short notice. The registered manager and branch nurse were addressing this and explained their plans to us. They showed us evidence that they had discussed this with people who used the service.

The service planned care shift cover for people three months in advance to identify any gaps. A competent nurse was available as back-up if none of the regular staff or appropriate agency staff were available. The service checked for us and in the month leading up to our inspection there were a small number of shifts they had been unable to cover. The service identified "must cover" shifts as those for people who absolutely depended on the health care provided, for whom no other person such as a relative was available.

The service used an overview board to identify where they needed more staff going forward, or where they often had difficulty finding cover. The service used this information to recruit more staff.

A staff member who had been with the provider for many years told us about staffing levels, "In the [care] packages I have been on we have been really good, we get a good team going. [Previously] there were some complications with [care] packages, staff left and the company found it hard to train a new person up. They have a couple of floating people trained up [now]. Most of ours are complex care, [and for those we] need to have specialist training in place."

We found that the recruitment of staff was robust. Care coordinators had completed relevant checks to ensure new staff were suitable to work with people who used the service. Before starting their "shadow shifts" alongside experienced staff, new starters had a "meet and greet" with people who used the service and relatives. This helped to ensure they were a good match for the needs of people who used the service and their families.

Staff we spoke with had no concerns about the service. Staff were clear about their responsibilities to keep people safe in their roles and were knowledgeable about safeguarding procedures. All staff we spoke with told us they had full confidence in branch staff and the registered manager acting on any concerns they may have.

A staff member said, "We get straight on to the office who are really good at helping us. They give us lots of support." Staff said they would feel confident to whistle-blow to other organisations, such as the local authority or CQC, if their concerns had not been listened to by the provider. A staff member said, "I would, because the safety of my clients is the most important to me."

Care plans and risk assessments were detailed. We found the service had improved information to keep people safe, for example for those who at times had epileptic seizures. There were clear descriptions of what different types of seizures usually looked like for the individual. There were also supporting images, for example to show recovery positions.

In people's care plans we saw that the service ensured equipment in use, such as hoists or specialist beds, had been checked for safety by contractors.

People and relatives told us they trusted their regular staff. The service relied on field staff informing branch staff if there were any incidents or issues. We found that staff had done so. It was good to find a culture that promoted trust and honesty across the service. We discussed with the registered manager additional or more regular checks. We considered these would strengthen prevention and accountability as part of good safeguarding practice.

The service relied on staff informing them of medicines errors as soon as possible and we saw examples where this had happened. Communication between staff providing care to people and office support staff was effective in these examples. We asked about reviews of medication administration records (MAR). We considered these further under the question whether the service was well-led.

We sampled three people's medication administration records (MAR) and found that staff had signed them appropriately. A relative told us about their confidence in staff to give medicines correctly. A person using the service said, "I always get my medicines on time."

We spoke to the branch nurse about protocols and records for people's 'as required' medicines. We asked them to clarify and review a person's 'as required' medicine, as staff had recorded giving the person one of their available doses every day.

People had care plans around their medicines. We considered that some 'as required' medicines guidance needed to be more detailed. We suggested that these plans could be part of the branch's review to ensure care plan information was clear to all readers. This was to ensure that staff who were just getting to know people had all the information they needed to give all medicines at the right time.

Staff received medication training when they commenced their employment and were assessed to be competent before giving people their medicines, and this was reassessed annually. For people that needed a more specialised route of medicine administration, staff received specific training and competency assessment to ensure safe practice.

The registered manager recorded all accidents and incidents, including concerns or complaints, on an electronic system. Staff knew the processes around accidents or incidents. The registered manager categorised the severity of the event, then noted any actions taken. The information was then used to check for any underlying causes and to ensure lessons were learned to help prevent incidents or accidents from happening again.

Staff explained their responsibilities regarding good infection control to us. Staff made this personal by

telling us how poor infection control would affect the person they were providing care to. Staff confirmed there was always plenty of personal protective equipment available, such as gloves or aprons.

Good

Is the service effective?

Our findings

We asked people who used the service and relatives whether staff had the right skills and training to meet their needs or those of their family member. Everyone we spoke with felt staff were competent.

A person using the service told us, "Absolutely, I cannot fault them at all! I am very, very happy with them." A relative told us, "We have a fantastic staff team of three at the moment, they are brilliant."

Another relative told us they expected a very high standard of care and they had worked closely with the service and staff to achieve this. They told us they had confidence in the skills of their regular staff team. The relative said, "I quite like the fact they stay abreast with nursing competencies. There is always a nurse on-call to give advice."

Training and competency assessments were in place to help staff meet people's care and health needs. Training completion by staff in the service was very high with 99% of employees having completed all their assigned learning. The branch nurse identified at assessment stage whether more specific training was needed for staff to be able to provide care effectively.

The service required new staff to have at least six months previous experience in health and social care. This meant there was no expectation for the service to support staff to complete the Care Certificate, which is a recommended induction standard.

However, the service followed the principles of the Care Certificate and ensured staff had a comprehensive induction into their role. In addition to this, they received specific and person-centred training based on the needs of individuals whose care teams they had been assigned to.

A staff member told us, "Once I had had my meet and greet with my client and their family and we agreed it was a good match, I shadowed the experienced staff. They had worked with the client for a long time and showed me everything I needed to know. They were so helpful."

Staff felt well supported in their role. Staff received formal supervision every three months and a yearly appraisal. Staff told us they could always speak to managers if they needed additional support.

Staff gave us examples of such support. For example, one staff member had an acute health concern about the wellbeing of a person. They told us the branch staff had been brilliant at giving clear direction to maintain the wellbeing of the person using the service, staff and others.

Another staff member told us about the branch nurse's response to a health concerns they had raised, "They came out straightaway and put a [health matter] care plan into place."

Staff also gave us examples of how they recognised changing health needs for people and worked with other professionals to address them effectively. We saw the service had worked in partnership with hospitals

for example to develop specific and detailed care plans to support people's wellbeing.

A person we spoke with explained to us how staff were competent to look after their very specific health needs.

People had care plans for staff to support them to eat and drink well. We saw clear guidance for staff how to support the needs of a person with diet controlled diabetes for example. There were clear recommendations and tips how to support the person to eat well with helpful examples. We saw that staff completed relevant records to document their support to the person around this.

Staff we spoke with were knowledgeable about the Mental Capacity Act 2005 and how this affected their work.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The service was working within the principles of the MCA. Branch nurses reviewed people's needs under the MCA as part of regular reassessments. The registered manager showed us an example of letters she had sent to people's social workers. This was to ensure appropriate authorisations were sought where people had transitioned from children's to adults' services. For community based services these authorisations need to be applied for by the local authority to the court of protection.

In care plans we saw clear directions to staff to use least restrictive options and not to use potentially restrictive equipment, such as bedrails, without appropriate consent. We saw an example whereby the service had documented the person's verbal consent clearly, but staff had to sign for the person as they could not do this themselves.

We asked people who used the service whether staff always sought their consent before providing care. One person said, "Yes absolutely, they always check", another told us, "Staff always ask for my consent."

Good

Is the service caring?

Our findings

All of the people who used the service and relatives we spoke with told us that staff were kind and caring.

One person told us, "They look after me really well. [Staff name] particularly is very, very good." They told us that the staff member often took them out to go shopping, to see their partner and also accompanied them to go to church and enjoyed it. To the person this was very important and made them feel good.

A relative told us, "Staff are mostly very caring. I see the way they interact with [relative], they make [relative] laugh and we want staff that can connect. [Relative] loves to be entertained and some staff are great at it, just the odd one that struggles to engage."

Staff we spoke with talked about people who used the service with kindness and warmth and knew what people liked to be called. Staff gave us good examples of knowing how to talk to people in a way that made sense to the individual and was respectful.

Staff described in a caring way how some people communicated without words. This showed an understanding of and positive connection with the person.
When branch nurses observed staff practice in the field, they focused on the interactions between staff and people who used the service. Although we suggested that practice observation could check other aspects of quality, it was good to see such a focus on the caring, personal aspects of the service.

Care plans described clearly how staff needed to support people to respect their dignity and privacy. We spoke with a person whose care we had looked at. They confirmed that staff always treated them with respect. Care supported people to be individuals with their own needs including relationships. Where people had a partner, care plans were very clear about how staff were to support the individual's privacy needs.

People had a copy of their care plan in their home. The start of the care plan was addressed to the individual, to make it clear it belonged to them.

One of the registered manager's aims was to provide care that helped people to achieve life goals, with the belief that nothing was unachievable. The registered manager told us, "A lot of our care is during the night and that makes it more difficult." Although care plans were currently focused on clinical care aspects, we also heard about examples of the service working together with families to achieve very positive outcomes for people's quality of life.

We saw that where possible the service had involved people in decisions about their care. A person told us they could speak to client managers at any time and would be listened to. Another person was not sure, but the service showed us their efforts and communications to make positive changes for the person following their concerns. Care plans also shared knowledge about what was important to people, what they liked and did not like.

The service involved families in the care planning for their loved ones. A relative told us, "I feel involved in my [relative's] care and making decisions."

The branch was paperless and used electronic documents only, which were protected by passwords. Training in the newly introduced General Data Protection Regulation (GDPR) and reading of the related policy was mandatory for all staff and all employees had completed this. This helped to protect people's confidentiality.

Good

Is the service responsive?

Our findings

At our last inspection we found the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because at times the service put people at risk through lack of detail in their care plans. Following our inspection, the provider sent us an action plan of how they had addressed this.

At this inspection we found the service had made the necessary improvements, maintained them and was no longer in breach of regulation regarding this. The registered manager and the branch team had reviewed care plans and risk assessments to make them more detailed.

Branch staff had looked at care plans together from different viewpoints. This helped to ensure information was clear to readers even if they did not know the person. We saw that care plans followed a similar format but contained information that was person-specific. For example, care plans described particular health conditions the person was more likely to develop, what person-specific signs staff needed to look out for and what to do.

We found that care plans for people particularly with complex health needs were very detailed. People's plans around their very specific clinical care needs gave staff clear directions. Images made the information accessible and plans used plain language as much as possible, although describing clinical care needs. A staff member told us, "My client's care plans are very detailed. The nurses review them regularly."

Branch nurses reviewed people's overall assessment at least every six months, or sooner if the person's needs changed. We saw that assessments had a clear link to care plans. Where a change in the person's need meant a different care plan was required, we saw this had been actioned. For example, where a person's dietary needs had changed and they needed a care plan around their diabetes.

The registered manager ensured they got people's opinion on the service and listened to their views. The service carried out quarterly surveys. These were based on CQC key questions. For example, the previous quarter's survey asked people who used the service and relatives whether the service was well-led. The most recent survey explored whether Interserve Healthcare Liverpool was caring. Findings led to improvements.

People who used the service and relatives we spoke to told us they took part in the surveys as much as possible. A relative commented, "I do complete them, but I usually have already told them if something is wrong and they have actioned it. They do listen most of the time."

People and relatives knew how to make a complaint, although they were not sure if there was a specific person to look after their complaints. The registered manager explained they had decided not to have a dedicated complaints person. Instead, they encouraged people to be able to speak to anyone in the branch about their concerns.

A person who used the service told us, "I can always ring [client manager], I really get on well with her." We

saw there were different systems to record conversations with people if things were not right, and what the service had done about this. Branch staff rang, wrote to or visited people who used the service regularly to keep in touch and see how things were going.

One person told us they were not sure what was happening about a complaint they had raised a few months ago, although the service showed us what they had done about this. The service may find it useful to review how information is shared in the most meaningful way with people about their complaints.

We heard some good examples of how the registered manager and their team listened to people with different communication needs and supported understanding by making information accessible. This included the use of sign language, knowing the meaning of people's sounds and gestures, as well as the use of an interpreter.

A staff member told us, "We do get really friendly with people in a professional way, it helps us to pick things up more quickly, like health concerns, we know something is not right. People are honest with me, tell me if they had a bad day. Everyone has a file in their house and that has the number to call for complaints in it."

Staff we spoke with told us they had cared for people at the end of their lives. Staff confirmed they received training in this and were supported by nurses as much as necessary.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that audit processes were not always effective as they had not identified a lack of details in care plans.

We found at this inspection that audits and reviews had been completed. However, the review of documents such as medication administration records (MAR) or daily records was at times delayed by several months. For one person we found that their January 2018 MAR had not been reviewed by nurses until April 2018. For another person we found their January, February and March 2018 MAR had not been reviewed until September 2018.

This was not in line with the provider's policy around good record keeping. This stated that records should be kept in the person's home for up to one month, then transferred safely to the branch. The policy referred to the need to review the accuracy of data regularly as part of assessments, to ensure care for people was safe and of good quality.

The registered manager had raised the length of time between record completion and review as a development need at provider level. The registered manager explained the provider was exploring electronic records, such as electronic MAR, to have up-to-date information.

Currently staff were supposed to send a completed month's record via recorded post to the branch to be scanned in, or deliver them in person.

An audit completed by a branch nurse noted on 31 August 2018 that some of a person's records were still outstanding. This included a daily bed and hoist safety check that had been introduced in May 2018. At the time of our inspection in October 2018 these had still not been scanned in. This meant that audits had identified improvement needs, but not always led to timely corrective actions.

It was clear that because the service had invested so much into the competence of staff and trusted them, they relied on staff informing them of issues right away. Auditing and checking of records are important parts of good care governance, as they help to identify any issues that staff may have overlooked or not raised. The service needed to improve the consistent and timely use of these 'safety nets', to ensure safe, effective care for people.

We recommend that the service continues to review the implementation of record checks to ensure systems in place to protect people are operated effectively.

We asked the branch nurse whether checking of correct record completion was part of their regular spot checks. While they informed us that these focused on the interaction with and care of people, the service clarified following our inspection that other regular checks were in place. The service was reviewing their implementation, which at times needed to be more effective while operating on a monthly delay of record reviews.

Comprehensive internal audits took place at provider level to check the service's compliance. The service's care coordinators focused on developing a good rapport with staff. One of the coordinators told us, "We have a chat with staff when we call them, not just to tell them to do something."

Staff we spoke with confirmed a good connection between the branch and staff out in the field. The registered manager explained it was this that had helped to achieve very high compliance in internal audits, especially the branch's training completion.

We asked field staff how they felt about the support from branch staff and managers. One staff member said, "I think we work quite well together. Communication with other team members [is through] a report sheet so you can read back through the previous night, there is a good handover."

Another staff member told us, "I feel like we work alright together. I have a good rapport, I have certain people I go to in the office. They usually know the [care] packages that you are on."

The service had a registered manager. They had led the branch through the big change of merging with another branch and communicated changes to people using the service. In a letter they explained to people and relatives what the change meant for them and introduced the staff team.

People who used the service, relatives and staff commented positively on the management of the service. Staff told us they felt there had been changes for the better since the new registered manager had taken over.

The registered manager made changes based on what people and relatives said about the service. For example, following the survey on whether the service was "well-led", the registered manager wrote to people and addressed them individually. The letter let them know how their input had developed the service.

This included regular contact by the branch with people using the service, keeping people informed, receiving care shift rotas in advance and the quality and frequency of the face to face visits people received. The registered manager had put improvement measures in place where needed.

The registered manager was well respected by their team and led on the service's vision to provide high-quality complex care. We asked staff if they felt everyone was working towards the same goal and whether they had regular staff meetings.

One staff member said, "You would like to think so [that all staff have the same aim]. The people I have come in contact with definitely do. From what my patients say, they are happy."

Staff we spoke with told us they had not recently had a team meeting. The registered manager explained it had been difficult to get staff to come into branch for these. They were setting up teleconferences for staff to dial into instead, to make it easier and impact less on staff's day. The registered manager shared with us some good examples of how they looked after staff's wellbeing and supported them.

Staff had access to a large variety of policies to guide them in their role. Mandatory policies became part of staff's learning commitments. The service checked this effectively as part of their compliance systems.

One of the policies we sampled was the provider's diversity policy. This described how Interserve Healthcare valued the diversity of its staff, clients and customers and how the provider sought to promote this. The

policy described a culture and clear stance against any discrimination based on race, sex, disability, sexual orientation, religion or belief, age, marital status or civil partnership, pregnancy/maternity, gender reassignment.

Staff told us how they embraced people's diverse needs. We heard two good examples of how staff were respectful of people's faiths. This included how specific items of clothing were worn or attending a church service with a person, to whom their faith was important.

The registered manager had submitted notifications to CQC in line with legal requirements. The provider had displayed ratings from our last inspection on the website for the service, as well as on the premises.