Independence Matters C.I.C.

Home Support Matters West

Inspection report

South Wootton Community Hub
Grimston Road
Kings Lynn
Norfolk
PE30 3HU

Tel: 01553614908
Website: www.independencematters.org.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place over two dates. The first date was 8 January 2018. This was an announced inspection in line with our methodology for domiciliary care agencies. We gave the service 48 hours' notice. During our visit to the office, we arranged to meet a service user, their family member and carer, which we did on 10 January 2018.

This was the first inspection to the service since its registration on 18 September 2015. At the time of our inspection, the service who are registered to provide personal care were only supporting one person and have rarely supported more than one or two people. However, the organisation provides support to about 15 hundred people across Norfolk. These are for services, which do not currently require registration and are not regulated by the CQC. For example, they provide community support services such as managing day services and supporting people in their own homes with paying bills, budgeting, housing issues, accessing the community and social support. They were also providing staff to residential homes where a person might require one to one support. For example, staff worked with a person with a learning disability who was in a care home for people who were predominantly older. The person with the learning disability was a younger adult with an unmet social need. The purpose of the one to one support was to help them access the community and engage in age appropriate, specific activities of their choosing. Another example is where a person might need an increased level of supervision due to ill health or behaviours, which might compromise the safety of others. The local authority would purchase care and support on an individual basis for a specified period to help support people in a crisis or due to change in circumstances, which might put them at increased risk.

The service had a registered manager. 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.

We found the service was well managed. Staff knew how to support people and risk assessments and needs assessments were completed before support could be provided. Staff did support people with a range of tasks and received training to help them carry out their duties appropriately. For example, staff were trained in safe moving and handling practices, medication administration and how to safeguard adults from abuse. Staff we spoke with were knowledge about all aspects of their role. There was sufficient management oversight of the services provided to help ensure staff were competent and people got the support they needed.

Staff recruitment processes were adequate. However, we could not find all the original documentation required to demonstrate that the service had safe recruitment practices. This was because some records were held at head office and we did not have sight of them. The registered manager confirmed they would address this. Staff were supported through induction, which included skills for care, which is a nationally recognised induction framework for new care staff working in adult social care. In addition, staff were given

opportunities to shadow staff that were more experienced and they received regular supervision and annual appraisal.

There was sharing across the organisation to help ensure lessons were learnt from any possible avoidable harm. Areas of good or poor practice were identified and shared so these could be implemented more widely or actions agreed to improve the service in any areas where a deficit was identified.

People were supported to access health care services as deemed appropriate and staff monitored people's health as appropriate. Some people being supported required more practical support with budgeting and shopping where others required support to eat and drink. This was agreed in the care plan, which highlighted any risk.

"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.

We checked whether the service was working within the principles of the MCA. We found staff were and had a good understanding of the law.

Staff spoken with demonstrated a passion and commitment to the people they were supporting. They demonstrated good interpersonal and communication skills. The organisation had clear expectations of its staff and monitored their performance in line with these. Staff recruitment and staff training was sufficiently robust which helped to ensure staff had the right attributes and skills.

People were consulted about their care but for most people the service was based on a short-term intervention, which was then reviewed with the agency and local authority if they commissioned the service. People did not have a say in wider organisational issues and there was not much evidence of feedback from people.

Care plans gave enough information for staff to be able to support people. Further information about what the person was able to do for themselves was documented. There were goals set, which enabled the care to be evaluated against what was agreed.

Staff sometimes supported people and their relatives when a person was approaching the end of their life. Staff received training to help them be aware of people's needs so they could support them appropriately.

There was an established complaints procedure and feedback was regularly sought from staff, people using the service or their families. No complaints had been received and there was little in the way of feedback although we saw people did have the opportunity. Everyone we spoke with were confident that management were approachable and acted on feedback given.

The service had an experienced registered manager who we had confidence in. They were knowledgeable about people's needs and how to access and signpost people to the right services. They had enough staff so they could deploy them as they needed and were responsive to people's changing needs.

There were systems in place to measure the effectiveness of the service against agreed aims and objectives and staff were aware of these. There was learning across the organisation to ensure areas for improvement

were identified and implemented.

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.

There were effective systems in place to help ensure people received safe care. Staff were trained before carrying out any identified task and there was monitoring and oversight of risk.

Staff recruitment was adequate but records were not always kept on the premises from which the regulated activity was being carried out.

Staff worked on varying contracts and were employed in sufficient numbers to meet people's assessed needs.

Medicines ,when given, were done so by trained staff

Is the service effective?

Good

The service was effective.

The registered manager kept up to date with best practice and had guidance about key areas of practice, which they shared with staff.

Staff were supported through regular supervision and appraisal of their performance. They were given training in accordance with their role to help them support people in their care.

People were supported to stay healthy and access health care professionals as required. Some people required assistance to eat and drink and this was monitored where required.

Staff had a good understanding of the legislation underpinning mental capacity. They involved, and consulted people about their care.

Is the service caring?

Good

The service was caring.

Staff were caring and demonstrated the right attributes.

People were consulted about their needs and had information about the service and what they could expect.

People had individually set goals, which took into account what they could do for themselves and what support they needed.

Is the service responsive?

Good

The service was responsive.

Care and support was identified as part of the initial assessments. People's needs were documented and took into account the persons individual circumstances and wishes.

The service took into account feedback in regards to how it planned and delivered the service

Is the service well-led?

Good

The service was well led.

The registered manager had the rights skills for their role and was knowledgeable about social care.

They were responsive to feedback and strived to deliver high standards of care.

There were formal mechanisms in place to measure and monitor the care provided and improve where they could.

The service took account of people's needs and wishes and acted on any feedback.

Home Support Matters West

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 was carried out on two separate days including the 8 and 10 January 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The second visit was arranged with the registered manager.

One inspector undertook the inspection. Prior to the inspection, we considered any information we already held about the service including notifications, which are important events the service is required to tell us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make.

We met with four staff and the registered manager. We also spoke with two professionals and one relative. We looked at one care/support plan and other records relating to the business. These included three staff recruitment files and records relating to staff training, induction and training. The statement of purpose and business reports. The complaints procedure and medication policy.

Good

Is the service safe?

Our findings

The service had an experienced registered manager who was clear about their responsibilities in terms of protecting people from the risk of abuse and harm. They were aware of key contacts and reporting procedures if they suspected a person to be at risk or experiencing abuse. They supported staff to ensure they were all familiar with the policies and procedures governing adult protection.

Staff told us they knew what and who to contact should they suspect a person was at risk of abuse. They had information cards with phone numbers of relevant, external agencies should they need them. Staff told us they had received training and were able to describe situations where a person had been vulnerable and where, in some instances, they had contacted the local authority adult safeguarding team.

Staff told us that before assisting people with moving they received manual handling training and were supported and observed using all the associated equipment to ensure they did this safely. They told us about the importance of recording on body maps and incident sheets and referring concerns to the registered manager.

Risk assessments were completed by staff at the point of assessment to help ensure that any risk was clearly documented and included actions to mitigate risk. For example, the assessor would look at the environment where care was being provided and note if there were any obvious hazards or safety concerns. Where there was equipment in place the form would specify who was responsible for maintaining it: such as smoke alarms or specialist mattresses.

Staff were made aware of any potential risks to their safety when entering premises and whenever possible were safeguarded against risks. There was a record of accident, incidents and any occurrences. These were reviewed by the registered manager and where necessary led to a change in practice. Staff were issued with a handbook, which detailed policies and procedures they should follow including lone working and the use of personal protective equipment to reduce the risk of cross infection. Staff spoken with were aware of policies supporting their working practices, knew to record, and report any incidents or concerns about people's care and support.

For the person being supported by the service there was a manual handling plan and equipment in place to support staff to do this safely. However, some of the information we might expect to see in their record, which would be helpful to support staff in providing safe care, was not there. For example, who maintained the equipment, the make and model of the hoist and the original occupational therapy assessment. Staff knew this persons needs well but we could not be assured that new staff would have enough information about this person specific manual handling needs.

Occasionally the service supported people with their finances mainly budgeting and bills. There were policies making it clear what staff could and could not do. There was also a bag and tag system where monies were held securely and there was a detailed log showing all transactions. Receipts were kept and provided a clear audit. Staff were not permitted to have people's credit card pin numbers or benefit from

loyalty points.

The service employed staff depending on how many people they were supporting and in what capacity. Care packages would not be accepted unless there were sufficient staff in place to deliver the care and support. The service was well planned and there were contingency plans in place to cover unexpected absence such as staff sickness or unplanned leave.

There was an established on call system which was managed locally. People using the service were given all necessary contacts and basic information about the service provision. Staff spoken with were confident about the support they received and said they could always get hold of a manager or senior when necessary.

The service had an electronic monitoring system, which enabled care staff to use their mobile phone to communicate when they had arrived and left a service user's address. This meant the registered manager knew where staff were at any time and were able to see if staff stayed for the correct amount of time. It also offered some protection for lone workers as the registered manager could track staffs movements.

Systems were in place to ensure people received their medicines safely. At the time of our inspection, the service was not supporting anyone with their medication. However, we saw that staff completed medication training before administering any medication. They were required to complete workbooks with questions and answers and had competency assessments to ensure they could give medication safety. Staff were made aware of what actions to take should medication be unavailable or if an error had occurred. They would only support people with medication if this was a task that had been identified.

Staff were only required to administer medication from original packaging and there was a clear assessment of what level of support the person required. This could include prompting or staff administration. Staff received specific training if more intervention was necessary such as medication received through a tube into the stomach. Records were kept of all medications administered by staff including creams and senior staff checked these. There was a self-administration checklist for people who were able to take their own medicines and this would be reviewed if there were any concerns about the person continuing to do this safely.

Staff had additional training for specific health care conditions people they support might have such as diabetes. This helped ensure staff would recognise symptoms of hyperglycaemia, (high blood sugar) or hypoglycaemia, (low blood sugar,) and would know what actions to take.

There were systems in place to minimise the risk of cross infection including staff training in infection control and the issuing of personal protective equipment for staff.

The service ensured lessons were learnt by analysing information received about the service provided particularly when this had resulted in risk to a service user. Investigations established fact and considered what went well or what needed to improve. There was a culture of continuous learning and sharing of good practice across the different locations registered under the same provider.

Staff recruitment was seen as a very important element as the service needed to ensure staff could work across services and had the flexibility and commitment required. Staff were on different contracted hours and some had zero contract hours. The registered manager said the first part of the recruitment stage was a meet and greet when potential new applicants would meet key members of the team and be given as much information as possible so candidates would be clear about their job role and situations they might face.

The second part of the recruitment process included an interview and a written assessment to ensure candidates could produce clear, legible work, which was important when keeping care records. Staff were given potential scenarios and their answers were assessed as part of the interview process.

We looked at recruitment folders and saw that staff were only appointed after the necessary checks had been undertaken. This helped ensure the candidate did not have a criminal record, which might make them unsuitable to work in care. Where an offence had been committed, this would be considered in line with the companies risk assessment to take into account the nature of the offence, how long ago and did they pose a risk. Job and personal references were also taken up. A full employment history, evidence of qualifications and proof of identification and address were also requested. However, we found for some staff records there was not a clear audit trail and it was difficult to establish if all recruitment checks were in place at the start of employment. This was because staff information was held at head office and scanned across. The registered manager assured us that all staff files were regularly audited and any discrepancies would be addressed.

Good

Is the service effective?

Our findings

The registered manager was knowledge about the care sector and relevant legislation and best practice in health care. They told us they kept their knowledge up to date and were supported through the organisations policies, procedures and memorandums.

Staff had the skills, knowledge and experience to deliver effective care and support. All four staff spoken with told us the training was very good and plentiful. They explained that as well as mandatory training they would cover training specific to the needs of people they were supporting such as dementia care, mental health, learning disability and diabetes awareness. We only spoke with one relative about the care and support provided by staff and they had the utmost confidence in the support being provided.

Before staff were employed, they were assessed as part of the recruitment process to ensure they had the right attributes and values. Staff new to care were supported by more experienced staff who accompanied them on visits whilst they 'learnt the ropes.' They also completed a care certificate, which is a nationally recognised induction for staff working in care. It covers all the essential subjects carers need to know. More experience staff might only need to complete elements of the care certificate or none at all. Training was refreshed to ensure staffs knowledge was kept up to date. Care staff were allocated buddies or mentors to ensure they had the support they needed but this was dependent on where they were working.

Staff files varied in the information they provided. The registered manager explained that a lot of information was held at head office. We asked the service to hold duplicate records so that they could evidence how they were meeting regulation. Staff were able to tell us what they covered in their induction but we could not see records to support this. The registered manager said evidence for induction was recorded in the induction booklet given to staff. Staff paper files were not fully complete making it more difficult to assess this key question.

The service had an electronic database, which provided details of all staff training, supervision and appraisal. This showed when it had been completed and when refresher training was due. It was up to date and planned well in advance. This meant staff were reminded as and when their training refreshers were due so it did not expire.

Spot checks on staff practice were not held but the service had a mentoring and buddy scheme and staff were supported according to their needs and levels of experience. Monthly meetings were held for managers and senior staff and information was cascaded down to staff in their monthly meetings.

Staff were kept up to date with current practice and thinking. For example, the service had dementia care coaches (staff who had completed intensive dementia care courses). They were able to support staff and cascade training down to them. The service had staff who were dementia friends. This was an initiative rolled out by the Alzheimer's Society who would provide free dementia training and resources. In return the person receiving the training was expected to deliver the training to others to help raise awareness of dementia. The service also attended a virtual dementia tour, which let staff experience how it might feel to

have a cognitive impairment.

The service supported people with dementia and were involved in a pilot run by the local authority in which a pot of money was ring fenced for supporting families where at least one person was living with dementia. The purpose of the project was to support the family over 72 hours, to assess their needs and the needs of the family and establish what support was required. The family would then be signposted to other service or found alternative residential or community care. The registered manager said it was sometimes necessary to support a family for more than 72 hours depending on the availability of other services. They gave an example of a person being cared for by their husband when they became unwell and taken to hospital. The service supported the couple for 2.5 weeks until both of them moved into residential care. Having the support from the agency helped make the transition as smooth as possible.

Staff also received training in mental health and learning disability awareness. The registered manager said if people had specialist health care needs staff would receive bespoke training before providing care to that person. For example, staff had supported a person who was fed directly through a tube in their stomach and staff were trained and signed of as competent to do this by a trained professional. In people's individual care plans there were established goals including how to support people with their health care needs.

At the time of our inspection, the service was not supporting anyone with eating or drinking. Staff told us they did support people with budgeting and ensuring they had enough food for the week. Where people were on restricted budgets, staff assisted people to access goods and services like the local food bank and benefits they were entitled to. Staff were fully trained to meet people's needs and pre admission assessments and assessments from other agencies documented the support a person would require. The registered manager said where necessary they would work with other agencies and demonstrated a good knowledge of other health care professionals and their roles.

Staff teams worked effectively across the organisation and were deployed depending on their skill set. They worked closely with the local authority and had some shared care arrangements in place when appropriate.

Part of the role of the service was to support the carer and the person being cared for. This helped ensure the relationship did not break down due to the additional stress caring put on the carer. Staff were mindful of people's wellbeing and played a supportive role in helping them access the services they might need to stay healthy. Staff monitored people's wellbeing and recorded this in their daily notes, reporting any change to the registered manager so this could be addressed.

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 decision, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. For this service, applications to deprive people of their liberty must be made to the Court of Protection. At the time of this inspection, no applications had been submitted.

Staff supported people in line with their wishes and the MCA whilst recognising that some people were vulnerable by their circumstances or disability. Staff were mindful of this but understood people had a right

to make decisions however unwise. It was the staff's role to support and advice. Staff felt able to raise concerns with the service and local authority if they felt a person was at risk of harm or were not able to make specific decisions in all areas of their lives.

The manager had a good understand of the MCA and gave us examples of people they had supported and how they had worked closely with them and the local authority to ensure the persons needs were met and they took into account the persons wishes and right to decide. This was considered alongside the risks and the person's capacity to decide.

We viewed the care plan of the person currently being supported, this included an assessment of capacity, and whether this was a permanent or fluctuating lack of capacity. There was a record of best interest decisions and how these had been reached.

Good

Is the service caring?

Our findings

The service provided individualised care to people in different circumstances. Staff spoken with demonstrated the right values and through discussion clearly showed how they cared about people and wanted the best outcomes for them. Staff spoke of some difficult situations people were sometimes managing and described people 'who had fallen through the net.' Staff described their role as being there for the person and giving them the support to develop their confidence and make their own decisions.

One member of staff told us, "I have the best job in the world. It is a good company to work for and you do not work in isolation." All staff spoken with said they enjoyed the variety the job gave them and felt the training equipped them to do the job well.

We observed one person being supported. The person had no verbal communication but was very expressive. We saw that they had a good relationship with the person supporting them and became very vocal and interactive. Staff were mindful of the persons dignity and when speaking with us included the person in the conversation. They also supported the relative who was unwell. All the staff told us they really loved their job, the people they worked with and the flexibility it gave them. This really shone through.

The company had signed up to dignity matters, which was rolled out locally and involved having dignity champions. Their role was to support and coach other staff to promote dignity in the workplace.

People were supported to make their own decisions and be involved on a daily basis. Reviews were held to establish what service was needed. Reviews were also held to assess how effective the service had been at meeting the person's needs and helping them achieve the goals set. These reviews took into account the persons wishes and held in consultation with them and their families. The service worked closely and in partnership with the individual, the family and other agencies.

Care plans and assessments reflected the person's wishes and the wishes of the extended families. The registered manager confirmed that information was collated to try and support the person in a way of their choosing

Good

Is the service responsive?

Our findings

The service was responsive to people's individual needs and circumstances. Each package of support provided required different skills and hours of support. Staff told us about individuals they supported and said this was usually for a defined period, but this was negotiable depending on the progress made by the person with the support in place. Staff were often involved in crisis management or supporting people who were going through transition from one service to another or whose circumstances had changed. For example, where a family carer had become unwell and needed support to look after the cared for person.

Staff were knowledgeable about people's needs and showed empathy when describing people they were supporting and their situations. Staff were able to tell us what assessments had been completed, what advice had been provided and what the persons needs were.

Support was provided following an initial referral and assessment of the person's needs and individual circumstances. The service had many staff on different contracted hours who were usually able to pick up the support needed immediately and for the specified period. Care plans and risk assessments were completed and reviewed as required. Staff kept daily notes, which were transferred to the office and audited for accuracy.

The registered manager delivered some of the care and support so was able to support staff and showed a good awareness of people's needs. Staff knew how to report any changes or concerns to the registered manager and told us they were readily available and provided staff with the necessary support. The registered manager worked closely with social services and other health and voluntary sector staff. The only concern we identified was communication was not always effective from one shift to another. Professionals raised concerns about communication. On our visit the care plan and daily notes were viewed but the relative was unaware they were there which either meant they had not been shared with them previously or had just been put in place. Either way the care plan is the property of the person receiving the care and should be shared with them.

Care and support plans varied according to what service people needed. Initial assessments and risk assessments were completed. We viewed one support plan and it contained basic information about the person's needs. It also included information about what the person could do for themselves and how staff should promote their independence. The information told us how the person communicated and how staff would know if they were distressed or unhappy.

Goals were set as a means to judge the effectiveness of the service. Long-term goals included short steps to help the person reach the longer-term goal.

At the time of this inspection, the service was not supporting anyone who was approaching the end of his or her life. The registered manager told us staff completed end of life training and had linked up with the funeral directors so they could understand the process.

The flexibility and diversity of the service meant that staff needed to have interchangeable skills to be able to meet a wide range of needs. The service was highly individualised. Most of the work came from the local authority but people could self-refer and pay privately. Examples of the work completed included where a main carer because of an accident were no longer able to continue with their caring duties and might need some additional support.

People using the service were given details about the service setting out what they could expect and what to do if the service did not meet their expectations. There was an established on call system and people were told how to raise concerns if they needed to. Feedback from people was collated to establish if they were happy with the service or where improvements were necessary. Feedback seen was minimal but people had every opportunity to raise issues either formally or informally.

Good

Is the service well-led?

Our findings

Home Support Matters is a diverse organisation, which aimed to support to people to stay independent and to live the life they wish to live. Support provided by the agency was agreed with the agency and local authority based on individual's needs. This resulted in a bespoke package of care being provided to help facilitate and support some of the most vulnerable people in the community or to support people at vulnerable times of their lives. This might be because of bereavement, illness, or other circumstance, which increased the risk to an individual.

The service had a registered manager and has since its registration. They had a wealth of knowledge and a varied background. A diverse group of staff supported them. We asked staff about the management of the service. One staff said, "We get brilliant support, very approachable, top bosses. They (the manager) is a good communicator. They listen and respond. "

Feedback about the service was not uniform given the different types of support and care they provided. Staff only supported most people for a short period and the success of the support was measured in terms of its impact and if the support had enabled the person to fulfil their needs and meet the objectives set by the local authority. Feedback forms were used to ascertain people's views. In addition to these forms, regular reviews were undertaken. The organisation produced annual reports, which included their achievements and reflected on people's experiences and what they had achieved since and after receiving support. Examples included how people had been supported to successfully transition from one care setting to another or had moved from their parents' home to independent living. The report also documented how they had supported people with learning disabilities or mental health to find a job or vocational course, which helped increase their independence. The publication showed how the organisation worked with communities to raise awareness and fundraise for various charities or specific equipment for different projects and community resources, such as a defibrillator for a community centre.

The report also stated how the organisation invested in its work force in terms of training and development and enabling staff to progress through the organisation. An example given to us by the registered manager was, 'Little things matter.' This was a series of workshops rolled out to all staff, which gave staff a chance to experience what it would feel like to need care and support. By being on the receiving end of care, it would help care staff understand and be able to empathise with those they provided support to who might have a cognitive, sensory or other disability, which affected their daily lives. The organisation continued to invest in its business by recruiting volunteers (68) across the organisation and supporting apprentices. They were not employed directly in the support of people in their own homes to deliver personal care. However, there were opportunities for people to gain experience in the care industry before applying to work in a paid capacity.

The organisation promoted staff values. The service had a clear framework for the recruitment, retention and support it gave to their staff to support their continuous professional development. Staff told us they received training for things like confidentiality and equality and diversity. The organisation had an internal award scheme where anyone could nominate a member of staff for an award. The trustees of the board who met at their annual general meetings considered nominations. Award ceremonies were held to celebrate

staff success. The registered manager told us they also entered staff for the Norfolk care awards and they were finalists in the dementia care category and were going forward to the national awards.

Newsletters helped people stay in touch with what was going on with the organisation. Literature was in an easy read format and could be translated into other languages where needed.

The registered manager showed us what information they collated and had oversight of including anything affecting the welfare and, or wellbeing of people using the service. Any issues relating to complaints, safeguarding, accident, incidents or near misses were recorded and analysed to identify any themes or patterns. There was also a review of actions taken to see if they were appropriate and what steps could be taken to prevent a repeat incident. The registered manager had a line manager who reviewed the information and actions the registered manager had taken. Regular reviews of people's needs meant things could be identified and rectified quickly. Feedback from staff fed into the review of the person's care.