Augusta Care Limited

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Inspection report

Chiltern House
Shrewsbury Avenue, Woodston
Peterborough
Cambridgeshire
PE2 7LB

Tel: 01733233725
Website: www.augustacare.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

Augusta Care Limited is registered to provide personal care to people living at home. People receiving the care have a range of needs, which includes learning and physical disabilities.

At the time of this inspection care was provided to 46 people who live with a learning disability and who may also have mental and physical health needs.

This comprehensive inspection took place on 14 June 2016 and was announced.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager was not in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the agency. 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. There was a manager operating the service and they had applied to be registered and was waiting for the CQC to consider their completed application.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and care was provided in their best interests. Staff were trained and knowledgeable about the application of the MCA. Arrangements were in place for external agencies to make DoLS applications to the Court of Protection [CoP], if these were required. The outcome of these decisions was pending.

People were looked after by staff who were trained and supported to do their job.

People were treated by kind staff who they liked. They and their relatives were given opportunities to be involved in the review of people's individual care plans.

People were supported to increase their integration into the community; they were helped to take part in recreational and work-related activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to

and these were acted upon.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

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 individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which vetted prospective employees before they were deemed suitable to safely look after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual physical and mental health needs were met.

People were supported to take part in activities that were important to them.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns and these were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Management systems were in place to help staff with developing their career.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

Augusta Care Limited

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 14 June 2016 and was announced. The provider was given 24 hours' notice because the location provides a supported living and domiciliary care service; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also 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.

Prior to the inspection we made contact with a local authority monitoring officer; this was to help with the planning of the inspection and to gain their views about how people were being looked after. Also before the inspection we sent out and received four out of 32 surveys from people who used the service; none were received from 32 relatives/friends; 12 out of 96 surveys from staff and four out of 26 surveys we had sent to community professionals.

During the inspection we visited the service's office and three of the homes where people lived. We spoke with seven people and one relative. We also spoke with the manager; a representative of the provider, called the Nominated Individual [NI]; two team managers; one training manager; two senior members of care staff and two members of care staff.

We looked at seven people's care records, medicines administration records and records in relation to the management of staff and management of the service, including audits and minutes of meetings.

Due to their complex communication needs some people were unable to verbally tell us their views about

their experience of being looked after. Therefore, we observed care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

People were kept safe because of how they were looked after. People told us in their surveys that they felt safe from the risk of harm and we saw that people interacted with members of staff without any reservation or qualms. This showed us that people felt safe and comfortable with the staff who looked after them.

The provider had a robust recruitment in place and wrote in their PIR, "We apply legislation through our policies and procedures to ensure people using our services are protected from harm. This is applied right from recruitment with DBS [Disclosure and Barring Service] checks and background references checks." One member of care staff confirmed that they had had all the required checks carried out, which included proof of their right to work, before they were allowed to work. One team manager described the recruitment process and said, "We definitely need a DBS; two written references – one from a previous employer – details of ID [identification] and the application form. We would look at previous employment: are there any gaps? That would lead us to question why the person [prospective staff member] has been unemployed."

People told us that there was enough staff to look after them and this included one-to-one support to help them with their shopping. One relative told us that their family member always had the same member of care staff; this was to provide their family member with one-to-one support to help with their personal care and going out for a walk. We saw that there were sufficient numbers of staff who had the time to support people with, for instance, getting a drink, making a GP appointment and talking to people in a sociable way. An increase in the number of staffing hours had been made in response to one person's changing needs, as part of their health promotion plan. One team manager said that staff were used from an external agency until permanent staff were recruited to fill staff vacancies. We were told that the same agency staff were used to provide people with consistent care from staff who were familiar to them. One team manager said, "A lot of our staff like to pick up overtime and agency staff are used until [permanent] staff are fully recruited. We are nearly there." This told us that there was sufficient staff to look after people who provided them with a continuity of care.

Records showed that staff had attended training in safeguarding people from the risk of harm. The training manager advised us that the safeguarding training was provided during staff's induction into their new role. Staff were aware of their roles and responsibilities in following the correct reporting procedures to minimise the risk of harm to people. They were also aware of the physical signs and emotional signs that people might display if they were being harmed. One team manager said, "I would look for a change in their [person's] behaviour. They may not be interacting as well as they normally do. I would look for bruising or redness of their skin." The provider had submitted notifications to us when there were occasions of people being placed at risk of harm. The information detailed in the notifications told us that appropriate actions had been taken to protect people from the risk of recurring harm. This included, for example, reviewing the suitability of members of staff in line with the provider's disciplinary procedure.

A community health care professional told us that they had some concern that staff had not followed their professional guidance to keep people safe from the risk of choking. This was confirmed by a local contracts monitoring officer. We checked to see if improvements had been made since these concerns were raised

and found that measures had been taken to reduce such a risk. This included encouraging the person, who was assessed to be able to make their own decisions around eating, to eat foods that reduced their risk of choking. One member of senior care staff demonstrated their knowledge in keeping people safe as much as possible from risks to their safety; they said, "It's not about reducing the risks completely but it's about managing the risks. Everyone has the right to take that risk, if they have the mental capacity to do so."

Risk assessments were in place and measures had been taken to minimise the identified risks. These included, for example, risks associated with accessing the community and risks related to people's homes. Measures taken included supporting people to go out with or without staff, depending on the person's ability to do this independently or otherwise. People were also supported by staff in preparing and cooking food, if this was needed. One person said, "[Name of member of care staff] helps with the cooker." They told us that they knew of the risk of the cooker being hot and that it would be unsafe for them to independently use this kitchen appliance.

A local authority contract monitoring officer told us that there had been concerns raised about the management of some people's medicines. In October 2015 we received concerns that one person declined to take their prescribed medicines and this omission had caused an increase in the person having unsettled behaviour. The NI informed us that remedial action was taken to minimise the risks of similar occurrences; this included, for example, the use of covert [hidden] administration of medicine. The change of how the person was to take their medicines was supported by a best interest decision making process, to ensure that the person had their medicines as prescribed in an authorised way.

There were satisfactory arrangements in place to ensure that people had their medicines as prescribed. People were satisfied with how they were supported to take their prescribed medicines. One person told us that they had their medicines when they needed them and this was during the evening. Another person told us that they were independent with taking their prescribed medicines. People were assessed before they were deemed safe to be able to independently take their medicines. Medicines administration records showed that these were accurately completed and demonstrated that people had taken their medicines as prescribed. Staff were trained and assessed to be competent in helping people to safely take their medicines. One member of care staff said, "I do give people their medicines and I have had the training and my senior [member of care staff] watched me [with giving people their medicines]." Records showed that staff members had attended training and had been observed to be competent in helping people with their prescribed medicines.

Good

Is the service effective?

Our findings

People were looked after by staff who were trained to meet their individual needs. People told us that they felt that the staff who looked after them had the skills and knowledge to meet their individual needs. The provider told us in their PIR, "Staff have induction which begins on day 1 as an introduction to the company and is developed over the next 12 weeks of employment; this gives them the skills and confidence to carry out their role and responsibilities effectively. Our induction programme reflects the care certificate". [The Care certificate is a nationally recognised training programme. One member of care staff described their induction which included theoretical 'class-room' based learning followed by 'shadowing' a more experienced member of staff to learn how to look after individual people. One team manager also told us that their induction had prepared them for the new role in managing staff. They said, "I was given a full management induction by the management team here. I was introduced to the services [people's homes] I would manage and was therefore introduced to people I had not previously met."

One member of staff responded in their survey, "[I] find my role very rewarding, knowing through knowledge and experience that I can carry out my role to the very best of my abilities." Other staff told us that they had the training to be able to meet people's individual needs. The training manager also told us that staff training included additional training to meet people's individual needs. They gave an example of how some of the staff had attended training to meet one person's mental health needs. One member of care staff said that they had attended this training and added, "They [managers] are always booking training. I recently had [product name of training course] and it really helped me learn about how to deal with certain situations. I'm more confident and we know what we can [legally] do. It was really helpful." Records demonstrated that staff attended a range of training, which included health and fire safety; food hygiene; moving and handling; epilepsy awareness; use of distraction techniques for people with behaviours that challenge; and communication skills.

Staff were supported to look after people. Nine out of 12 staff who responded in our survey told us that they had supervision and an appraisal. However, the remaining members of surveyed staff said that they did not get this support to supervise and develop their career. The manager said, "That was an area that was highlighted when I came into post and we are developing a consistent staff team." They told us that this had helped improve the support and supervision of members of staff. One team manager said, "I manage my staff through supervision and appraisals. I meet with my senior support workers [care staff] monthly to discuss their work performance and if they need support in any areas of their job." Staff members told us that they received monthly one-to one supervision with their manager and this enabled both parties to review training and development needs of the individual staff member. Observation of members of staff at work complemented the one-to-one supervision. One member of care staff told us that they received feedback about their work performance and said, "So far it's [feedback has] been good. It makes me want to work harder." The provider told us in their PIR, "We regard supervision and appraisal as vital tools to develop and motivate staff and review their practice and behaviours."

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 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 application procedures for this in registered services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager advised us that they had made contact with the appropriate authority regarding some people who were in constant supervision by members of staff. Records confirmed this action and showed that the provider was aware of their responsibilities in keeping people safe legally.

The provider told us how they ensured people's rights were protected: they said in their PIR, "Our observations show that staff consider people's capacity to make particular decisions and know what they need to do to make sure decisions are taken in people's best interests and involve the right professionals if required. This is evidenced in our MCA day to day decision forms." We found documented evidence that these forms were in place and showed that people's mental capacity was assessed to determine their ability to make day-to-day decisions for themselves.

The majority [92%] of surveyed staff said that they had attended training in the application of the Mental Capacity Act 2005 [MCA]. Staff told us that they had attended this training and were able to demonstrate their understanding of the application of this legislation. One member of senior care staff said, "[The MCA] is all around people making decisions for themselves. You should always assume that they [people] have [mental] capacity unless it's proven they haven't. And providing care in the least restrictive way possible. And even if they [people] don't have mental capacity, they need still to be involved." We saw members of staff support people in making decisions about when they wanted to eat and planning their evening activities. When people were unable to make decisions for themselves, which included taking prescribed medicines, they were supported to make a decision about this essential part of their care. This decision making process was in conjunction with senior care staff, a GP, relatives and a community learning disability nurse; this approach was to determine what action needed to be taken in the best interests of the person.

People said that they had enough to eat and drink and had what they liked. One relative confirmed that their family member had enough to eat and drink and was able to choose what they wanted. We saw that one person had a picture and easy-to-read plan of what they liked to eat and drink on certain days of the week.

People's nutritional needs were met and they were enabled to make choices of what and where they would like to eat. People had opportunities to eat out or help with making their meals at home. One person told us that they had been shopping for food and was looking forward to eating a pizza. One team manager and staff member told us how the person wanted to lose weight and staff encouraged them to eat a healthier diet. This was successful as the person had a slow weight loss of four kilogrammes over a period of two months. The member of care staff knew what the person liked and did not like to eat: they said, "We do different types of food. We know what food [name of person] likes and we help plan [person's] meals [with them]." The person said, "They [staff] help me with some bits [food planning and preparation]." Information about the person's preferred dietary and food choices was detailed in their care records. Another person was going to watch a film at a local cinema and described how they enjoyed the different types of food sold at the venue. They were aware of the need to eat healthily and we saw that staff involved them in discussions relating to mutually agreed portion sizes. We also saw another person was drinking a milk shake to complement their nutritional intake.

In one person's care records we found that they had difficulties in eating sufficient amounts. The records demonstrated that the person's food intake was monitored and that members of staff did not watch them when they ate; this was part of the person's planned care and their choice which helped them keep their focus on eating.

People were helped to keep healthy and well. One health care professional had written a compliment to the provider which read, "[Name of person] remains the best we have seen [person] for a long time, if not the best ever…This is no small part due to your efforts and your staff team." People told us that they were kept well and, if needed, staff helped them make appointments to see their GP. We saw one member of care staff make a GP appointment on behalf of a person and the person knew the reason for the GP appointment. One person told us that they were under the care of a dentist and were aware of the reason for the recommended treatment to protect the condition of their teeth. Another person told us that they felt "much better" as they appreciated staffs' encouragement and support to control their substance mis-use behaviour. One member of senior care staff told us that people [females] were provided with opportunities to attend well-women screening procedures to keep them well and promote and maintain their health.

Good

Is the service caring?

Our findings

People were looked after by kind staff. The provider had received a number of written compliments from people's relatives. One of these read, "We all really appreciate everything you are doing for [family member and can't thank you enough…I can't tell you how happy we are to see [name of family member] so happy." One relative said that, due to the consistency of one member of staff who looked after their family member, this helped forge a good relationship between their family member and the member of care staff. They also added, "If we ask [member of care staff] to do anything extra, they will do it."

The arrangement of how staff worked helped people to be looked after by staff who they knew them and who they got to know. One team manager described the need for consistency of care to help people trust the members of staff who looked after them. They said that this sense of trust helped people to become more confident; we saw that when people spoke with us and members of staff, they were confident and comfortable in doing so. Another team manager told us that when external agency staff were used, this was in only one person's home, to ensure consistency of their care. Two members of permanent care staff told us that they always looked after the same people and this had helped people build up their trust with them. We saw how people responded to these two members of care staff and there was a good standard of social interaction between all parties.

People responded in their surveys to tell us that they were treated well by kind staff and were happy with how they were looked after. People told us that they knew the names of staff and which care staff were due to look after them as part of their planned care. They also told us that they were introduced to members of staff before they were due to be looked after by them. One person's care records showed that there was a process in place to introduce staff to the person as they had not met the member of care staff before.

People told us that they were enabled to make choices about how to spend their time and that staff respected these choices. One member of staff wrote in their survey, "…proof of me enjoying my role as a support worker to ensure who I support have the choice on their day to day activities."

In their completed surveys, people and community professionals told us that the care and support that people received had enabled them to remain as independent as possible. We found that people's independence was encouraged and promoted in a number of ways. This included independence with booking a taxi; preparing meals; and doing their own laundry. One person said, "I'm happier as I can do more things myself. I do my own jobs and I'm still working with [names of members of the management team] at head office and computer work. I get to do my own cooking and if I need help staff help me." This showed that people's right to independence was valued and respected.

Staff respected people's privacy and choices of how they wanted to have their personal care provided. For one person they preferred female care staff only and their care records showed that the person's gender preference was valued. In addition, the records showed how staff respected the person's privacy and independence with carrying out their personal care.

People's choices were valued in a number of other ways. People were enabled to sit where they liked and choose who they wanted to be with or when to be alone in their own room. They were able to make choices and decisions about how they wanted to spend their time. One person said that they chose to go out to work and were supported to do this. Another person said that since moving into supported living, they found making decisions difficult but told us that they were starting to be more confident with this change. One team manager advised us that the change in how people were encouraged to make choices was part of the transition process and said, "[Our work] is encouraging people to make their own choices [as part of] transitioning from [living in a] care home to supported living." They told us this enabled people to become more confident and independent than when they previously lived in institutional care. Another team manager said, "I feel enabled to make positive changes in people's lives."

People maintained contact with their relatives and made friends with each other and out in the community. We heard one person talking to members of care staff about when they were due to visit their relative. Another person told us that "it is getting round to be sorted" so that they could spend more time with a close relative who lived a distance away. One member of care staff told us that people had met friends and invited them back home. Two people described how senior staff supported them to make sure that external contacts in their close circle were only those people who they wanted to be friends with. Therefore this helped people to be kept safe from the risk of harm from members of the public who did not share with them the same values as theirs.

One team manager told us that advocacy services were used to represent people at their reviews. We also found that this included advocates to support people to manage their financial affairs. Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People told us that they were happy with how they were being looked after. We saw that they had a range of needs and how staff were able to meet these. These included, for instance, communication needs when staff spoke with people in a way that they were able to understand. Basic sign language and information in picture and easy-to-read formats were also used to help people and staff communicate with each other. People's other individual needs included help with continence and their mobility. Aids and equipment were provided and used by trained members of staff.

The provider wrote in their PIR, "We recognise that occupation is a vital need and our care plans and support provide people with the opportunity for engagement and interaction within the wider community. We support and encourage people we support into further education or supported employment." One person told us that they enjoyed working in a charity shop and said, "I get to do a bit of till [payments] work and putting stuff out on shelves." Other people attended college courses, day services and work-related activities. One person told us that they were going to college and learning drama; they said that they were looking forward to the presentation of the play, in which they were playing the part of a maid. People were encouraged in taking part in domestic activities which included personal laundry and cleaning. Recreational activities that people took part in included watching television and DVDs at home; visiting local parks; bowling; visiting friends and relatives; and eating and drinking out.

People's care records and risk assessments were reviewed and kept up-to-date to ensure that staff had the right information to meet people's current needs. One member of care staff said that they found the information in the care records was easy to read so that they were able to safely and appropriately meet people's individual needs. Care plans were up-dated in response to people's changed needs or choices; this included, for example, a change in their health and a change in how they preferred to have their personal care provided. One team manager told us that one person wanted a change in the times of when they received care; the times of their planned care were changed to a later time of day and this was as the person had requested.

There was a process in place to formally review people's care to ensure that it was meeting their individual needs. One person told us that they attended their review and their suggestion to go on holiday was being reviewed. Care records demonstrated that people and people who were important to them, were invited to take part in their reviews and be part of the process.

During our inspection people told us the name of the member of staff who they would speak with if they were unhappy about something. One relative said that they would contact office-based staff if they needed to raise a complaint. Three out of four people told us in their surveys that they knew what to do if they wished to raise a complaint and they also said that they were satisfied with how the provider responded to their complaints. Members of staff were aware of the provider's complaints procedure and one senior member of care staff demonstrated how they supported people to make written complaints for the management team to respond to. The provider told us in their PIR that the three complaints they had received, during the previous 12 months, were used to improve the quality of people's care. This included

increasing a person's level of care to meet their needs and increasing the frequency of a person's visits to their family members. This demonstrated that the provider listened to people's concerns and responded to them in a satisfactory way.

Good

Is the service well-led?

Our findings

A registered manager was not in post at the time when we inspected the service although the manager was in the process of applying to be registered. Two out of four community professionals believed that the service was well-managed. The local authority contract monitoring officer was satisfied with how the provider dealt with any issues in relation to the quality and safety of people's care. These included, for example, taking satisfactory action in response to any errors occurring in the management of people's medicines.

People told us that they knew which manager they would contact if they needed to and were able to name them. They also recognised an individual team manager and senior members of care staff who looked after them.

We received positive views about the management of the service. One member of staff added comments to their survey, in which they wrote, "The new manager [name of manager], who has recently started is offering some well needed changes, and ensuring that the staff team are made to feel valued." A community professional also wrote in their survey positive comments about the management of the agency: they wrote, "There has recently been an improvement evident in the organisational and management of their services, which has been very positive." Another community professional also added a positive comment in their survey, which read, "Generally I feel that Augusta Care [Limited] are a good agency [service]."

However, we also received less positive comments about the management of the service: one member of staff wrote, "Although the service users [people] receive a good quality of care, the way that the company treat the staff team needs some improvement. The company deems it ok to put you onto shifts without checking /asking first and do not take into account any personal commitments they may have." Another member of staff also wrote in their survey to express their strong, negative views about how they felt they were being managed. These less than positive comments were counteracted by one senior member of care staff who attributed this to the previous management arrangements in one person's home; this belief was confirmed by the NI. During the inspection we found members of staff were positive about how they were managed and we frequently heard that the manager was "approachable."

People were provided with opportunities to let the provider know their views. One team manager told us that this was during unannounced 'spot checks' when they observed staff at work and spoke with people who were being looked after; they said, "I chat with service users [people] and I'll ask them about the care they receive." Records of staff 'spot checks' confirmed that people were asked for their feedback during these provider's quality assurance visits.

People attended meetings at home when they discussed what they wanted to do, such as recreational activities. In addition to these meetings, people were enabled to attend meetings, known as 'forums' to meet up and discuss with each other how they were and what activities they wanted to be involved with. One person confirmed that they had attended these 'forum' meetings and another person showed how much they enjoyed these, with laughing and using a 'thumbs up' sign. One team manager told us that two

people had requested the provider for a change in the management arrangements of the home and their request was respected and acted on.

Members of staff were offered the opportunity to attend meetings during which they were enabled to make suggestions and comments. One team manager gave an example of how their suggestion helped with the moving and handling training for members of care staff.

The provider told us in their PIR that there were quality assurance systems in place; they wrote, "Through our quality monitoring procedure we implement probationary periods, supervisions, work performance observations, medication competency assessments, performance reviews and service audits. Service user [people] issues and outcomes are the prominent focus of all these processes." In their PIR the provider identified actions with the aim to improve the quality of people's care. This included, for example, "As part of our business plan for 2016-17 we are looking at implementing a management training programme to ensure that all managers at all levels receive the training that they need to develop their skills." One team leader told us that they had had a job promotion as part of their career development and was due to start a management course.

Other quality assurance systems included audits of people's care records. One team manager said, "I audit the folder of people; medicine charts; accidents and incidents; I check the procedures are being followed." They also told us that their audits were checked again by their manager to ensure that their work was completed to a satisfactory standard. Records of these audits were maintained; any deficiencies were recorded and information regarding the action to be taken by whom and when was detailed. The completion of the actions was checked to ensure that people were protected from incomplete or out-of-date records.

Ten out of 12 staff responding in their surveys said that they would be confident in blowing the whistle in relation to witnessing or suspecting poor care practices. The remaining respondents were unable to say if they would be confident in following the provider's whistle blowing procedure. However, during our inspection staff told us that they knew about the whistle blowing policy and when this was to be used. One team manager said, "The whistle blowing is a very strong policy. If I have witnessed any incorrect care I would not hesitate in blowing the whistle."