ADL Plc

Warley House

Inspection report

Warley Road
Scunthorpe
Lincolnshire
DN16 1PL

Tel: 01724861507

Date of inspection visit:
05 February 2018

Date of publication:
13 April 2018

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

Warley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Warley House accommodates up to 39 older people, including those who may be living with dementia, across one adapted property. Communal accommodation is provided in a variety of lounge and dining areas and bedroom accommodation is provided in single rooms, some with en-suite facilities. The home is situated in a residential area on a main road and close to local amenities and bus routes into the centre of Scunthorpe. At the time of this inspection a service was being provided to twelve people.

At the last inspection in January 2017 the service met The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, but it was rated 'Requires Improvement'. This was because there were issues with promoting respect, dignity and independence and effective audits, for which we issued recommendations.

This comprehensive inspection of Warley House took place on 5 February 2018 and was unannounced. We saw that improvements had been made in the activities offered to people and that medicine and environmental audits of the service were carried out more regularly. We found the overall rating for this service to be 'Good'. The rating is based on an aggregation of the ratings awarded for all 5 key questions.

The registered provider was required to have a registered manager in post. On the day of the inspection we found that the registered manager had been in post for the past seven years. 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.

At this inspection we found that the provider had addressed the recommendations with regard to promoting respect, privacy and independence and using audits more effectively to identify shortfalls in service delivery.

There were systems to safeguard people from harm and risks were reduced. The premises were safely maintained. Staffing levels and recruitment practices were safe and protected people. The management of medication was safely carried out.

People were supported by qualified and competent staff that received regular supervision. People's mental capacity was assessed and their rights protected. The registered manager worked with other professionals and families to ensure decisions were made in people's best interests where they lacked capacity. People's nutrition and hydration were monitored. The premises were suitable for those living with dementia.

People received compassionate care from kind staff. People were supplied with the information they needed, involved in all aspects of their care and their consent was sought.

Person-centred care plans reflected people's needs well and were regularly reviewed. People were supported to maintain friend and family connections and networks. An effective complaint procedure meant that complaints were investigated without bias.

The service was well-led. The culture and the management style of the service were positive. Satisfaction surveys and meetings aided the quality audit system so that improvements in service delivery were made. The registered manager maintained a status quo, but had not been proactive in seeking current best practice to enhance the service delivery in general and in looking to the future.

The recording systems used in the service protected people's privacy and confidentiality as records were well maintained and securely held on the premises.

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 were protected from the risk of harm using safeguarding systems and risk management.

The premises were safe, staffing numbers were sufficient and recruitment practices were robust. People's medicines were safely managed and infection control was maintained.

Is the service effective?

Good

The service was effective.

People were supported by competent staff that were regularly supervised. People's mental capacity was assessed and their rights protected.

Nutrition and hydration was provided for good health and wellbeing. The premises were suitable for those living with dementia, but in general the premises had stagnated.

Is the service caring?

Good

The service was caring.

Staff were kind and caring. People received the information they needed and were involved in their care.

Wellbeing, privacy, dignity and independence were monitored and respected.

Is the service responsive?

Good

The service was responsive.

People had person-centred care plans, which were regularly reviewed. They engaged in some pastimes and activities.

Complaints were investigated without bias. Relationships with friends and family were supported.

End of life support was appropriately and sensitively provided.

Is the service well-led?

Good

The service was well-led.

The culture and the management style of the service were positive. Quality audits and surveys were effective.

The registered manager was not so proactive in seeking continuous learning for best practice and looking to the future.

Recording systems protected people's privacy and confidentiality. Records were well maintained and held securely on the premises. The service worked well in partnership with other organisations.

Warley House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection of Warley House took place on 5 February 2018 and was unannounced. One adult social care inspector carried out the inspection. Information had been gathered before the inspection from notifications sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received feedback from local authorities that contracted services with Warley House and reviewed information from people who had contacted CQC to make their views known about the service. We received a 'provider information return' from the provider for this inspection. This is a form that asks them to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people that used the service and two friends that were visiting. We observed some interactions between people and the staff. We spoke with the registered manager and two of the staff on duty. We looked at care files for three people that used the service and at recruitment files and training records for three staff. We viewed records and documentation relating to the running of the service, including those on quality assurance and monitoring, medication management and premises safety.

We also looked at equipment maintenance records and records held in respect of complaints and compliments. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People at Warley House told us they felt safe living there. People said, "It is safe and warm here", "Staff are very good and keep us safe" and "No one has ever harmed me." One visitor said, "I have been a good neighbour to [Name] for some years and am perfectly satisfied that they are now safely cared for here."

The provider ensured safeguarding incidents were reported to the local authority and that staff were trained in safeguarding people from abuse. Staff understood their responsibilities to refer suspected or actual incidents to the safeguarding team. Training records evidenced that staff were trained in this area. Safeguarding records were held in respect of handling incidents and the referrals that had been made.

We discussed with staff the use of any means of restraint in their daily work. They told us that the policy of the organisation stated there was zero tolerance of physical restraint. However, discussions revealed that staff were aware of the people who may express particular behaviour that challenged the way in which they were supported. For example, people living with dementia who may have refused personal care or put themselves in situations where they or others were at risk of harm or injury. In these circumstances staff explained how they removed themselves from people's presence for a period of time, then returned and offered support again or asked another staff member to approach a person that was reluctant to receive care. They also told us how they spoke quietly to people to calm situations and give reassurance. Staff knew they should intervene when necessary to protect people.

The provider had accident and incident policies and records in place, which evidenced that accidents and incidents were recorded thoroughly and action taken to treat injured persons and prevent any re-occurrence.

We received formal notifications regarding incidents, which meant the provider was meeting the requirements of their registration. People were unable to discuss risks but we saw they had freedom to move around the property, which was spacious and contained few hazards. A pet dog and a house rabbit were absolutely adored by everyone and both had been assessed as part of the service's general risk assessments. We saw that other risks were reduced as much as possible for individuals. These included, for example, risks from falls, poor positioning, moving around the premises, inadequate nutritional intake, accidents when bathing and the use of bed safety rails. People had personal safety documentation for evacuating them individually from the building in an emergency or in case of fire.

Maintenance safety certificates were in place for utilities and equipment used in the service, and these were all up-to-date, with load weight bearing checks on lifting equipment due soon. Contracts of maintenance were in place for ensuring the premises and equipment were regularly maintained. Audits were carried out to ensure fire safety and equipment safety measures were followed. All of this ensured people, staff and visitors' safety.

Staff effectively used equipment to assist people to move or transfer. People were assessed for the use of equipment and risk assessments helped to ensure it was used correctly. Safety bed rails were also risk

assessed for safe use.

The provider's recruitment procedure ensured staff were suitable for the job. Staff files contained documentation for the vetting and screening of candidates. The recruitment practices around requesting job applications, references and Disclosure and Barring Service (DBS) checks were consistently followed. A DBS check is a legal requirement for anyone applying to work with children or vulnerable adults. It checks if they have a criminal record that would bar them from working with these people and helps employers make safer recruitment decisions. We evidenced that all safety checks had been carried out for the staff whose files we reviewed. Staff provided proof of their identities, made declarations about having no convictions and signed contracts of employment.

People felt there were enough staff to support them. They said, "Staff are always around" and "We get the help we need." A visitor said, "It is a shame there are not many people living here, as [Name] would enjoy more company, but they do get more attention from the staff." Staffing rotas corresponded with those staff on duty during our inspection, except for one staff who had gone home following a personal issue. Their absence had been covered by a staff member that worked as carer and domestic, so they swapped over from cleaning to caring. Therefore there were two care staff and a cook on duty for the eleven people that were in the service. The registered manager's hours were not included in care hours provided but sometimes assisted care staff at busy times. A resident dependency graph was used to calculate staff needed. Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities to meet people's needs. Shifts consisted of twelve hours throughout the day and night, with some daytime split shifts of six hours duration.

People said, "I prefer staff to manage medicines" and "I always get my tablets when I need them." Medicines were safely managed and medication administration record (MAR) charts we looked at were accurately completed. Medicines were obtained in a timely way so that people did not run out of them. They were securely stored, administered on time, recorded correctly and disposed of appropriately. Medicines were administered from pre-prepared dosage packs put together by the dispensing pharmacist, which meant that doses were measured for ease of administration.

Protocols were in place where people had 'as required' medicines and separate MARs were used to record these. Body maps were used to record where topical creams should be applied. There were no people receiving controlled drugs (CDs) when we inspected, but one person had anticipatory drugs in store to be administered by the district nurse, should they require these. CDs are those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. We observed a senior staff member administering several people's medicines and saw they did so safely and respectfully.

People said they thought the premises were clean and comfortable. Systems in place ensured that prevention and control of infection was appropriately managed. Staff had completed infection control training, followed guidelines for good practice and had personal protective equipment that they required to carry out their roles. Domestic staff were not on duty the day we inspected and while the premises were clean not all bedrooms were free from unpleasant odours, as we found two that were unpleasant. This was discussed with the registered manager who explained about the care needs of people that occupied the two rooms and how staff worked to improve the environment for them.

Good

Is the service effective?

Our findings

Most people were unable to tell us about the effectiveness of the care they received, but staff at Warley House followed an assessment and care planning process and understood people's needs. People said, "It's alright here" and "Staff are very helpful." A visitor said, "All the staff are lovely and [Name] gets all the support they need."

People were encouraged to exercise choice and control as much as possible with regard to care planning, individual care and treatment, their relationships with others such as family and friends and as citizens beyond the health and social care services that they were using. For example, people were encouraged to say how their day should go and how they expected support to be given and so preferences were recorded. Sometimes their choice with regard to service development was limited because they were living with dementia and unable to make direct choices beyond those to meet their daily living needs. They couldn't always influence how the service was delivered and how changes should be made to ensure continuous development. However, staff were experienced in observing when changes in needs required changes in service delivery.

The provider ensured staff received the training and learned the skills they required to carry out their roles. A staff training record (matrix) was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. The matrix showed that most training (fire safety, moving and handling, infection control, safeguarding people, management of medicines) was up to date but there was a gap in staff training on the Mental Capacity Act 2005 (MCA) with just under half of the care staff having completed it. It is important for as many staff as possible to follow this legislation to ensure people's rights are upheld.

Staff understood about their responsibilities regarding capacity issues and had information about the MCA and DoLS. They knew there was sometimes a fine line to seeking consent, which they knew they should not cross. Staff gave examples of when some people refused support and said, "With [Name] I usually come back several times to try again", "[Name] likes certain staff to help so we go with that" and "Situations can be different for [Name] so I offer lots of reassurance."

Staff were inducted into their roles, received one-to-one supervision and took part in a staff appraisal scheme. These were evidenced from documentation in staff files and via discussion with staff. Staff confirmed that they had completed mandatory training (minimum training as required of them by the provider to ensure their competence) and had the opportunity to study for qualifications in health and social care. One staff stated they needed to complete MCA training.

People received appropriate nutrition and health care professionals were involved if necessary before support was delivered, as staff sought the advice of a Speech and Language Therapist (SALT) when required. Nutritional risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink. Nutritional needs were met, wherever possible, through consultation with people about their dietary likes and dislikes, allergies and medical conditions on admission. People also made their

choices known regarding meals through offers made to them on a daily basis and staff took note of the foods they didn't eat, as we were told by the registered manager that not everyone could make their preferences known. We observed people eating well and making choices with drinks and meals. Where people needed support to eat this was provided sensitively.

Staff told us they worked well with other care and healthcare professionals. We had received information in October 2017 that one person's moving and handling was inappropriate and lacking the correct equipment. The occupational therapy team provided the correct equipment and instructed staff in its use so that the person was appropriately supported. No other comments or testimonies were received from healthcare professionals that visited the service.

Staff knew about people's medical conditions and liaised appropriately with healthcare professionals. Information was recorded and reviewed with changes in people's conditions. Staff told us that people could see their doctor on request and the services of the district nurse, chiropodist, dentist and optician were accessed whenever necessary. Records held in people's files confirmed when they had seen a professional and the reason why. They contained guidance on how to manage health care needs and recorded the outcome of any consultations.

Those people living with dementia had signage and some colour schemes that aided their orientation. Carpets, furniture fabrics and wallpapers were plain in the main, which helped to ensure people's confusion was kept to a minimum, but they were not defined according to block colouring. Environment incorporates design and building layout, colour schemes, textures, experience, light, sound and smell. The provider was making every effort to ensure the environment was suitable for its use. However, we saw that some areas were looking worn and tired and while they were safe, they were not welcoming. For example, the bathroom and toilet floor coverings were in need of an upgrade for easier cleaning, paintwork was scuffed in many corridors and on door thresholds and there was some plaster damage in a small number of bedrooms. While the environment was not unsafe or unsightly it had not been decorated with consideration to optimum dementia friendly concepts. These examples were brought to the attention of the registered manager who told us they liaised with the provider to acquire funds for repairs and redecoration and would do so.

Warley House had communal areas on the upper floor: activity / coffee and memorabilia rooms, for people's use and socialisation, but these were not independently accessible to people living with dementia as they needed to be accompanied upstairs by staff. The rooms were not used by anyone on the day we inspected, except for by one person who liked to sit in the coffee room.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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. Where people were assessed as having no capacity to make their own decisions, the registered manager arranged for best interests decisions to be reached, DoLS applications to be made and reviews to be carried out. This was managed

within the requirements of the MCA legislation and while we saw that some DoLS were in need of review, having passed their expiry date, they had already been referred to the local authority for renewal.

We spoke with staff about seeking consent after observing they used persuasion and hand/arm holding to walk some people to the toilet or to the dining room for meals. Staff knew about their responsibilities to seek consent and the reasons why it was important.

Good

Is the service caring?

Our findings

People told us they had good relationships with staff and each other. They said, "I like the staff", "Staff are friendly" and "We all get on rather well together." We heard staff speaking kindly to people and reassuring them when they were anxious.

At the last inspection we made a recommendation for the provider to ensure people's privacy and independence were respected. At this inspection we saw that staff had a pleasant approach with people and knew about their needs and preferences. We saw that staff were kind when they offered and gave help to people. Even when people's wishes were unknown staff treated them in a humanitarian way and with respect. An audit had been introduced and used to check that staff treated people respectfully.

The registered manager led by example and was polite, caring, attentive and informative in their daily approach to people and staff. The registered manager was happy to stand in when required to help support people, and with resident numbers being low and only two care staff on duty, this was often necessary. They maintained a presence in the service.

At the time of our inspection, the service was providing care and support to people with differing needs. People said that their individual needs were well respected. The registered manager said that any information they required was supplied in a format they required so they understood it. For example, in large print, on loop system or pictorially if necessary.

Where people had a particular communication need this was taken into consideration so that they had the means and technology they required to receive and understand information. For example, anyone with poor or no sight received clear verbal instructions and staff used touch a lot of the time. Anyone with poor hearing was encouraged to use their hearing aids and spoken with while maintaining eye contact and using short sentences. Those for whom English was a second language would receive written translations if they showed no understanding of the information they were given. The registered manager was aware of the Accessible Information Standard but felt that so far everyone that needed to process information had been able to do so without the means of any specialist assessment and intervention.

People's general well-being was monitored by the staff who knew about people's routines and preferences and what events might upset them in any way. People were supported to engage in old and new pastimes, which meant they were able to maintain some of the lifestyle they used to lead and learn new skills if they wished. Activity and occupation helped people to feel their lives were worthwhile and purposeful, which aided their overall wellbeing.

Staff provided people with choice wherever possible, so that people continued to make decisions for themselves and stayed in control of their lives. People had a choice of main menu each day and if they changed their mind the cook was responsive to this and prepared something else for them. Where appropriate people were offered the use of adaptive cutlery and crockery aids so that they could maintain their independence. They chose where they sat and who with, what they wore each day and whether or not

they went out or joined in with entertainment and activities. People had a say in when they got up and went to bed although sometimes staff worked to discourage people from living in a way that confused their night with day.

The registered manager told us that ten from twelve people living at Warley House did not have relatives to represent them, which was an unusually high percentage, but some did have friends or neighbours that visited and aided them. These people were referred to the local advocacy services that were available. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. Some people's friends were regular visitors and liaised with the staff.

People experienced equal treatment for their needs to be met while staff recognised their differences in relation to age, disability, gender, race, religion and belief and sexual orientation. Staff understood people's differing needs, for example, with regard to religion and food.

One person of the Muslim faith, but not practicing, was always offered appropriate meals. However, they often chose what they saw others eat and also enjoyed an alcoholic beverage from time to time, but staff were still mindful of the person's past beliefs and offered what was appropriate for them. The person's care plan had been updated to reflect that they may have forgotten about their religion due to living with dementia and stated that any choices they made, in line with or against their belief, should be respected.

There were two people of the Catholic faith who received visits for Holy communion from the local priest, and anyone that requested to only receive personal care from a staff member of the same gender, had this wish respected.

People's confidentiality was upheld and privacy, dignity and independence were encouraged and respected. People said, "I can do whatever I am capable of and the staff like me to try", "The girls always make sure I am covered up" and "I have my own room, which is really nice." Staff maintained a discreet approach to providing personal care to people and ensured they knocked on bedrooms doors before entering and ensured bathroom doors were closed quickly if they had to enter and exit, so that people were never seen in an undignified state. Staff said, "I work as discreetly as I can with people" and "We maintain confidentialities of information." We observed that people were treated respectfully when offered assistance with mobility, eating and drinking and going to the toilet.

Good

Is the service responsive?

Our findings

People said, "I think the staff look after us well" and "Help is there when we need it. The girls are invaluable." Care files for people that used the service reflected the needs and wishes that people expressed. People's individual needs were assessed, with their involvement, and a care plan put in place to meet these. Care plans were person-centred and contained information under several areas of need for staff on how best to support people. We were unable to talk in detail with people about their care plans. However, the staff were knowledgeable about the people who used the service and displayed a good understanding of their preferences and interests, as well as their health and support needs. Risk assessment forms coincided with care plans areas to show how risk to people was reduced. We saw that care plans and risk assessments were reviewed monthly or as people's needs changed.

We saw from pictures of past events posted on the walls, that activities were held in-house with staff in relation to the seasons and religious or traditional festivals. Pictures of Christmas and Easter celebrations and, for example, Halloween and bonfire night activities were posted around the service. People told us, "I join in with pampering" and "I like the sing-alongs." We saw the service had a dedicated activities/craft room with mock bar although the room was not being used at the time we visited. Other function areas were available but again people were not using them.

There were opportunities for socialising in the dining room or lounges, but because resident numbers were low activities tended to be on an individual basis. One person only liked to be taken to the pub if their favourite drink was on offer. Another showed us their nails which had been painted recently. Newspapers, magazines and puzzle books were on offer. We found on the day we inspected that most people seemed to enjoy meal times as an activity and a time to get together. The 'resident' dog and rabbit also provided entertainment. Staff said they encouraged people to do movement to music and to be independent with dressing where possible to aid physical ability. They explained that one person liked to pair up socks from the laundry and fold table cloths as well as wipe tables over.

People's relationships were respected and staff supported both those with family members and those with friends and neighbours to keep in touch with them. There were no restrictions on visiting and two family members stayed throughout the day with one of the people living at Warley House. Staff got to know people's families and friends and kept them informed about people's situations if this was appropriate and consent was for them to do so. Staff encouraged people to receive visitors and we heard them speaking with people about family members and friends.

The provider's complaint policy and procedure were available for anyone to follow. Records showed that complaints and concerns were handled within timescales and complainants had been given written details of explanations and solutions following investigation. There had been four complaints in the last twelve months and all four were appropriately addressed and resolved. Staff were aware of the complaint procedure and had an understanding approach to receiving complaints as they accepted that complaints helped them to improve the care they provided.

Compliments were also recorded in the form of letters and cards and we saw that at least seven had been received in the last twelve months.

We discussed with the registered manager and staff about how people were cared for at the end of their life and found that staff sought appropriate healthcare support to enable people to have a comfortable, pain-free and dignified death. All care and end of life arrangements were recorded within people's care plans and took into consideration any religious, cultural or specific requirements.

Good

Is the service well-led?

Our findings

At the last inspection the provider was recommended to ensure audits were used effectively to highlight issues with medication needs to protect people's rights and environmental issues to respect people's dignity.

At this inspection we looked at the systems in place for monitoring and quality assuring the delivery of the service. There were quality audits completed on a regular basis and these were used to identify any shortfalls, particularly with regard to issues with falls and other accidents, infection control, care plans, medicines, health & safety, kitchen cleanliness, staff files, and nutrition. Any shortfalls were logged and passed to staff concerned so they could make amendments or improvements. Action plans were produced, for example, for specific cleaning required in the kitchen, referrals to the 'falls team' and health screening following several falls and ensuring people saw their doctor following a significant weight loss. These were recorded and signed off by the registered manager on completion.

Specifically in relation to medicine and environmental audits we saw these were being used to identify concerns, although no issues had been raised for several months. We saw that in addition to the main medicines audit, staff were now checking one another's practice with regard to administering and recording medicines and highlighting any errors they had made. We considered that this approach of observing one another was the reason why errors were not happening with medicines as much as before. We also saw that the environmental audits included checks on such as safety, furniture, equipment and any damages. These were being referred to the handyperson.

People told us they felt the registered manager did a good job of running the service. They said, "The manager is lovely" and "The place is well run." Staff we spoke with said the culture of the service was, "Friendly and caring" and "Open and honest." We found the registered manager had not been proactive in seeking current best practice to enhance the service delivery in general. While improvements for people were experienced on an individual basis following on from addressing identified shortfalls and obtaining some people's views, the registered manager was not so proactive at seeking continuous learning around best practice generally within the service. While they sustained a status quo regarding the quality of service delivery, nor were they innovative in finding new ways to progress the development of quality and measure and review this against good practice guidelines. As ten of the twelve people living at Warley House were also living with dementia the service looking to future development would improve more readily if research and learning were accessed.

The management style of the registered manager was open, inclusive and approachable. Staff told us they expressed concerns or ideas freely, felt these were fairly considered and that they could speak with the registered manager any time about anything. Staff told us they respected the registered manager. We saw that the registered manager was well-like among people that lived at Warley House too and that their relationships with some people had been long lasting.

People kept links with the local community, where possible, through friends, their church connections and

visitors to the service. Staff brought the community into the service as well by speaking about their family and friends and sometimes visiting on days off with their children or grandchildren. Day-to-day activity remained routine and constant.

The service kept records regarding people that used the service, staff and the running of the business. These were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held.

The registered provider was required to have a registered manager in post and on the day of the inspection there was a manager, who had been registered for the last seven years. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. They had informed CQC of significant events in a timely way and therefore fulfilled their responsibility to ensure any required notifications were sent to us. This meant we could check that appropriate action had been taken to address these events. The registered manager also understood about the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made). They had good relationships with the friends of people and the few family members that visited the service.

So as to obtain people's views and engage them in the running of the service themed satisfaction surveys were issued to people that used the service, relatives and health care professionals. However, because only two people were able to complete these, responses were very few. Two friends and four relatives of people had completed surveys on the theme of 'abuse'. Responses had all been positive with only one concern raised. This had been discussed with the family members concerned and while arrangements were put in place to resolve the issue, the resolution was still not to everyone's satisfaction. The registered manager still maintained a position that favoured the needs of people that used the service. For example, where people became anxious and tired with long visiting times, then visitors would be asked to leave. Three staff surveys were still to be received but others had shown satisfaction with the way in which the service was run. Staff and other meetings were also held to obtain people's views of service delivery, but these were infrequent and attendance at these was always low. The provider did not use any other means of obtaining people's views of the service.

The registered manager gave us examples of how they and the staff worked in partnership with other agencies and organisations. These included health care professions, other care providers and social services teams within the local authority. Contact we had with the local authority safeguarding and contract monitoring teams at North Lincolnshire Council revealed that generally the registered manager cooperated well with their requests.