Elm Lodge Nursing and Residential Home

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Inspection report

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Date of inspection visit:
10 May 2016

Date of publication:
15 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out 10 May 2016 and was unannounced. During our last inspection in January 2014 we found that the service met the legal requirements in the areas we looked at.

Elm Lodge Nursing and Residential Home provides care and accommodation for up to 64 people. Some people may require nursing care and people living at the home may have dementia. At the time of our inspection there were 61 people living at the home, 22 of whom required nursing care.

The home had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (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.

People received their medicines as they had been prescribed.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were enough skilled, qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They received training to ensure that they had the necessary skills to care for and support the people who lived at the home and were supported by way of supervisions and appraisals.

People's needs had been assessed before they moved into the home and they had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had a variety of nutritious food and drink available to them. There were freshly made, home cooked meals from a menu that had been devised using people's likes and dislikes. Snacks and fruit were available to people throughout the day.

Staff were kind, caring and protected people's dignity. They treated people with respect and supported people in a way that allowed them to be as independent as possible.

There was an effective complaints system in place. Information was available to people about how they could make a complaint should they need to and the services provided at the home. People were assisted to

access other healthcare professionals to maintain their health and well-being.

People and staff were encouraged to attend meetings with the registered manager at which they could discuss aspects of the service and care delivery. People were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place and the provider was an active participant in the day to day running of the service. .

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were administered safely and as it had been prescribed. Arrangements for the ordering, storage and disposal of medicines were robust.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Good

The service was responsive.

People were supported to follow their interests and hobbies.

There was an effective complaints policy in place.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

The registered manager was visible and approachable. The provider was involved in the overall management of the home.

There was an effective quality assurance system in place

Elm Lodge Nursing and Residential Home

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 10 May 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with seven people and 10 relative and friends of people who lived at the home. We also spoke with a nurse, two care workers, two cooks, the activities coordinator, the business support manager, the registered manager and two of the parnerss of the provider company.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for six people. We also looked at how people's medicines were managed and the ways in which complaints were handled. We looked at three staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us they felt that they or their relative was safe living at the home. One person said, "I do feel safe here. I feel safe in my room, I don't leave it. I feel more secure in my room." Another person said, "That is just it isn't it? You need to feel safe and I do." A third person said, "Safe? Yes oh yes absolutely, much better than when I was at home." A relative told us, "[Relative] is absolutely safe here. There are no problems with that at all."

The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm but would also be used to ensure that the building was properly evacuated in the event of an emergency.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the home. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I had my safeguarding training the week before I started work here." Staff we spoke with were able to explain the types of harm that people may experience and the ways in which they looked for these, such as investigating the cause of any bruising they noticed.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with the use of bedrails and wheelchairs. We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of both of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and talking about people's experiences, moods and behaviour at shift handovers. Staff told us that information on risk was shared at handover in both oral and written forms. One staff member said, "There is a special box on the handover form to write this on." This gave staff up to date information and enabled them to reduce the risk of harm occurring.

The registered manager had carried out annual assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances. Checks were also carried out to ensure that equipment such as lifts and hoists had been serviced and portable appliances had been tested. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Accidents and incidents were reported to the registered manager. We saw that they kept a record of all

incidents, and where required, people's care plans and risk assessments had been updated. The records were reviewed by the registered manager to identify any possible trends to enable appropriate action to be taken to reduce the risk of an accident or incident re-occurring.

People, relatives and staff we spoke with told us that there were enough staff on duty. One staff member said, "We have bank staff we can call on if someone is sick but we try not to call agency staff in because we like to work as a team and support each other." The registered manager explained that staffing levels had been determined based on the level of dependency of the people who lived at the home. They told us that there was always at least one nurse and one senior care worker on duty. During our inspection there was a visible staff presence in all the communal areas.

We looked at the recruitment documentation for three members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Only qualified nurses or competent senior care workers administered medicines and they confirmed they had received regular training updates. Each medicines administration record (MAR chart) included information about any 'as required' (PRN) medicine a person had been prescribed, including information about the medicine and any possible contra-indication with their regular medicines. We looked at the MAR charts for three of the people living at the home and saw that these had been completed correctly and medicines received had been recorded. We checked stocks of medicines held which were in accordance with those recorded. There were robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the skills that were required to care for them. One person said, "Oh yes there do seem well trained, I sit and watch them move people at lunchtime and they all do it a certain way – the way they have been trained." Another person told us, "They are all experienced and well trained." When we asked a relative they told us, "Yes they do seem to be well trained. I observe them all and they all seem to know to support peoples feet etc. They all seem to follow the same moving and handling schemes."

Staff told us that they received a full induction when they started working at the home and there was a programme in place which included the training they required for their roles. One member of staff told us, "I had my safeguarding training the week before I started. I had all of the statutory training at this time including infection control, moving and handling and how to understand our care plans and all of our policies. The induction training was very thorough and my first week here was shadowing experienced staff, even though I was a carer at a nearby care home I had to learn how to do things here."

They went on to tell us of the on-going training that they received and that they felt supported by regular supervision. They said "We have very good supervisions with the nurses monthly. I am interested in end of life care, so although I am doing my NVQ level 2 I am still able to go on this additional training. "They said that the training had increased their awareness of people's needs and went on to say, "I want to stay being a carer and so I want to be an excellent carer and understand how to do my job very well."

The business support manager showed us the training record which was used to monitor staff training. They told us that they looked at the record and booked people onto the relevant training courses. If there had been any evidence of poor practice outside of the normal refresher cycle the member of staff would be booked onto the next session of the relevant training. Each member of staff had their own individual training record and all the certificates from training they had completed were held in this.

Staff also had a regular appraisal. One member of staff told us, "I have had regular supervisions and appraisals. We have a form to fill in at our appraisal meetings and we have to explain what we want in the future. I want to be a nurse so I have a career path written up for me." Another member of staff said, "I have just completed my medication competency within the last 12 months. I am doing my diabetic training currently. Training, supervision and appraisal all happen here and we all feel we matter." This demonstrated that staff were supported to maintain and increase their skills to enable them to support people effectively.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that, where applicable, assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest.

People told us that staff asked for permission before they supported them. We observed staff ask people before they provided care or support to them. Staff told us that they always gained consent to support from people. One staff member said, "We always inform them of what we would like to do and look for a reply. We usually use a question so that they have to answer us. If they can't communicate verbally we look for acknowledgement, it could be their eyes, a nod or squeeze of your hand. We always try to explain what we are needing to do and why. We explain very fully so that they know why."

People told us that they had a good variety of quality nutritious food and drink. One person told us, "The food is very good, Excellent." Another person said, "Very good food, I go down to the dining room. The variety is good." Relatives stated that the food was very good and that they were welcomed to eat with their relative regularly. One relative said, "I eat all of the food all of the time. The three chefs are all good." We observed the lunch time experience for people who lived at the home. The tables were set with table cloths and paper napkins. Condiments were available in the centre of the table. People were served with a cold drink before the main course food was brought out. Each person was treated as an individual, they were allowed to eat at their own pace and eat what they wanted to eat. They were supported to eat independently whenever possible but where assistance was required for them to eat their meal this was provided in a sensitive way.

We spoke with two of the cooks. They told us that they had a good knowledge of people's likes and dislikes. The main meals were prepared freshly on site. This was more cost-effective for the service as well as giving people foods that they preferred. People's religious and cultural requirements were considered when the menus had been prepared and an alternative was always available to meet people's needs. Low sugar versions of the sweets were prepared for the people who were living with diabetes. These foods were plated first to enable staff to identify the low sugar meals and ensure that they were given to the people who needed them. Fresh fruit was available to people throughout the day. People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake that provided detailed information on what they had consumed. Where needed, referrals had been made to the local dietetic service and the speech and language therapists.

People told us that they were supported to attend appointments with other healthcare professionals, such as dentists, opticians and chiropodists, to maintain their health and well-being. Records we saw confirmed this. One person told us, "They do look after me well yes. I see the G.P. if I need to but they are very good here. I see a chiropodist here. Now and again a dentist comes to see me here. I feel my health needs are looked after well really." Another person said, "They get the doctor no problem if I need to see him. I see the psychiatrist here. Everything I need is here for me, no problems." A third person said, "I have had a urine infection in the last month but the G.P. came out no problems all better than. If you are unwell they are on to it straight away."

One member of staff told us how they involved other health care professionals in the care of the people who lived at the home. This included district nurses, speech and language therapists, physiotherapists, occupational health professionals, GP's and aromatherapy masseurs as required by the individual. Records

indicated that each person had an annual health check and a review of the medicines that they had been prescribed. The records also showed that people had been supported to attend appointments with audiologists, memory clinics and physiotherapists.

Good

Is the service caring?

Our findings

People and the relatives we spoke with told us that the staff were kind and considerate. One person told us, "They are all kind to me here and treat me with respect. No one talks to you badly." Another person said, "The staff are always kind to me and I am not worried about anyone or anything." A third person told us, "They are all marvellous here." One relative told us, "I come daily; I always get a cup of tea and kindness."

Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives, and from the 'life bubbles' within people's care records. Life bubbles had been developed in discussion with the people and their relatives to give as full a picture of the person as possible. One member of staff told us, "I talk to family members and ask questions about what people liked, what their hobbies were, what they liked to read and what music they liked. I used this information to fill in the life bubbles in the care plan."

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. We saw that staff communicated appropriately with people. One member of staff told us, "We do not use childlike language when speaking with them." Interactions were not all task focussed and staff we observed to take the time to sit and chat with people throughout the day.

People told us that the staff protected their dignity and treated them with respect. One person told us, "There are no problems with privacy or treating me with dignity. They keep the curtains and door closed. I see them look after the other residents really well, they are kind caring and patient." Staff were able to describe ways in which they respected people's dignity. For example one staff member said, "We always keep the door and curtains closed until the person is up. We give them a towel to use to cover themselves to ensure their private areas are covered. When we take them down to the bathroom, they get undressed in the bathroom with our help if they ask for it. We wait outside for some people once they are in the bath and keep checking that they are alright. Again, when we help them out of the bath, we offer them a robe to cover themselves and assist them getting dressed if necessary. They come out of the bathroom fully clothed."

We saw that there was a 15 point 'Dignity Charter' in place that was displayed on noticeboards around the home. Staff were able to explain how information held about people was treated as confidential. They told us that this would not be discussed outside of the home to protect people's privacy.

People told us that they were encouraged to be as independent as possible. One person told us, "I get myself washed and dressed. They will help me if I ask." One of the cooks told us that, where possible, people had been provided with special plates and cutlery that enabled them to eat their meals unaided. This had promoted their sense of independence.

People were supported to maintain relationships with friends and family. Relatives were encouraged to spend as much time with people as possible and were provided with food and drinks when they visited. Relatives described the 24 hour support that they had been given over a number of days when their relative

passed away at the home recently.

Information was displayed on notices in the hallway for people and visitors. This included information about safeguarding, the complaints system, fire evacuation instructions and details about planned activities for the month. This meant that people, their friends and relatives had the information that they needed and could plan how they wanted to spend their time. There was also a board containing photographs of the staff team to enable people and relatives to identify the staff who provided care and support to the people who lived at the home and their roles within it.

Good

Is the service responsive?

Our findings

People and their relatives told us that they had been involved in deciding what care they were to receive and how this was to be given. Before people joined the service the registered manager had visited them to assess their needs and whether the service was able to fully meet them.

People and their relatives told us that the care they received reflected their individual needs. The care plans followed a standard template which included information on people's personal history, their individual preferences and their interests. One relative, of somebody who had recently moved into the home, told us, "We sat down with the manager in the beginning. [We discussed] likes and dislikes to include it all in the plan. It has not been reviewed yet." Each care plan was individualised to reflect people's needs and included clear instructions for staff on how best to support people with their specific needs. One care record included plans that covered the individuals' loss of the use of their hand following a stroke. The plan indicated that a soft ball should be placed in their hand to prevent it from closing in a gripped position and becoming sore. We saw that the intervention had been documented in the daily records for the person. We observed the person to have the ball in their hand during our inspection.

People told us that they or their relative were involved in the regular review of their care needs. One relative told us, "The care plan is reviewed regularly with us, every three months. We can ask for any changes to be made. For example we asked for [relative] not to have tomato soup and that is now in [their] care plan." Another relative said, "From time to time they come and we go over it together." Staff told us that care plans were reviewed on a monthly basis or more often if this was appropriate due to changes in people's physical or mental health. The care records that we looked at showed that care plans had been reviewed each month.

People took part in various activities and there was an activities timetable on the noticeboards so people could plan their time. On our arrival we saw that the activities coordinator was holding a singing exercise session with people in a communal area. People were encouraged to join in with both the singing and the movements. We spoke with the activities coordinator who told us that they worked for 30 hours a week but varied their shifts to enable them to assist those residents who were able and wished to attend services at the local churches to do so. Also some people liked to attend a local market on a Saturday so they adjusted their working hours to facilitate this. They told us that they also accompanied people to a local Italian restaurant where they had coffee and could chat with the staff in Italian. This was particularly beneficial to one person who was able to speak in their native language on these occasions. We saw that there was a range of equipment available for people and their relatives to use. During our inspection we saw one person and two of their relatives have a game of dominoes. We also saw that people were having aromatherapy massage whilst other people were knitting. We noted that the activities coordinator spent time on an individual basis with people, talking with them and encouraging them in their activities. The activities coordinator told us that the support provided to individuals was reflective of the information in their care plans as to their previous hobbies and interests. For example, not everybody was able to get out to a local market on Tuesday mornings. The activities coordinator bought items that one person who could not get out really enjoyed, such as stuffed olives, jellied eels and roll-mops, back to the home for them. This enabled

them to enjoy these treats as they had done before they moved into the home. The group activities offered included table games, movie shows, bingo and baking.

The activities coordinator told us of specific activities undertaken with people who were living with dementia. These had included hand massage and also involved the use of knitted blanket squares that had various items attached that people liked to touch and play with.

There was an effective complaints policy in place and the registered manager listened to people's concerns. Information about the complaints system was available in people's rooms and had been given to relatives when a person first came to live at the home. Although the people we spoke with were aware of the complaints system they said that they had no cause to use it. One person told us, "If you are not happy you just tell a carer and its sorted out – not a complaint really." A relative told us, "I would go and see the manager, her door is always open. We have in two years never had to make a complaint. The staff here are very approachable if you mention anything it is sorted out straight away." However another relative told us, "I have made a complaint….I reported it to the manager who acted straight away and I know the member of staff has been dealt with. [The manager] was very apologetic and it has never happened again."

We saw that the service had recorded any concerns that were raised with them as well as formal complaints that had been dealt with through the complaints system. Following an analysis of the complaints received in 2015 the business support manager had arranged for additional training to be held to increase the staff's knowledge of Parkinson's disease and how this affected people. Actions that had been taken following a specific complaint received had included a care review and regular discussions with a family member. This showed that complaints were used to improve the care and support provided.

Good

Is the service well-led?

Our findings

People and staff had confidence in the registered manager. They found them to be open and approachable. One member of staff said of the registered manager, "She is very hands on. If they are a nurse down we see her in her uniform helping out. She comes in to see us in the morning or if she wants to know anything she comes and sees us." Another member of staff said, "I think she is a good manager. If I have I have a problem I can approach her. If I have a suggestion she will listen." A third member of staff said, "She is very good at listening to us. We all feel listened to." The registered manager told us that they operated an 'open door' policy to discuss personal issues. They told us, "I don't discuss any personal issues in a public forum." We noted that the registered manager had achieved a Leadership and Management Development Award in 2009.

People were asked their opinion of the service that was provided and for ways in which this could be improved by way of an annual satisfaction survey. The last survey had been completed in October 2015 and the feedback from this had been positive. However people had made suggestions as to ways the service could be improved. These had included a request that people had more one to one time to support them in their activities. The service had responded to this request by expanding the number of volunteers who worked with the service and had given a care worker additional hours of duty during which they supported the activities coordinator. Another suggestion had been around improving the telephone service. The registered manager told us that an emergency back-up line had been installed for times when the normal line fails. There had also been suggestions around changes to the menu and these were reflected in the current food offered.

In addition to the questionnaires the provider had established a 'Friends of Elm Lodge' group for people, their relatives and friends. This group held regular meetings at which they were able to discuss the operation of the home and ways in which the service provided could be improved. They were also used as opportunities for people to learn more about different things that affected people, such as dementia and how it could impact on people's lives. These opportunities allowed people and their relatives to contribute to the development of the service.

A relative also undertook informal, unannounced quality assurance visits during which they talked with people on the different units at the home. Following completion of their informal audit the relative produced a short report of their findings for the manager. During these informal audits the relative had identified ways in which people could be more involved in the organisation. For example one person really enjoyed doing shorthand and the business support manager was looking at ways in which they could use this skill. The flower arranging activity had also been identified through the relative's talking with people, as had the inclusion of more lamb dishes on the menu.

Staff were able to contribute to the development of the service during supervisions and staff meetings. One member of staff told us, "I feel we are using too many sheets to repeat our recording of medication, and I asked if we could approach the pharmacy to look into streamlining the process. The manager said she would look into this with the pharmacy for us." Minutes of a meeting held with nurses and senior care

workers in March 2016 showed that staff had discussed the timing of the medicines round and requested that this was reviewed so that medicines could be given at a time that better suited the people at the home. The registered manager was looking into this. They had also discussed the falls protocol, care plans and the use of mobile phones and social media by staff.

Staff told us that they were supported by regular reviews of their competency. They were knowledgeable about their roles and what was expected of them and were able to tell us of the values and vision of the service. One member of staff told us, "We give the highest quality of care and treat everyone as an individual."

There was an effective quality assurance system in place. Quality audits completed by the registered manager covered a range of areas, including audits of care plans, medicines and infection control. Improvement plans had been developed where shortfalls had been identified and the actions were signed off when they had been completed. The registered manager told us that they regularly worked in units with the staff and were able to monitor the quality of the care provided in this way. If they identified any areas for improvement in practice with any member of staff these were addressed with the member of staff immediately. We saw that the registered manager also completed unannounced checks during the night. These involved a check of the working practices of the staff on duty and monitoring the quality of the care and support provided. We noted that the latest of these checks had been completed on 7 April 2016 when it was noted that if people used their call bells for assistance these had been answered promptly.

An annual review of the quality assurance system results was produced and an improvement plan developed from this. We saw that an improvement plan was in place for 2015/16 and actions were being monitored by the registered manager to ensure that the identified improvements were made.

The provider was actively involved in the day to day operation of the home. One of the three partners was at the home on a daily basis and was had an office there. They were responsible for the overall operation of the home but told us that the registered manager ran the home on a day to day basis with support from the business support manager. The registered manager told us that the partner did not interfere with the day to day running of the home but that they could go to them at any time, such as for when they wanted to increase staffing numbers. Another of the partners had responsibility for the maintenance of the property and the supplies needed for the operation of the service, including the food. They were at the home most days and told us that they were supported by a full time maintenance person who carried out the repairs and improvements required.

We saw that there were robust arrangements for the management and storage of data and documents. People's written records were stored securely and data was password protected and could be accessed only by authorised staff.