BSR London Limited

Chesterholm Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

About the service:
Chesterholm Lodge 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. Chesterholm Lodge is registered to provide care for up to 15 people, including people living with dementia and mental health needs. At the time of the inspection, there were 15 people living at the service.

People's experience of using this service:
• Medicines were not always managed safely. People received support to take their oral medicines safely and as prescribed. However, processes in place to manage other medicines were not always robust.
• There were sufficient numbers of staff available to keep people safe and meet their personal care needs. However, staff were not always available to meet people's social needs.
• People told us they felt that they received safe care.
• The environment was clean and homely.
• Individual and environmental risks were managed appropriately. People had access to appropriate equipment where needed, which meant people were safe from harm.
• Staff had received appropriate training and support to enable them to carry out their role safely. They received regular supervision to help develop their skills and support them in their role.
• People's rights to make their own decisions were respected. Staff recognised people's individual needs and supported them to make choices in line with legislation.
• People were supported to access health and social care professionals if needed.
• People received enough to eat and drink and were happy with the food provided.
• Staff were kind, patient and responsive to people's needs. People were treated with dignity and staff respected their privacy.
• Staff knew the people they supported well and had a good understanding of their needs which enabled them to provide person centred care.
• People knew how to complain and were confident that if they raised concerns, the registered manager would act promptly to address these.
• People and staff were fully engaged in the running of the service.
• The management team were open and transparent. They understood their regulatory responsibilities.
• The management team had effective quality assurance systems in place and there was an emphasis on continuous improvement.

The service met the characteristics of Good overall. More information is in the full report.

Rating at last inspection:
The service was rated as Good at the last full comprehensive inspection, the report for which was published on 14 September 2018.

Why we inspected:
This inspection was a responsive inspection. We inspected following concerns raised to us by whistle blowers and members of the public.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-Led findings below.

Chesterholm Lodge

Detailed findings

Background to this inspection

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

The inspection was prompted by concerns raised from whistle blowers and members of the public.

Inspection team:
The inspection was completed by two inspectors.

Service and service type:
Chesterholm Lodge is a care home registered to accommodate up to 15 adults living with dementia or mental health needs. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection. Inspection site visit activity started and ended on 25 March 2019.

What we did:
Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also reviewed information we had received from the local authority and safeguarding team.

During the inspection we gathered information from:

- Eight people using the service.
- One person's relative.

- Nine people's care records.
- The registered manager.
- Three support workers.
- The cook.
- The housekeeper.
- One external healthcare professional.
- One social care professional.
- Records of accidents, incidents and complaints.
- Audits and quality assurance reports.
- Records of recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely:
• Medicines were not always managed safely.
• Medicine administration records (MARs) confirmed people had received their oral medicines as prescribed. However, some gaps were noted in the MARs relating to prescribed topical creams. Where these had been prescribed to be applied once or twice a day, records did not demonstrate this had always occurred, placing people's skin integrity at risk. These gaps were discussed with the staff, who were unable to confirm if cream had or had not been applied.
• Not all prescribed topical creams or liquid medicines were labelled with opening and expiry dates. This meant staff were not aware of the expiration date of the item and when the cream would no longer be safe to use.
• Some people living at the home required insulin to help manage their diabetes. Staff explained that they would check the amount within the insulin pen then hand this to the person to allow them to self-administer. However, we found that the MAR did not state the dose of insulin prescribed. Staff told us that the dose prescribed was noted within people's care plans. On viewing care plans we saw that although the dose was recorded, this had not been double signed as per best practice guidance. In addition, there was no further information as to why this amount was being administered.
• Medicine administration care plans provided information for staff on how people liked to take their medicines and important information about the risks or side effects associated with them. They also included information, such as the need for medicines to be taken at set times or what to do if a person refused them.
• Each person who needed 'as required' (PRN) medicines had information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved.
• Appropriate arrangements were in place for obtaining, administering, recording and disposing of medicines safely and in accordance with best practice guidance.
• Staff had been trained to administer medicines and had been assessed as competent to do so safely.
• People told us they got their medicines when needed and as prescribed. They also confirmed they could ask for additional medicines such as pain relief if required.
• The concerns noted by the inspectors in relation to the management of medicines was discussed on the day of the inspection with the registered manager. Following the inspection, information was received from the registered manager which demonstrated that all issues had been addressed.

Staffing and recruitment:
• One of the concerns raised that prompted this inspection, was that there were not sufficient levels of staff to keep people safe and maintain their social needs.

• We found there were sufficient numbers of staff available to keep people safe and to meet their personal care needs. However, people told us that staff were not always available to meet their social needs. This was discussed with the registered manager who told us that an activities coordinator had recently been employed, but they were currently covering care shifts to help ensure people's personal care needs and safety could be maintained. They added that existing care staff had been offered additional hours, to help maintain social needs and that they were actively recruiting for staff.
• Staffing levels were determined by the number of people using the service and the level of care they required.
• The registered manager used a dependency tool to help determine the number of staff required, which they reviewed monthly. The registered manager said that although this dependency tool calculated the number of staff required, they also observed care, spoke with staff and people, worked alongside staff and completed staffing level audits, to ensure that staffing levels remained sufficient.
• People were supported by consistent staff. The registered manager told us that they, or existing staff members, would cover short term staff absences. Agency staff were used when shifts were unable to be covered by these arrangements. The registered manager said that all agency staff that attended the home were given an in-house induction and that they would try and use agency staff that had previously worked at the home to provide people with consistency.
• There were thorough recruitment processes in place.
• Recruitment checks were completed before staff were appointed. This helped ensure suitable staff were appointed to support people.

Systems and processes to safeguard people from the risk of abuse:
• People told us they felt safe living at Chesterholm Lodge. When we asked one person if they felt safe their response was, "Oh yes." Another person told us, "Yes, I do feel safe, it is safe here." The visitor we spoke with, also confirmed they had no concerns about their relative's safety.
• Staff had received training in safeguarding and knew how to identify, prevent and report abuse. Staff had access to phone numbers for the local authority safeguarding team and were aware of how to contact them should the need arise. A staff member said, "I would go to [the registered manager] if I had any concerns; I know they would act, but if they didn't I would talk to the safeguarding team."
• There were processes in place for investigating any safeguarding incidents. Where safeguarding concerns had been highlighted, they had been investigated robustly and reported appropriately to CQC and the local safeguarding team.

Assessing risk, safety monitoring and management:
• All individual risks to people had been considered and were managed effectively. Risk assessments had been completed and these demonstrated that least restrictive measures were put in place, to promote independence and safety of people.
• Risk assessments identified possible risks to people, along with actions staff needed to take to reduce the risks. For example, one person was at risk of falling, the cause of this had been investigated by the registered manager. The risk and possible cause was clearly documented within the person's care file which included, clear information for staff about how to support the person, with body positioning to help mitigate the risk.
• People who were at risk of malnutrition and dehydration had clear and up to date information within their risk assessment of how this should be monitored and managed by staff. This included information about their likes and dislikes of certain food and the implementation of food and fluid charts, so that their intake could be closely monitored.
• Equipment such as stair lifts and bath seats were serviced and checked regularly.
• Environmental risk assessments and general audit checks of the home were done regularly and health and safety audits were completed.
• There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in

the event of a fire and fire safety equipment was checked regularly.

Preventing and controlling infection:
• We found the home to be clean and tidy.
• There were processes in place to manage the risk of infection and personal protective equipment (PPE), such as gloves and aprons was available throughout all areas of the home. Staff were seen using these when appropriate.
• The laundry room was clean, organised and measures had been taken to ensure the risk of infection was minimised. For example, clean laundry was stored in a separate cupboard away from dirty laundry which helped to prevent cross contamination.
• Infection control audits were completed regularly by the registered manager and we saw that actions had been taken where required.
• The staff were trained in infection control.
• There was an infection control policy in place, which was understood by staff.

Learning lessons when things go wrong:
• There was a process in place to monitor, act upon and analyse incidents, accidents and near misses.
• The registered manager completed monthly audits for all incidents and accidents which identified any trends or themes to help mitigate risk and prevent reoccurrence. For example, one person was identified as having an increased number of falls. This resulted in a change to the type of mobility aid used and a referral being made to the falls clinic.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People felt the care was effective.
• People's needs were assessed prior to their admission, to ensure their care needs could be met in line with current guidance and best practice. This included guidance from healthcare professionals. A healthcare professional told us that staff, "follows their guidance and suggestions."
• Staff applied learning effectively in line with best practice, which helped lead to good outcomes for people and supported a good quality of life.
• Where appropriate, there was guidance for staff in people's files which reflected good practice.
• A range of well-known tools were used to monitor people's health and wellbeing. For example, staff used nationally recognised tools to assess people's risks of developing pressure injuries and monitor people's moods and behaviours.

Staff support: induction, training, skills and experience:
• Throughout the inspection staff demonstrated they had the necessary knowledge, skills and experience to perform their respective roles.
• Staff had undertaken appropriate training in areas such as, fire safety, health and safety, infection control, mental health awareness, safeguarding and the mental capacity act.
• A staff member said, "I have had load of training."
• Reviewing the staff training log, it was noted that some staff training was out of date. However, the registered manager was able to provide additional evidence that actions had been taken to address this.
• New staff completed an induction to the service and a probation period before being permitted to work unsupervised. Agency staff who worked at the home were also provided with an induction specific to the home.
• Staff received one to one supervision with the registered manager approximately every three months and an annual appraisal. This gave them an opportunity to discuss their progress and any concerns they had. These one to one supervisions and annual appraisals were recorded in detail. Staff told us they felt supported by the registered manager, who they could approach at any time.

Supporting people to eat and drink enough to maintain a balanced diet:
• One of the concerns raised that prompted this inspection, was that people did not receive adequate food and fluid. On the day of the inspection we found that people received enough to eat and drink. People were happy with the food provided, they told us they had enough to eat and drink and we saw that drinks and snacks were available to people throughout the day. One person said they got plenty of drinks and "could always go to the kitchen and get one."
• The registered manager informed us that following the concern being raised with them, changes had been

made in the way food stocks were ordered. The registered manager had been given control over the ordering of food and this had resulted in food stores being replenished in a timelier way. We reviewed the food stocks available to people and found sufficient levels of food available.
• The menus had been agreed jointly during resident meetings. This helped to ensure that people's food choices were respected. Staff encouraged people to make healthy food choices to help them maintain optimal health.
• Where people were at risk of poor nutrition and dehydration, their food and fluid intake was closely monitored. Where concerns were noted in relation to a weight decrease or reduced intake, healthcare professional support was requested in a timely way.

Adapting service, design, decoration to meet people's needs:
• The environment had been designed and adapted to promote people's safety, independence and social inclusion.
• The home was well maintained, calm and homely and people could move around freely.
• There were two communal lounge/dining rooms and a conservatory so people could socialise or spend time alone.
• Some decoration throughout the home supported people living with dementia or poor vision, which included signs on toilet, bathrooms and bedroom doors.
• Floors could be accessed by a chairlift and stairwells and the flooring was suitable for people with mobility needs.
• People's rooms were furnished and adapted to meet their individual needs and preferences. Paintings, pictures and soft furnishings evidenced people were involved in adapting their rooms.
• People could access the garden freely which had adequate seating and level ground.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care:
• People confirmed that they would be supported to access dentists and opticians if they required and that the doctor would be contacted if they were unwell. Care records confirmed people were regularly seen by health professionals including doctors, specialist nurses, dentists and opticians.
• Peoples care records contained essential health information, including information about people's general health, current concerns and emotional needs. These care plans were comprehensive and individualised to people's specific health needs. For example, a diabetic care plan provided information of actions staff should take in relation to the person's blood sugar levels.
• Staff were mindful of maintaining optimum physical and emotional health for people. For example, one staff member had time to take a person, who had a recent hospital stay due to a decline in physical health, to the local shop in a wheelchair. This staff member later told us, they felt the fresh air would do the person good and it had helped encourage the person to spend some time downstairs rather than in their bedroom.
• The service ensured that people received consistent and coordinated care if they were required to move between services; such as requiring a hospital stay. The registered manager said that the person would be sent with a 'hospital pack', which provided clear and up to date information about the person, including their needs, level of support they required and current concerns.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• People were supported by staff that understood the principles of The Mental Capacity Act 2005.

• Records of mental capacity assessments and best interest decision meetings were recorded in people's care plans.
• Most people living at Chesterholm Lodge had full capacity to make decisions about all aspects of their care. Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.
• People's right to decline care was respected. For example, one person declined their medicine, this was respected by the staff member and discussed during the staff handover about action to take, should the person continue to decline. This was documented within the person's care records.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.
• We found that applications for DoLS had been submitted to the appropriate authorities as required.
• The registered manager and staff understood their role and responsibilities in relation to the MCA and DoLS.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• Feedback from people reflected they felt that the staff were caring. Comments included, "The staff speak to me nice, it's alright here" and "I have nothing bad to say about the manager, she is perfect and the staff are really good too."
• Throughout the inspection we found the staff to be friendly, polite and respectful to people. Interactions between staff and people were natural and showed positive relationships had been developed. People clearly trusted the staff and the registered manager and felt at ease talking to them.
• Information about people's life history was recorded, which staff used to get to know people and to build positive relationships.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. For example, we saw that where people had religious beliefs, they were supported to maintain their faith.
• Discussions with the registered manager showed that they respected people's differences so people could feel accepted and welcomed in the service. The equality policy covered all aspects of diversity including race, sex, sexual orientation, gender re-assignment and religion.
• Staff knew how people liked to be addressed and called people by their preferred name.

Supporting people to express their views and be involved in making decisions about their care:
• People were given the opportunity to express their views, both on a one to one bases with staff or the registered manager and during resident's meetings. Resident meeting minutes confirmed that discussions were held with people about the day to day running of the home and demonstrated that people were involved in making decisions about their care. For example, at the previous meeting, people had requested a change in the menu and were able to confirm with us that this change had been implemented.
• People were involved in planning their care and the day to day support they received. Care plans contained detailed personal information, evidencing people and their relatives had contributed to the creation of their care plans. Records also showed people were involved in reviews of their care.
• Family members were kept up to date with any changes to their relative's health needs.

Respecting and promoting people's privacy, dignity and independence:
• People were encouraged to do as much as they could for themselves. For example, staff described how some people could complete their personal care tasks themselves with a little prompting. Where appropriate, people were also encouraged to participate in completing their own laundry tasks and keeping their rooms clean and tidy. On person said, "I do struggle to keep my room organised and put my clothes away so the [registered manager] helps me with this."
• People's care plans provided clear information for staff about what people could do for themselves and

where additional support may be required.
• Staff respected people's right to privacy. Staff ensured they delivered personal care to people in private. Staff were seen knocking on bedroom and bathroom doors before entering. A staff member said that when assisting someone with personal care they would, "Close the door and curtains." A person told us, "They will knock on my door."
• People could have their bedroom doors locked if the wished and were provided with keys to their room.
• Some people's care records highlighted that they preferred to have a staff member of a particular gender to support them with personal care. Staff demonstrated that they understood who this applied to and told us this was respected.
• The provider ensured people's information was kept confidential. People's information was stored securely at the office and staff had their own password logins to access electronic records.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Staff knew the people they supported well and had a good understanding of their needs which enabled them to provide person centred care.
• Care plans were in place for all people which highlighted their specific needs. Care plans contained detailed and person-centred information about people. Information included, their life history, likes and dislikes, specific health and emotional needs, personal abilities and levels of support required.
• Care plans also identified people's accessible communication needs: whether they needed glasses or hearing aids, and where staff should position themselves to speak to people.
• People were empowered to make their own decisions and choices and people confirmed they could make choices in relation to their day to day lives. For example, what time they liked to get up or go to bed, what they ate, where they spent their time in the home and if they wanted to go out. This was observed throughout the inspection.
• Staff were responsive to people's changing physical and emotional needs. For example, on the day of the inspection two people showed signs of being unwell and contact was made with healthcare professionals.
• People told us that they didn't have enough to do. One person said, "It's alright here, but there is nothing to do. I take myself out on my scooter sometimes but I would like to go to places like museums or the sea life centre." People also told us the activities coordinator had left and they were not sure what the plans for activities were now. They added that they had been used to going out in the home's transport and enjoyed this. This was discussed with the registered manager who told us that an activities coordinator had recently been employed, however they were currently covering care shifts. They added that current staff had been offered additional hours to help maintain social needs and that they were currently rearranging the car insurance to allow more outings to people.
• People told us about some visiting entertainers and confirmed they enjoyed these.
• Regular resident's meetings gave people the opportunity to make suggestions about any future activities provided. Minutes from the last resident meeting which took place in March 2019 highlighted that it was agreed that a summer barbecue would be arranged, people would be supported to attend a community church coffee morning and discussions took place about having a picnic.

Improving care quality in response to complaints or concerns:
• There was a complaints policy in place which was understood by staff.
• One formal complaint had been received since the previous inspection. The registered manager was able to demonstrate this was being investigated robustly and the concern raised was being monitored to help ensure effective action could be taken. Furthermore, the concerns we received from whistle-blowers and members of the public had been investigated by the registered manager and actions had been taken were required.
• Information on how to make a complaint had been provided to each person when admitted and was

displayed within the home.
• People told us they knew how to make a complaint and were confident that any concerns raised would be dealt with effectively. One person said they had complained to the registered manager about loud music late at night from the person in the room next to them. The registered manager had acted and the loud music had stopped.

End of life care and support:
• No people living at Chesterholm Lodge were receiving end of life care at the time of our inspection. However, the registered manager told us that staff would receive training in this area if the need arose.
• The registered manager spoke positively about their desire to provide people with high quality care at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death. Whenever possible people would be supported to remain at the home, however if their needs could not be met they would be supported to move to alternative more suitable accommodation.
• Furthermore, they told us they would work closely with relevant healthcare professionals, provide support to people's families and the other people living at the home.
• People's end of life wishes had been captured within their person-centred care plans. Information within people's care records detailed any funeral plans and information about whether they wished to be buried or cremated.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Quality performance, risks and regulatory requirements:
• People and professionals felt the service was well led. A social care professional said, "I would place people here in the future if vacancies arose." A person told us, "If I didn't have the support of [registered manager] I don't know what I would do."
• The registered manager demonstrated an open approach and encouraged staff to do the same. Where people had come to harm, relevant people were informed in writing, in line with the duty of candour requirements.
• The previous performance rating was prominently displayed in the reception area and on the providers website.
• The provider is required to notify CQC of all significant events. This helps us fulfil our monitoring and regulatory responsibilities. The registered manager understood their responsibilities and had notified CQC about all incidents, safeguarding concerns and events as required.
• Policies and procedures were in place and relevant to the service. For example, there were policies on equality and diversity, safeguarding, whistleblowing, complaints and infection control.
• There were quality assurance procedures in place to aid the smooth running of the service. These processes included the completion of audits for care plans, cleaning records, medicine administration, environmental audits, training and infection control. The registered manager also completed weekly reports which they sent to the provider to keep them updated on the running of the service.
• The registered manager and staff made appropriate use of technology to support people and to help ensure that audits and checks on the service were completed in a timely way. The service used a computerised system to document each person's care plan and this system would notify the registered manager when staff had not completed specific tasks. The registered manager also demonstrated how this system aided the auditing process and other management tasks, enabling them to appropriately complete audits in line with the provider's policies.
• The registered manager worked closely with the staff and completed unannounced spot checks to ensure that an appropriate standard of care was provided to people 24 hours a day.

Managers and staff being clear about their roles; Planning and promoting person-centred, high-quality care and support:
• There was a clear management structure in place, consisting of the provider, registered manager and head of care, each had clear roles and responsibilities.
• There was a clear vision to deliver high-quality care and support and promote a positive culture that was person-centred, open, inclusive and empowering, which achieved good outcomes for people.
• Staff understood the provider's vision for the service and they told us they worked as a team to deliver

support that met the needs of individual people.
• People we spoke with knew the registered manager and felt the service was well run. Throughout the inspection we saw the registered manager speaking with and supporting people in a friendly, familiar manner. We saw that people were clearly comfortable in the company of the registered manager and felt able to approach her.
• The registered manager had plans in place to develop the service, which included developing staff 'Champions of care' roles. They told us that this would help to ensure that high quality care could be provided to people.
• All the staff spoken to were very positive about the registered manager and the way in which they ran the service. A staff member said, "I like the manager a lot, she really cares about people and the home." A social care professional described the registered manager as "Very good."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• People and their families were given the opportunity to be fully involved in the running of the service.
• The management team created opportunities for people to provide feedback. For example, people had regular reviews, during which they could provide feedback about the care and the service received. Regular meetings were held for people who used the service and their families and quality assurance questionnaires were sent to people, families, and professionals annually.
• The management team monitored all feedback received, which was collated and action taken where required.
• Where people had made suggestions or shared ideas about the running of the service, these were taken seriously, considered and if appropriate acted upon.
• Friends and family members could visit at any time.

Continuous learning and improving care:
• There was an emphasis on continuous improvement.
• The registered manager monitored complaints, accidents, incidents and near misses and other occurrences on a monthly basis or more frequently if required. If a pattern emerged, actions would be taken to prevent a reoccurrence.
• Staff performance was closely monitored by the management team.
• All learning was shared with staff during staff meetings, handovers and supervision.

Working in partnership with others and community involvement:
• The service worked well and in collaboration with all relevant agencies, including health and social care professionals. This helped to ensure there was joined-up care provision.
• Staff supported people to attend local community events, when available.
• Plans were in place to develop stronger links with the community including a local Brownies group.