Sussex Oakleaf Housing Association Limited

Sussex Oakleaf Housing Association Limited - 26 Shakespeare Road

Inspection report

26 Shakespeare Road
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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

The inspection took place on 19 July 2016 and was unannounced.

Sussex Oakleaf Housing Association – 26 Shakespeare Road – is registered to provide accommodation and support for up to eight people living with complex mental health conditions, such as schizophrenia, bi-polar disorder and autism. At the time of our inspection, there were eight people living at the service. Rooms are of single occupancy and all have en-suite facilities. Three people have their own individual flats with kitchen, two within the main building and one adjoining it. Communal areas include a sitting room, with kitchen and dining areas and an accessible garden surrounds the house. Shakespeare Road is within walking distance of the town centre and seafront, with access to public transport.

A new manager had been appointed recently and had commenced employment at the service approximately six weeks before our inspection. They had applied to register as manager and had submitted their application to the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were free to come and go as they pleased at the service and their movements were not restricted. Risk assessments were in place to protect people and their risks had been identified, assessed and managed appropriately. They were protected from the risk of abuse by trained staff who knew what action to take if they suspected abuse was taking place. Accidents and incidents were managed safely and action taken to prevent the risk of reoccurrence. Staffing levels were sufficient to meet people's needs and new staff were vetted as to their suitability before they commenced employment. Medicines were managed safely.

People were supported by staff who had completed all essential training and were encouraged to study for additional vocational qualifications. New staff completed the provider's induction training programme covering the regulations relating to health and social care. Staff received regular supervisions and the majority of staff had completed annual appraisals. Team meetings were held fortnightly and the new manager was using these meetings as mini training sessions and for staff to reflect on their experiences to improve the way they worked. The requirements of legislation under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were met by staff who understood their responsibilities and the implications of these codes of practice. People were supported to have sufficient to eat and drink and to maintain a healthy diet. They had access to a range of healthcare professionals and services.

People were cared for and supported by kind, friendly staff who knew them well. Staff were patient and understanding of people's mental and physical health needs and supported them in an empathic way. People were encouraged to express their feelings and share their emotions at informal group meetings. Their cultural and spiritual beliefs were acknowledged and respected. Cultural events were organised and people were treated with dignity and respect.

Care was personalised and was responsive to people's complex needs. Care plans included information and guidance to staff on people's personal care needs, physical and mental health and how they wished to be supported. People were involved in all aspects of their care and met regularly with their keyworkers to discuss their mental and emotional wellbeing. People participated in activities that were important to them and could freely access the community. A range of events was also organised at the service and a minibus trip was planned for the future. Complaints were managed appropriately and to the satisfaction of the complainant.

People and their families were extremely complimentary about the service and the quality of the care delivered. Their feedback was obtained through formal surveys and responses overall were positive. The manager had recently come into post and prior to his employment, the assistant manager had taken over the running of the service. Staff felt supported by their immediate managers and by the provider. Their emotional wellbeing was supported through supervision meetings and by a 'Staff Wellbeing Day' which the provider had organised. A range of audits was in place to measure the quality of care delivered and the service overall.

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 safe living at the service and were free to come and go. Their risks had been identified, assessed and were managed appropriately.

Staff had been trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place.

Staffing levels were sufficient to meet people's needs. A range of checks were carried out before new staff commenced employment to ensure they were safe to work in a care setting.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People received care from staff who had been appropriately trained and new staff followed the provider's induction programme. Staff had regular supervision meetings with their managers.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People were supported to have sufficient to eat and drink and to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were looked after by kind, friendly and caring staff who knew them well. People were involved in all aspects of their care and were treated with dignity and respect.

People were encouraged to express their views and their cultural and religious beliefs were acknowledged and respected.

Is the service responsive?

Good

The service was responsive.

Personalised care was delivered to people which met their needs and preferences. Care plans provided comprehensive and detailed information to staff about how people wished to be supported. People met regularly with their keyworkers who encouraged them to talk about their mental and emotional wellbeing.

People had free access to the community and were encouraged to pursue activities of importance to them. A range of activities was also organised at the service.

Complaints were managed appropriately and to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well led.

People were encouraged to be involved in developing the service and their feedback was obtained through house meetings and formal questionnaires. Their relatives were also asked for their feedback.

A new manager had recently come into post and staff felt supported. Their emotional wellbeing was maintained through supervisions and an event organised by the provider.

Systems were in place to measure, monitor and audit the quality of the care delivered and the service overall.

Sussex Oakleaf Housing Association Limited - 26 Shakespeare Road

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 took place on 19 July 2016 and was unannounced. One inspector undertook this inspection.

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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with three people living at the service and spoke with one relative. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the manager, the assistant manager, two recovery workers (care staff employed at the service) and a member of bank staff.

The service was last inspected on 25 February 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People were safe living at the service and were free to come and go, either independently or with staff. One person had an informal contract which they had signed in agreement that showed they had been risk assessed against leaving the grounds and were safer if accompanied by staff. They still had the right to leave the house at any time. In the Provider Information Return (PIR), the assistant manager stated, 'Freedom is not restricted with open front door access 7am – 11pm and the door can be opened easily from inside at night. 'Keep Safe' reminder displayed by door. Clients encouraged to lock room doors'.

Staff had been trained to recognise the signs of potential abuse and were aware of the local authority's guidelines on safeguarding vulnerable adults, a copy of which was kept in the office. Records confirmed that staff had received training and that this was up to date. One member of staff referred to safeguarding and explained, "It's making sure the clients aren't being abused in any way". They went on to name different types of potential abuse such as sexual, physical and mental, before giving an example of how they helped support people at the service in managing relationships.

Risks to people and at the service were managed to protect people and they were involved in reviews of their risk assessments which they had signed. The PIR stated, 'Risks regularly discussed at staff handovers, team meetings, with clients themselves and with the Community Mental Health Team. Risk assessments and management plans were reviewed regularly and updated if necessary after any incident. Changes to risks were signposted to staff in the Communication Book and paperwork included in the New Information File until all staff have signed as read. Risks were identified, assessed and managed safely and documented within people's care plans. For example, one person had risk assessments for their mental health that included information relating to self-neglect, self-harm, suicide attempts or suicidal thoughts, substance misuse and vulnerability to exploitation or abuse. The area of each risk was identified, the factual supporting evidence, including how the risks were currently managed, who would be at risk, the likelihood of the risk and severity were all scored. Each risk was scored and the total identified the person's overall risk as being low, medium or high.

Risks also included risk management plans which provided advice and guidance to staff on the area of risk, who was at risk, risk rating, early warning signs and risk management actions. The risk management plans were cross-referenced across people's care plans, for example, in relation to people's mental health needs, support and management. Some people were permitted to smoke in their rooms and the risk relating to this had been assessed. Fire blankets had been purchased and people know what the blankets were for and how to use them, in the event of fire caused through lit cigarettes. The manager told us, "We are constantly risk assessing. Is their mental health stable or is it changing? Is it physical health need or mental health need?"

Accidents and incidents were reported and managed appropriately by staff. Records showed there had been three incidents between January and March, all of which had been managed in line with the provider's accidents and incidents policy.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. In addition to the manager and assistant manager, there were five permanent staff working at the service. The assistant manager told us that they had one full-time recovery worker vacancy which they were advertising. Where needed, bank staff could fill any rota gaps, for example when permanent staff were on annual leave, training or were on sick leave. The same bank staff were used consistently and they knew people very well. During the day, there were two care staff on shift (either a recovery worker or bank staff), in addition to the manager or assistant manager on certain days of the week. At night there was one 'sleep-in' member of staff. The PIR stated, 'Fixed rolling seven week staff rota in place for continuity. Staffing levels increased if risks dictate, e.g. waking night staff additional to the sleep-in'. The fixed rolling rota ensured staff always had at least two consecutive days off. Staff may then choose to do overtime on one of them and this was monitored. Staffing levels were consistent and in line with the last few weeks' rotas which we checked.

Safe recruitment practices were in place. Before new staff commenced employment, checks were made with the Disclosure and Barring Service to ensure they were safe to work in care. Where there were recorded convictions, the new staff member had been risk assessed to ensure they posed no ongoing risk to people living at the service. Two references were obtained and employment histories checked, as well as people's identity through passports, driving licences or birth certificates.

Generally people's medicines were managed so they received them safely. In the past, one person had inadvertently taken another person's medicines due to a misunderstanding. We discussed this issue with the assistant manager who had taken the necessary action required, including receiving advice from the GP, monitoring the person for any ill effects, notifying the person's family and reviewing why the error had occurred to prevent the risk of reoccurrence. No-one administered their medicine independently and people were encouraged to come to the staff office to receive their medicines from trained staff. Two people chose to 'pop' their tablets from the blister packs and were overseen by staff as they did this. When these two people had taken their medicines, they signed their Medication Administration Records (MAR) in confirmation. We observed people coming to the office to take their medicines during the morning. Staff and people ensured their hands were clean and used an alcohol handwash prior to handling their medicines. During the administration of one person's medicine, the telephone rang, but the member of staff ignored it, ensuring that the medicines were not left unattended.

Some medicines were prescribed by the hospital and were supplied in boxes, rather than through a blister pack in a monitored dosage system. One person had been risk assessed as safe to collect their own medicine from the hospital pharmacy every 28 days, which they then returned for safe storage in the service's secure medicines cabinet. We checked a random sample of boxed medicines and stock levels tallied with those recorded in a 'countdown book' which was in use. We were told that some medicines could be used as a last resort if people became extremely anxious or agitated. The PIR stated, 'When required, medications for mood are used sparingly with explicit instruction from CMHT and reviewed regularly'. CMHT refers to the Community Mental Health Team. Staff were trained in the administration of medicines and certificates in staff files confirmed this. Staff competency to administer medicines was checked annually by the assistant manager.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. New staff followed the provider's induction programme and study guide, which covered the standards that health and social care workers are required to meet to work effectively. In addition, staff were encouraged to study for additional qualifications in health and social care, for example, a National Vocational Qualification, a work-based award that is externally assessed. Staff completed training in a range of areas, either face to face, or through e-learning. Topics included: fire safety, first aid, food hygiene, infection control, health and safety, moving and handling, mental health, challenging behaviour, depression, anxiety, obsessive compulsive disorder and diabetes. Bank staff also completed essential training and records confirmed that all staff training had been completed as required. Some staff had received additional training in medicines and health and safety which enabled them to be the lead member of staff in these areas and provide support, advice and guidance to staff. In the Provider Information Return (PIR), an area for improvement was identified as, 'Change lead roles amongst the team to increase skill base and assistant manager to transfer more skills to the staff team – within three months of new service manager starting'.

Staff had supervision meetings with their line managers approximately ten times during the year. We checked staff files which included records of discussions that had taken place at supervision meetings. The assistant manager acknowledged that not all staff had received an annual appraisal and that they proposed to complete outstanding appraisals for three staff by the end-August 2016. The new manager felt that supervisions were an opportunity, "For me to get to know people [staff] on a 1:1 basis better. I'm asking a lot of them and their self-reflective ability". Staff attended team meetings and the manager had decided these should be held more frequently, every fortnight. The manager felt that more team meetings were beneficial for staff and would enable them to meet together often, to participate in mini training sessions and reflective practice. (Reflective practice is a way of studying your own experiences to improve the way you work and to increase confidence.) We saw records which confirmed staff meetings had taken place twice a month in April, May and June.

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. Capacity assessments within care records showed the process by which people were involved in making specific decisions about their care and treatment. For example, one person with a particular health condition, had to consider whether they wanted to receive treatment for the condition. An advocate was employed to support the person to make the decision that was right for them. Capacity assessments for people showed the two-stage test of capacity had been followed, that the person had an impairment of the mind or brain which might mean the person was unable to make the decision in question at the time it needed to be made. Staff had received training on the MCA and had a good understanding of the requirements of this legislation. One staff member explained, "Everyone has mental capacity unless proven otherwise. People can make bad decisions and do not have to feel rail-roaded into making decisions".

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 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. No-one living at the service was subject to DoLS and people were free to leave the premises, although the door was locked at 11pm for security reasons. Some people were completely independent and went out into the community, whilst others preferred not to go out on their own, so were supported by staff or family members. One person had a key to their flat which had a separate front door accessed through the garden.

People were supported to have sufficient to eat and drink and were encouraged with healthy eating. One person self-catered for the majority of the time, only joining other people at the service on Fridays for fish and chips and for the Sunday roast. People took it in turns to prepare the main meal of the day which was served in the evening and were supported by staff to do this. People helped to plan the weekly menu, a copy of which was posted on the refrigerator door, so people could easily see what food was on offer on any particular day. If people chose to eat the main meal choice, then they were required to sign the menu sheet to this effect by 2pm on the day. If they chose not have the main meal choice, then alternatives were available. People's weights were monitored to check for any increase or loss in weight and appropriate action taken where needed. We saw that people's weights had not been taken or recorded since May 2016 and drew this to the attention of the assistant manager who told us that this was an oversight. There was no significant impact of this lack of recent recording to people's welfare, as no-one was currently at risk of malnourishment and their weights had been regularly monitored in the preceding months.

People were supported to maintain good health and had access to a range of healthcare professionals and services. People's mental health needs were monitored and treated by specialists and care co-ordinators, according to their diagnosed mental illness. Other health professionals were also involved in caring for people such as optician, dentist, podiatrist and GP. Care plans documented people's healthcare appointments and for women, for example, included breast and cervical screening. One person was supported by staff to complete daily physiotherapy exercises, devised by the physiotherapist, to help with their mobility. Staff accompanied people to their hospital appointments as needed.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed staff chatting with people throughout the day. When people appeared anxious or distressed, staff took time to sit and talk with them and provided reassurance as needed. The atmosphere at the service was warm and friendly; people appeared to be very comfortable and relaxed in their surroundings, despite the intrusion of the inspection visit. A relative told us, "I like the way they treat him [referring to family member] here, the staff are all good. [Named assistant manager] is very good with the men. He's well looked after in every sense".

The manager said, "What I feel works here is that there is always 'through traffic' on the ground floor – there's always someone around, always someone to talk to". They added, "Interaction with clients is really important. We have a good sense of family and knowledge of each other. The care, the compassion that staff have are lovely and I think they're pretty well liked by the residents".

Staff were patient and kind with people and treated them with empathy and understanding. At times, people's behaviour could be quite challenging, with each other or with staff. Staff had been trained in a range of de-escalation techniques to calm people and felt supported by senior staff to deal with different behaviours, for example, when people tried to self-harm. Informal meetings took place where people were encouraged to talk and share their emotions and experiences. One member of staff had taken the lead in this and used 'mood cards' to promote discussion. Mood cards, like playing cards, have a single word printed on one side which is an emotion or feeling and ideas to initiate discussion were printed on the reverse. For example, the word 'regret' provoked discussion within the group, with one person explaining and talking through things they had cause to regret in their lives. We saw a flipchart poster that had been drawn up by a staff member following one of these discussions with people and this depicted, in a very accessible way, what people had said and the outcomes.

People were supported to express their views, such as through informal meetings and were involved in making decisions about their care. Each person had a keyworker who co-ordinated all aspects of their care and met with people formally every three to six months to review their care plans. We saw that people had signed different parts of their care plan to indicate they had been involved. In the Provider Information Return (PIR), it stated, 'Clients and their family members are invited to attend CPA meetings. Beforehand, staff meet to identify what clients wish to discuss and any support (if requested, advocate). They are encouraged to put across their point of view, including when it may differ to professional expertise'. ('CPA' refers to Care Programme Approach which is the way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems.)

People's cultural and religious beliefs were acknowledged and respected. Many people had made plans that reflected their end of life wishes and funeral arrangements. An Equality and Diversity Service Improvement Plan was in place. The objectives were, 'Promote client activity in upcoming cultural events. Communicate with clients in a way accessible to them. Understand the role that cultural and religious beliefs play in people's experience of the service. Treat everyone with dignity and respect at all times' and included the action required of staff. An Equality and Diversity Calendar was in place for 2016 and showed

that various events had been organised, including celebrations for St Patrick's Day, Easter and the Chinese New Year.

We observed that people were treated with dignity and respect by staff. People would check with each other first before they visited each other's rooms.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans included people's personal details, their medical history, likes, dislikes and preferences. The care plan relating to people's mental health issues was entitled, 'My Recovery Plan' and provided information and guidance to staff on people's health and day-to-day care needs. For example, one recovery plan we looked at detailed the person's mental health, their medicines, physical health, finances and activities of daily living. People helped to plan their weekly programme and, for one person, this included being independent with their personal care, housekeeping duties and trips out. We saw they enjoyed a trip to a local café and a visit to the library every fortnight. They talked enthusiastically with us about a planned short break to Brighton, where they were staying and what they planned to do, which included eating fish and chips on the seafront. People were encouraged to be as independent as possible, to keep their rooms clean, change their bedding and manage their own laundry.

People were able to access the community freely and to pursue interests of importance to them. In addition, some organised activities were available to people at the service. There were plans for a Birthday BBQ for one person and everyone was invited to contribute to this, with ideas for food and activities. People were given information about the local elections held in May, to vote for councillors and the Sussex Police and Crime Commissioner. Discussion had taken place on the EU Referendum and arrangements if people wanted to vote. Other organised events included a poetry writing group, a house teaparty, baking and cake making and a 'cooked breakfast' meeting. A weekly activity planner was on display and showed the organised activities that people could be involved with if they chose. People had discussed the possibility of a minibus trip and everyone was visiting Birdworld in Kent in the near future.

People met regularly with their keyworker to discuss their mental and emotional wellbeing. The Warwick-Edinburgh Mental Well-being Scale was being used on a trial basis as a new assessment tool. This is a 14 positively worded item scale with five response categories and covers most aspects of positive mental health, thoughts and feelings. For example, people were asked to comment on each of the 14 statements, which might include, 'I've been feeling optimistic about the future' or 'I've been feeling good about myself'. They then ticked the box next to the statement which best described their experience of each statement over the last two weeks. Responses included choices from, 'None of the time, rarely, some of the time, often, all of the time'. This tool provided a clear indicator of how people had been feeling and could be used to monitor and compare people's mental wellbeing over time. People's mental health conditions were managed effectively as they took their prescribed medicines. Staff knew people really well and were alert to any changes to people's behaviour, which would be addressed appropriately. For example, one person had periods of time when they felt positive, enthusiastic and engaged in meaningful activities. However, there were periods when they felt depressed, negative and unenthused and required a higher level of support and involvement from staff. Staff were flexible in meeting people's needs. The manager said, "Staff are very understanding and willing to try new techniques".

Handover meetings took place daily between shifts. We sat in on a handover meeting during the early afternoon, when the morning staff were handing over to the afternoon/night staff. Each person was

discussed and included information about their personal care, medicines, meals, laundry, emotions and how they had spent the day.

Complaints were managed appropriately. We looked at the complaints policy which stated that complaints would be acknowledged within five working days and investigated within 10 days. In the first instance, complaints were investigated by the manager, but if the complainant was not satisfied with the outcome, the complaint could be escalated to more senior staff of the provider. The complaints book showed that one complaint had been received in 2016 which related to a concern raised by a person living at the service. We saw that the complaint had been investigated and the person had met with a member of the management team to discuss their concerns. The complaint was resolved to the satisfaction of the person and they had signed a record of the meeting to confirm this. We asked a relative how they would make a complaint and they said they had never had cause to do this, even though their family member had, "Been looked after here a long time".

Good

Is the service well-led?

Our findings

People were involved in developing the service. House meetings were held every two weeks and people were encouraged to attend to discuss a range of items. At a meeting held in May 2016, minutes showed that people were welcomed to the meeting, minutes from the previous meeting were reviewed and discussions took place on healthy eating that included a quiz, outings and activities. A suggestion was made to move the day of the house meeting to a Monday so that the manager and assistant manager would be available to attend; this was agreed. Summaries of what had been discussed at house meetings were posted on the refrigerator in the kitchen, so people who had been unable to attend any meeting could see at a glance what had been discussed. A box was provided in the sitting room for people to post any comments or suggestions, which would then be discussed at house meetings. Following house meetings, a newsletter was produced and circulated to people and staff which provided regular updates about the service.

People were asked for their views about the service through a residents' questionnaire and the last survey was completed in March/April 2016. Several questions were asked including, 'Do you feel able to approach staff with any concerns?', 'Do you know how to make a complaint?', 'Is the house clean and comfortable? What do you think could be done to improve it' and, 'Are you happy with the support you receive?' Seven people had responded and comments included, 'Staff very helpful and understanding, nearly always make me feel better' and 'Happy with the way things are'. One person had suggested that the clothes drier needed repairing and this had been done. Relatives were also asked for their feedback through a family questionnaire, the last of which was completed in March/April 2016. Nine responses were returned including, 'I do not think you can do anything better than you are doing already'. Another relative stated, 'Yes, issues had been dealt with and I always feel I can raise any concerns'. Another response was, 'We are very happy with the service and can't think of any improvements'. Some relatives asked for more regular contact and news about their family members and with the service. As a result, the assistant manager had made arrangements for families to receive regular emails and updates about their family members. This was especially helpful for families who lived far away or who were unable to visit.

The last registered manager had left the service in March 2016 and the assistant manager had taken over the management of the home in the interim, until the new manager came into post approximately six weeks ago. The manager told us, "Staff are very capable. Paperwork seems to have been overseen pretty well". Staff spoke highly of the support they received and of the assistant manager. One member of staff said, "I feel very supported. It's never the same day twice. You may plan your day, then you come in and it's all turned upside down!" The provider acknowledged the difficulties, emotions and challenges that staff may experience in supporting people with mental health needs. A 'Staff Wellbeing Day' was organised and included sessions on mindfulness, yoga and games. In addition, staff could have extra supervision meetings if needed.

The service delivered high quality care and it was evident that people were at the heart of the service. One family responded in a survey, 'I would like to thank all the staff for their commitment and hard work. You are always courteous and caring and we appreciate you all and the work you do'. A range of audits were in place to monitor the quality of care delivered and the service overall. Audits related to medicines

management, the kitchen, care plans, health and safety and an analysis of accidents and incidents. Where actions had been identified, steps were taken to rectify and make improvements. The provider had recently created a new job role of Quality and Compliance Manager and they would be working alongside the service.