Honeybourne House Ltd

Honeybourne House

Inspection report

98 Sheridan Road
Manadon
Plymouth
Devon
PL5 3HA

Tel: 01752242789
Website: www.alliedcare.co.uk

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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

Honeybourne House provides residential and nursing care for a maximum of 21 people with a learning disability and associated conditions, such as Autism. The service is situated on a residential street and is divided into two parts; a purpose built nursing unit known as the Bungalow, and the residential service referred to by people as, The House. For the purpose of this report we will refer to the whole service as Honeybourne House but may also refer specifically to the nursing or residential unit. At the time of the inspection eight people were being supported in the nursing unit and 11 people in the residential part of the home.
Honeybourne House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People were safe living at the home and with the staff supporting them. We saw people were happy and trusted the staff. There were systems and processes in place to minimise risks to people. These included a robust recruitment process and making sure staff knew how to recognise and report abuse. There were adequate numbers of staff available to meet people's needs in a timely manner.

People received effective care from staff who knew them well, and had the skills and knowledge to meet their needs. Staff monitored people's health and wellbeing and made sure they had access to healthcare professionals according to their individual needs. Registered nurses were available to support people's day to day nursing needs.

People had their medicines managed safely, and received their medicines in a way they chose and preferred. Staff undertook regular training and understood the importance of safe administration of medicines. Staff said they undertook regular competency checks to test their knowledge and to help ensure their skills were up to date, and in line with best practice.
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People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible, and the policies and systems in the service support this practice.

People were supported by staff who were kind and caring. Where people were distressed or found it difficult to express themselves, staff showed patience and understanding. People's privacy and dignity was mainly promoted and respected. It had been noted that the layout of people's bedrooms and bathrooms in the unit could mean people's privacy and dignity was compromised. However, the registered manager and provider were prompt to address this matter during the inspection.

The service was responsive to people's needs and people were able to make choices about their daily routines and how support was delivered. People had access to a range of organised and informal activities. Relatives were welcomed in the home and their views and feedback were taken into account, when planning care.

Systems were in place to deal promptly and appropriately with any complaints or concerns raised about the service. The registered manager and provider treated complaints as an opportunity to learn and improve.

The home was well led by an experienced registered manager and management team. The provider had systems in place to monitor the quality of the service, seek people's views and make on-going improvements.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good	**Good**

Honeybourne 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.
We carried out an unannounced comprehensive inspection at Honeybourne House on 20 and 21 February 2018.One Adult Social Care Inspector carried out this inspection.

Before the inspection we reviewed information we held about the service. We reviewed notifications of incidents the provider had sent to us since the last inspection. A notification is information about important events, which the service is required to send us by law.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make.

People living at Honeybourne House had limited or no verbal communication. Therefore, they were unable to tell us about their experiences of the services. During our inspection we spent time with people observing daily routines and interactions between people and staff supporting them. This helped us gain a better understanding of people and the care they received at Honeybourne House.

During the inspection we spoke with twelve members of staff. This included care staff, the registered manager, deputy manager, area manager and associate Director for the organisation.

We looked at five care records, which related to people's individual care needs. This included support plans, risk assessments and daily monitoring records. We also looked at records that related to people's medicines, as well as documentation relating to the management of the service. These included auditing records, policies and procedures, accident and incident reports and training records. We looked at the recruitment, induction and training records of staff recently employed to work in the service.

Following the inspection we spoke with two social workers from the local authority adult social care team,

and two independent advocates who had supported people at the service. We also spoke with a representative from the local authority safeguarding team in relation to a recent incident in the service. Their feedback can be found throughout the inspection report.

Good

Is the service safe?

Our findings

The service remained safe.

People were protected from abuse and avoidable harm. This was because staff understood the provider's policy and procedure about safeguarding. They also attended training about locally agreed safeguarding procedures, and knew what to do if they suspected someone was being abused, mistreated or neglected. Staff spoke confidently about how they would protect people by raising their concerns immediately with the registered manager or with external agencies, such as the local authority safeguarding team or the police. Safeguarding concerns raised with the provider had been investigated appropriately. We saw staff disciplinary processes had been followed when required, and action taken when necessary to help ensure people felt safe with the staff supporting them. Staff, were recruited safely to ensure they were suitable to work with vulnerable people.

Staff recognised people's rights to make choices and to take everyday risks. Assessments had been carried out to identify any risks to the person and staff supporting them. This included environmental risks as well as risks associated with their health, wellbeing and lifestyle choices. Risk assessments included information about any action needed to minimise the risk of harm to the individual or others, whilst also recognising the need to promote people's rights, choices and independence. For example, one person had known risks in relation to eating and drinking. The person was able to make choices about what they wanted to eat and drink, but would at times choose food, which increased choking risks. Risk assessments were in place and eating and drinking plans had been agreed in liaison with other specialist agencies, including dieticians and speech and language therapists. Staff spoke regularly with the person concerned about potential risks and safer food options. Guidelines were in place for staff to supervise the person from a distance when they were eating, whilst also allowing them their right to make choices and have control over their decisions and lifestyle. Another person had known risks in relation to their mobility. Guidelines were in place for staff, which included the need to reassure the person when they were mobilising to reduce the risks of them falling. Staff had a good understanding of people's behaviours and undertook relevant training to manage behaviours safely,and in line with current best practice.

People lived in an environment, which the provider had assessed to be safe. Maintenance staff, had been employed in the home and were responsible for ensuring the home was well maintained and safe. Staff undertook visual daily checks of the environment and reported to the maintenance staff and registered manager, any issues which needed addressing. People had personal emergency evacuation plans in place (PEEPS), so their individual needs were known to staff and emergency services in the event of a fire. Contracts were in place to ensure equipment was regularly serviced and remained fit for purpose. A fire risk assessment was in place, and regular checks undertaken of fire safety equipment. A plan was in place detailing the action to be taken in the event of a major incident. This included emergency contacts and alternative support arrangements for people using the service.

People received their medicines safely from care staff who had received specific, updated training to safely carry out this task. All staff who administered medicines had their competency assessed on a regular basis

to make sure their practice remained safe and in accordance with the provider's policies and procedures. Staff administering medicines to people who lived in the nursing part of the home were supported by a registered nurse on a 24 hour basis. People's care records held detailed information regarding their prescribed medicines, and how they needed and preferred them to be administered. For example, one person liked their medicines with a drink, and the drinks had to be placed in a particular order and position on the table in front of them. We saw this person being supported to take their medicines in the way they chose and preferred.
Medicines were stored and disposed of safely. Arrangements were in place for the return and safe disposal of medicines and excess stock was kept to a minimum. Clear systems were in place for recording when people took medicines out of the home, for example when they visited family or went on holiday. During the first day of the inspection one person returned from a hospital visit. The medicines they had taken with them were checked back in by the lead nurse and appropriate forms completed. Information was clearly available for staff about people who needed "when required" (PRN) medicines. These protocols helped staff understood the reasons for these medicines and how they should be given. The application of prescribed creams/ointments was clearly recorded and these types of medicines were appropriately stored.

People were cared for by suitable numbers of skilled staff who knew people well and met their needs. Staffing levels had been organised for each person dependent on their assessed needs. For example, the nursing part of the service was supported at all times by a registered nurse and staffing levels were organised to ensure people's nursing needs were met appropriately and safely. Staffing levels were regularly reviewed and adjusted when needs changed or to accommodate the planning of activities, and other appointments. Staff said staffing levels were sufficient to meet people's needs and to keep them safe. Comments included, "We are never left with unsafe staffing levels".

People were protected by the provider's infection control procedures, which helped maintain a clean and hygienic environment. Staff, were trained and followed infection control practices, by wearing gloves and aprons when preparing medicines and providing personal care. We found the environment to be clean and odour free throughout.

The provider had systems to audit all accidents and incidents which occurred and took action to minimise further risks to people. The provider learnt from incidents and used them to improve practice. For example, prior to the inspection we had received information from the service regarding the death of a person who had lived at the service. The provider informed us that although the person had died of natural causes they had reviewed their practices, to help ensure all people using the service were safe. This demonstrated that the provider reflected on incidents that occurred and used these situations to consider practice and make improvements where needed.

Good

Is the service effective?

Our findings

The service remained effective.

People received care and support from staff who knew them well and had the skills and training to meet their needs. There was a strong emphasis on training and continuing professional development by the provider, and throughout the staff team. Other agencies we spoke with were positive about the service. They said staff had a good understanding of the needs of people they supported, and met their needs effectively.

Staff confirmed they undertook a thorough induction when they started working in the service. Staff who had no experience in the care sector completed the Care Certificate. The Care Certificate is a nationally recognised qualification for care workers new to the industry. Staff undertook a range of training to help ensure they could effectively meet people's needs. Comments from staff included, "The training is second to none, they are really proactive with getting us trained". Each staff member had a training plan and this was regularly discussed and reviewed as part of team meetings,and one to one supervision sessions. Training was provided either internally or by external agencies and consisted of a range of topics relevant to the service and needs of people being supported. For example, all staff undertook mandatory training such as health and safety, Mental Capacity Awareness and safeguarding. In addition training had been provided by the local learning disability services in relation to epilepsy, and management and understanding of people's communication and behaviour. Staff told us they felt supported by management and staff. Comments included, "Staff and the managers are always supportive. We can raise any questions. I have just been on holiday, and the records and handover meetings provide me with everything I need to catch up with information about people".

People were supported to have a good diet which met their needs and preferences. Each person had a food and diet plan, which included guidance for staff about people's specific dietary needs, risks and preferences. Risk assessments had been completed for some people in liaison with the Speech and Language Team (SALT) and where risks had been identified the SALT had provided guidance for staff and training about how to support the person safely. Guidelines included information about how the person needed to be positioned when eating, consistency of food, equipment and staffing levels needed. Staff were aware of these guidelines and followed them in practice. For example, one person needed staff with them at all times when eating or drinking, due to risks of choking. We saw these required staffing levels were in place.

Some people due to their health needs received their food via a Percutaneous endeoscopic gastrostomy site (PEG). Care plans held a gastrostomy feed regime chart to support
staff. Other charts provided information to staff about how to manage care for the gastrostomy site for example cleaning the gastrostomy site.

Some people were able to use the kitchen area with support from staff. We saw people making choices and being supported to prepare their own drinks and snacks. Other people who were unable to use the kitchen were asked regularly if they were hungry or thirsty, and their requests were responded to promptly.

Staff monitored people's health and worked closely with other professionals to make sure care and treatment provided good outcomes for people. Other agencies were positive about the healthcare provided at the service and said they felt this was in part due to nursing staff being on site at all times. People's health records included detailed information about their past and current health. A range of healthcare checks such as bowel and urine charts, continence and repositioning plans were in place to help ensure people's needs were met consistently and to enable staff to identify and respond promptly to any concerns. 'Hospital passports' were in place to support any admissions to hospital. Hospital passports contained important information about the person to help ensure their needs were met appropriately should they require an admission to hospital or other healthcare facility.

People only received care and support with their consent. We heard staff asking people if they required help and respecting their wishes and choices. For example, staff had been to one person's bedroom to give them their morning medicines. The person had said they didn't want them, so the staff member left and offered them a little later when the person was up and dressed.

People's legal rights were upheld. Consent to care was sought in line with guidance and legislation. The manager and provider understood their responsibility in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (Dols). The 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 as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the capacity to make a particular decision, any made on their behalf must be in their best interest and be the least restrictive. 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 application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's care records demonstrated their capacity had been assessed when planning care and that DoLS applications, had been made when necessary to the supervisory body. People's rights to make choices about their care and lifestyle was promoted and understood by staff. One care plan stated a person was able to make choices, and if staff felt a decision was not in their best interest they needed to explain the pros and cons and allow the person time to process the information,and make a decision. Best interest's discussions had taken place when people had been assessed as lacking capacity to make a particular decision.

Staff were familiar with people's communication methods and used this knowledge and understanding to support people to make choices and to have control over their routines and lifestyle.

Honeybourne House was situated on a residential street and comprised of two separate units, the main house, which is a residential unit and a separate nursing unit known to people as The Bungalow. The Bungalow had facilities provided on one level with access to an enclosed garden area. People's bedrooms in the nursing unit had en-suite bathroom facilities with a range of equipment to meet people's specific care needs. The main house had bedrooms on two floors as well as a large sitting room, kitchen and laundry and garden. The registered manager told us plans were in place to renovate parts of the residential unit to make it more accessible to people as their needs changed due to age and general health. This would include altering part of the first floor of the building to allow people access to a separate sitting room, and the installation of a stair lift to support people with limited mobility to access their bedrooms more independently and safely.

Good

Is the service caring?

Our findings

The service continued to be caring.

People received care from staff who were kind and who respected them as individuals. Other agencies and relatives were positive about the care provided at Honeybourne House. Throughout the inspection we heard and saw staff speaking, and treating people in a dignified and respectful manner.

We saw cards the provider had received from family and friends. Comments included, "Thankyou for the wonderful care you give to my brother. It is good to know he is happy and loved" and "All the staff provide highly skilled care, respect, genuine and heartfelt fondness".

Staff, were calm, relaxed and confident in their role. One person due to their health condition became unwell during the inspection. Staff recognised without delay that the person was unwell, and responded promptly with treatment as agreed in the person's support plan. The staff reassured the person concerned and supported them to their bedroom so they could relax and recover away from the noise in the rest of the house.

People were treated with kindness and made to feel special. We heard staff complimenting and praising people about how they looked and about tasks they had performed. One person wanted reassurances from the manager and staff about issues that were sensitive and private to them. The registered manager spent time with the person concerned reassuring them and providing positive feedback. This clearly pleased the person concerned, making them relax and smile. The smiles, laughter and interactions we observed suggested people felt valued and important.

Staff recognised and responded promptly when people showed signs of distress or discomfort. For example, one person was unable to reposition themselves in their wheelchair. A staff member recognised the person's coughing and body language suggested they were uncomfortable. They spoke gently to the person concerned, repositioned their legs and closed a window that could have been making them feel cold. Following this response the person visibly relaxed and looked more comfortable.

Staff, were respectful and sensitive to people's views and lifestyle choices. One person wanted staff to share their views about religion. The staff member was open and honest about their views, whilst remaining sensitive to the views and values of others. The person listened to the staff member and their responses suggested they were pleased to have this open and two way conversation. The registered manager said the service promoted an environment where people were treated equally and that their equality and diversity needs were respected. A poster was on the wall in the entrance to the service stating that people's needs in relation to their sexuality, race, gender and age would be protected and respected.

Staff, were enthusiastic about their work and celebrated people's progress no matter how big or small. For example, staff were keen to tell us about one person who had moved into the home after a long stay in hospital. The person concerned initially required a high level of staff support and was unable to bath and

mobilise without support from staff and the use of equipment. Staff said they worked hard to build the person's trust and to help them regain their skills, confidence and independence. Staff were clearly delighted with the person's progress and the positive impact this change had had on their lifestyle and wellbeing.

Staff respected people's rights to make choices, and used innovative and creative methods to involve people in their care. People's care records contained detailed information about their daily routines and these were followed and understood by the whole staff team. Staff had a good understanding about people's likes and dislikes as well as important information about their past, interests and relationships. People had access to advocacy support when required. We spoke with two advocates who said they felt staff respected people's rights, and accessed advocacy support when appropriate. Also each person had a key-worker in the home, who had a particular responsibility to ensure they were listened to and had their voice heard. Staff and management recognised the importance of family and friends. Relatives were kept updated about significant events when appropriate, and their views were listened to and taken into consideration when planning people's support arrangements.

People's dignity and privacy was promoted. Where people were unable to promote their own dignity staff discreetly helped people. Staff knocked on people's doors before entering and said there was a policy relating to this area of practice, which outlined the reasons and expectations on the staff team. Staff respected people's personal belongings and kept them safe. For example, a staff member said, "[…] loves his watch, and […] IPAD is really important to them and needs to be charged every night".

It was noted that en-suite bathrooms in the nursing part of the service did not have doors and were open into the person's bedroom area. The registered manager said this had been planned to enable people and staff to access bathrooms more easily when using large pieces of equipment. However, some people did not need staff support at all times when using their bathroom and were able to have private time. The absence of a door or screening meant people's privacy and dignity may not always be respected. This was discussed with the registered manager at the time of the inspection. On the second day of the inspection, plans had been put in place to add doors or other suitable privacy screening to all en-suite bathrooms.

People's records were safely stored and written in a way that protected their dignity and confidentiality.

Good

Is the service responsive?

Our findings

The service remained responsive.

People were supported to lead active, meaningful and interesting lives and Health and Social Care agencies said they felt the service was responsive to people's needs. A professional from the specialist learning disability team said a relative had told them how pleased they had been with how the service had met the needs of their loved one so well.

People's support plans included very clear and detailed information about people's health and social care needs. Support plans were divided into separate sections and included; What is happening now? What are your hopes? What would you like to achieve? and our plan to support you. The plans were personalised and detailed how the person needed and preferred care and support to be delivered. For example, one care plan stated the person was very particular about their appearance and liked to have their hair and nails done regularly at a salon. During the inspection we heard staff making these arrangements.

There was a system of review so people's progress and developments were recognised and monitored. Their care plan was constantly updated to make sure it was an accurate and useful working document. Relatives and other agencies were invited to attend review meetings or were contacted for their views and feedback.

Staff we met, and observed, knew people well and were able to provide care that was personalised to their individual needs and wishes. For example, one person had very particular ritualistic behaviours and liked their belongings to be placed in front of them in a certain way. Staff, were very aware that the person's behaviours and anxiety were likely to escalate without care being provided consistently and how the person wanted.

We saw people were supported to occupy their time in a meaningful way. We saw staff in the nursing unit spending time with people listening to music, playing instruments and using a range of sensory equipment. A separate sensory room was also available with a range of sensory lighting and equipment, which staff said they used when people needed a quieter space.

We saw some people occupying their time with particular hobbies and interests. One person was knitting and said they were making a blanket for one of the staff. Another person was watching a favourite programme on their IPAD. They were very amused by the programme and enjoyed staff watching and laughing with them. Staff said, "They love churches and love watching programmes about different churches and religious buildings". During the afternoon people were enjoying a karaoke session in the main sitting room. People had a microphone and enjoyed dancing and singing to the music.

Staff helped people to stay in touch with family and friends to promote their emotional wellbeing. Relatives said they were always able to visit and were made to feel welcome and important.

We saw information was available to people about the service and daily routines. Staff said some people

were able to understand verbal information whilst others needed information to be provided in a specific way, such as signs, symbols and photographs. Large, colourful notice boards in the communal areas had pictures of activities available to people each day of the week. Daily menus were available in pictures as well as photos of staff to help people know who would be on duty.

A complaints policy and procedure was available and the registered manager said this would be made available in a format people could understand if needed. In addition to the formal complaints procedure a number of different systems were also used to monitor daily how people were and if they had any concerns. This included daily monitoring forms, handover meetings and a keyworker system. The views of others such as relatives and other agencies were also listened to and acted on, as a way of further ensuring people remained happy and confident with the service being provided.

Management and staff demonstrated compassion and provided people with respectful and dignified end of life care. Prior to the inspection a person who had lived in the home had sadly passed away. The staff spoke fondly of this person and plans were in place for a celebration of their life. Management and staff had supported each other with this loss and had thought sensitively about how best to support people who lived in the home.

People's religious beliefs and end of life wishes were documented as part of their care plan. We saw a care plan for one person called, "What If…Celebrating my Life". The plan detailed how the person would want to be supported in their final days, and how they may want their life to be celebrated. The plan had been completed by the person concerned and a close relative.

The registered manager had completed an end of life training programme and said the skills and information gained from this course had helped them understand, and support people experiencing loss. They said as well as the emotional aspects the training had also helped them support families with practical tasks, such as funeral arrangements.

Good

Is the service well-led?

Our findings

The service continued to be well-led.

There was a registered manager in post who was experienced and had the skills required to effectively manage the service. 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.

Health and Social care agencies spoke highly of the registered manager and management team. One professional told us there was always a team leader present to speak to whenever they visited and management were always available if they needed to speak to them.

The registered manager was supported by a deputy manager, and both worked regular hours in the home. A management on-call system was in place for when managers were not available within the service. The registered manager undertook spot checks at different times of the day and night and also completed regular audits of care records, medicines, health and safety checks and other records relating to the running of the service.

Senior managers within the organisation visited the home frequently to make sure high standards were maintained. At the time of the inspection two area managers were undertaking audits of people's care records as well as other records relating to health and safety, recruitment and the day to day running of the service.

The registered manager was clear about their role and staff said they felt well supported by the management team. The provider information return (PIR) stated, 'Good service provision starts with good leadership. We have invested to recruit the right leaders, the managers to the team leaders in charge of all aspects of our service delivery. I understand the need to be consistent, lead by example and be available to staff for guidance and support. This provides staff with constructive feedback and clear lines of accountability. Comments from staff included, "The management are all very supportive and regularly in the home, they will help with care whenever it is needed" and "Some of the senior managers have previously worked in the home so they know and care about the people who live here".

The registered manager maintained their professional development by attending regular training and kept up to date with best practice. As well as completing mandatory training, they also attended quarterly Dignity in Care Forums run by Plymouth City Council and had recently completed an end of life training programme. They said this training had provided them with improved skills to support people, staff and relatives following the sad loss of a person who had lived in the home.

Staff meetings were held to provide an opportunity for open communication. Staff said daily handover meetings between shifts helped ensure staff had accurate and up to date information about people's needs,

and other important information. Staff said they felt their views were listened to and valued.

The provider used complaints and incidents to continually improve the service. For example, one person had started to fall when getting up from their chair. The person's care plan had been reviewed and staffing arrangements changed so staff were always in close proximity of the person concerned. This change had worked well and helped prevent the person from falling.

Consideration had been given to the long term needs of people who lived at Honeybourne. Plans were in place to renovate part of the building and to install a stair lift. The registered manager said this would help ensure people could maintain their independence as much as possible as they became older and less mobile.

The provider sought the views of people, their relatives and other agencies by satisfaction surveys and regular meetings. Feedback from surveys had been analysed and action plans put in place to address any issues raised.

The provider had effective quality monitoring systems which ensured standards were maintained and constantly looked at ways to improve practice. The registered manager and provider measured the quality of the service from the perspective of people they supported. They gathered this information from outcomes of keyworker meetings, reviews and daily records and analysed this against people's support plans and specific goals.

The registered manager undertook spot checks at different times of the day and night and also completed regular audits of care records, medicines, health and safety checks and other records relating to the running of the service.

The service had an up to date whistleblowing policy, which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt safe to raise any concerns and felt confident the management would act on their concerns appropriately.

The provider promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the ethos of the Duty Of Candour. The Duty of Candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment.

The provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. Where concerns had been raised with them they had sought advice and shared information with the CQC and the commissioners of the service.