Southdown Housing Association Limited

Wynford House

Inspection report

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Date of inspection visit:
16 March 2016

Date of publication:
28 April 2016

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 16 March 2016 and was announced.

Wynford House is a large detached house that provides care for up to eleven people who live with a learning disability and/or other complex needs. It is situated near to Seaford town centre and At the time of our inspection, there were eleven people living at the home. All bedrooms are single occupancy, and equipped with ensuite facilities six were fitted out as wet rooms. People have access to the kitchen and laundry room beyond, a sitting room and a dining room. The property is surrounded by gardens which are accessible to people.

This is the first inspection since the service was registered in December 2014. Wynford House is unique in that three homes were closed and all the people were moved into one location.

There was a registered manager in post. 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 protected from harm by trained staff who knew how to keep people safe and what action to take if they suspected abuse was happening. Potential risks to people had been identified and assessed appropriately. When accidents or incidents occurred, risk assessments were updated as needed. There were sufficient numbers of staff to support people and safe recruitment practices were followed. Medicines were managed safely.

Staff had received all essential training and there were opportunities for them to study for additional qualifications. All staff training was up-to-date. Regular supervision meetings were organised and the senior support worker was in the process of planning supervisions with staff as well as annual appraisals. Team meetings were held and staff had regular communication with each other at handover meetings which took place between each shift. Consent to care and treatment was sought in line with the requirements of the Mental Capacity Act 2005. The registered manager had sought authorisation for people under the Deprivation of Liberty Safeguards legislation. People were supported to have sufficient to eat and drink and to maintain a healthy diet. They had access to healthcare professionals. People's rooms were decorated in line with their personal preferences.

Staff knew people well and positive, caring relationships had been developed. People were encouraged to express their views and these were communicated to staff in a variety of ways, verbally, through physical gestures or body language. People were involved in decisions about their care as much as they were able. Their privacy and dignity were respected and promoted. Staff understood how to care for people in a sensitive way.

Care plans provided comprehensive information about people in a person-centred way. People's personal histories had been recorded and their preferences, likes and dislikes were documented so that staff knew how people wished to be supported. Staffing levels were dependent on peoples activities and plans. Some people went to specific social meetings, during the day and there was a variety of activities and outings on offer which people could choose to do. Complaints were dealt with in line with the provider's policy, but there had been no formal complaints logged in the previous year.

People could express their views and discuss any issues or concerns with their keyworker, who co-ordinated all aspects of their care. The provider organised surveys for clients, relatives and stakeholders. The culture of the service was homely and family-orientated. Regular audits measured the quality of the care and service provided.

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.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident that their loved ones were safe and supported by the staff.

There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks.

Comprehensive staff recruitment procedures were followed.

There were enough staff to meet people's individual needs. Staffing arrangements were flexible to provide additional cover when needed, for example during staff sickness or when people's needs increased.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff had received all essential training and had formal personal development plans, such as one to one supervision. There were opportunities for staff to take additional qualifications.

Mental Capacity Act 2005 (MCA) assessments were completed routinely and in line with legal requirements. Deprivation of Liberty Safeguards (DoLS) had been submitted and were in place for those that required them.

People were given choice about what they wanted to eat and drink and were supported to stay healthy.

People had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

The service was caring.

Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated with respect and dignity.

Each person's care plan was individualised. They included information about what was important to the individual and their preferences for staff support.

Staff interacted positively with people. Staff had built a good rapport with people and they responded well to this.

Is the service responsive?

Good

The service was responsive.

People had access to the complaints procedure. They were able to tell us who they would talk to if they had any worries or concerns.

People were involved in making decisions with support from their relatives or best interest meetings were organised for people who were not able to make informed choices.

People received care which was personalised to reflect their needs, wishes and aspirations. Care records showed that a detailed assessment had taken place and that people were involved in the initial drawing up of their care plan.

The opportunity for social activity and recreational outings was available should people wish to participate.

Is the service well-led?

Good

The service was well led.

People gave their feedback about the service provided by communicating their views to their keyworker.

The manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure.

Quality assurance audits were being undertaken to ensure the home delivered a good level of care and identified shortfalls had been addressed.

There were systems in place to capture the views of people and staff and it was evident that care was based on people's individual needs and wishes.

Incidents and accidents were documented and analysed. There were systems in place to ensure the risk of reoccurrence was minimised.

Wynford House

Detailed findings

Background to this inspection

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

This inspection took place on the 16 March 2016 and was announced. The previous visits on the 9 and 15 December 2015 were unannounced and the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also used information obtained during our visits on 9 and 15 December 2015. 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, three 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 four people living at the service. Due to the nature of people's complex needs, we did not ask direct questions. For some people, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, senior support worker, a visitor and support workers.

Good

Is the service safe?

Our findings

In our observations during the inspection, people were supported by staff to be safe. People were protected from abuse and harm and staff recognised the signs of potential abuse. Staff knew what action to take if they suspected people were being abused. One member of staff said, "I would report it firstly to [named team leader]. If they couldn't deal with it, then [named registered manager]." Another member of care staff said, "I'd speak to my manager. If she was away, I would go to the manager on call" and added, "If I saw evidence of harm I would complete an incident form." Staff had received training in adults at risk and were able to name different types of abuse that might occur such as physical, mental and financial abuse.

Risks to people and the service were managed so that people were protected. Accidents and incidents were dealt with appropriately, recorded and reported promptly to the registered manager by staff. The registered manager would then investigate the accident or incident, take any further necessary action and log this information on to the provider's database. Risk assessments were reviewed when needed following an accident or incident, but at least annually and care records confirmed this. One person's care record showed they had been identified and assessed as at risk in relation to taking a shower, safety in the kitchen, finances, falls, in their room at night and out in the community. General risk assessments such as pedestrian access to the home, using a wheelchair, use of the kitchen and infection control were all in place. Risk assessments provided information to staff and guidance on how people should be looked after to keep them safe.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. In addition, the registered manager was also available to provide additional cover. We were told that staffing levels were assessed and reviewed regularly. The staffing levels were flexible to meet peoples individual needs. For example, if a person was going out and needed support then an extra staff member would be on duty. This ensured that peoples safety and well-being was assured. Safe recruitment practices were followed and staff records confirmed that new staff were vetted before they were allowed to start work, to ensure they were safe to work with adults at risk.

Recent medicine audits had identified some errors and poor recording. These issues had been addressed and support in medicine practices sought from the medicine provider. The registered manager had improved the audits undertaken on medicines and was confident that they had learnt from past errors. During our inspection we identified some areas of practice that needed further embedding and monitoring to ensure peoples and staff safety. By the third day of inspection these areas were being monitored and staff had received support and further training. For example the management of disposing of 'sharps' such as needles.

Medicines were managed so that people received them safely. Medicines were stored in individual lockable drawers in people's bedrooms. These drawers were only accessible to staff who kept the keys safely and were trained in the administration of medicines. There were organisational policies and procedures should a person be supported to self administer their own medicines. This would only happen if a person had been appropriately assessed as safe and competent. Staff confirmed they had been trained and that their training was regularly updated. A 'medication profile' had been completed for each person which showed the

prescribed medicines that needed to be administered and any topical creams to be applied. Topical creams were kept in individual, transparent bags for people in a locked upstairs office; where necessary, creams were stored in a refrigerator to maintain their effectiveness. The provider had a medicines policy which had been read by all staff who administered medicines. Medication Administration Records (MAR) sheets showed when people had received their medicines and staff had signed the MAR to confirm this. Medicines were ordered in a timely fashion and any unwanted or out of date medicines were disposed of safely.

Good

Is the service effective?

Our findings

People we spoke with told us, "Really good," and "We all get the care we need, I see the doctor when I need to, I have also seen an optician and dentist." Without exception, people and visitors felt that the care staff were skilled and experienced to care and support the people living at Wynford House. People felt very confident with the home's staff.

People were supported to maintain good health and received on-going healthcare support. People commented they regularly saw the GP, chiropodist and optician and relatives felt staff were effective in responding to people's changing needs. One health professional told us, "The staff are good, they soon pick up if there is a problem. "Staff recognised that people's health needs could change rapidly and people might not be able to verbally share their health problems. One staff member told us, "We monitor for signs, changes in their mobility and eating habits which may indicate their physical health is deteriorating." 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 commenced their training. In addition, they would shadow experienced staff as they learned about their job role and began to get to know the people they would be supporting. One member of staff described the induction programme at one of the provider's other locations and said, "Then I came here and did two shadow shifts and then I did a shift and [named senior support worker] followed me."

Staff received all essential training, which was managed by the provider, in a range of areas. These related to safety: fire, manual handling, food hygiene, infection control, food and nutrition and training that focused on people and on communication. Staff were also encouraged to work towards external qualifications, for example, some staff had achieved a National Vocational Qualification Level 3 in Health and Social Care. The provider used an online system and also kept training records on individual staff files where reminders were sent to the registered manager when staff training was due. The registered manager then contacted staff and arranged for them to attend the training. Records confirmed that staff training was up to date.

Staff had supervision meetings with their manager and staff records confirmed that staff had received two monthly supervisions in 2015. Issues such as people, holidays, handovers, keyworking, learning and development and medicines were discussed. Progress was measured against the previous supervision, strengths and areas for improvement were discussed and action points set. Not all staff, who had been in post in excess of a year, had received an appraisal within the last 12 months. However, only a few staff met this criterion. The registered manager said that some appraisals had been undertaken by the senior support worker at their previous employment location (within the same organisation).

Team meetings were held regularly with staff. At the last team meeting held the minutes recorded that discussion had taken place on health and safety, night duty, sleep-in staff, laundry, and issues relating to people living at the service. Handover meetings were held three times a day between shifts and these afforded regular opportunities for the registered manager and staff to meet and discuss issues informally.

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. Some people had good verbal communication skills and were able to make day-to-day decisions, whilst others with more complex needs used signs or body language to indicate their agreement to care. People had been assessed on their capacity to make decisions and records confirmed this. Where people had been assessed as being unable to make a decision, then a Best Interest meeting was held. This is where health and social care professionals, and people's relatives, get together to make a decision on the person's behalf. A Best Interest meeting was held for one person when they left hospital, to ensure that the provider could meet their changed needs on their return from hospital. A member of staff, referring to these meetings, told us, "We ensure that everybody has the support to make important and daily choices. This might include their family." Another member of staff demonstrated their understanding of the MCA and said it was about, "Looking at someone and assessing whether they fully understand a certain situation."

Nine people living at the home was subject to Deprivation of Liberty Safeguards (DoLS) and the registered manager had applied and received authorisation of DoLS from the local authority. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

People were supported to have sufficient to eat and drink and were encouraged to maintain a healthy and balanced diet. The main meal of the day was served in the evening as the majority of people were out during the day. Menus took account of people's likes and dislikes. If people did not like the main meal on offer, then there were always alternatives available. The registered manager said that people liked to have a takeaway meal too, for example, if it was someone's birthday. Comments received included, "Really like the food." Another comment, "We get takeaways." We observed people getting food, drinks and snacks from the kitchen, staff observed and supported as required." Care staff prepared and cooked the evening meal and people were encouraged to help with this. A member of staff said, "Sometimes we eat with the residents". When people were at risk of malnutrition they were assessed by a speech and language therapist. Appropriate diets were in place that were of a higher calorific value or were blended so that people could eat their food easily. Diabetic alternatives were readily available. Records were kept of the amount people ate and drank. Weights were recorded monthly for each person, so that any increase or decrease in weight could be monitored and managed safely.

People were supported to maintain good health and had access to healthcare services. People received support from a variety of professionals such as a GP, diabetic clinics, dentist, optician and chiropodist. A member of staff told us, "We take them to hospital, their doctor or dentist. The chiropodist visits every six weeks. Care records confirmed that people had visited a range of healthcare professionals. We saw that the home had close contact with district nurses and specific health care specialists, such as the community psychiatric nurses. Hospital passports had also been drawn up for people. These provided essential information about people if they had to be admitted to hospital, which included information about how to effectively communicate with the person to ensure their needs were met by people who did not know them.

People's individual needs were met by the adaptation, design and decoration of the service. Bathrooms were fitted out as wet rooms which made them more accessible for people. People's rooms were decorated in their favourite colours and were personalised, with photos and posters on display.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that people were cared for by kind, caring and attentive staff who understood their individual needs. People told us, "I like them (staff) all," "I'm very lucky to be here, this place is really nice," "My mother wouldn't put me in here if it wasn't nice," staff always speak nicely," and "people that need more help than I do always have someone with them." Visitors told us, "loves their food, and loves their friends here," and "I want (name) to be looked after, have a lovely home and be happy, When (name) calls I can hear they are happy and content."

When asked about people's preferences and choices, one member of staff said, "By getting to know our residents, asking them and watching how they respond, we then write it in their care plan so everyone is aware." We were also told by staff, "That understanding their condition, like autism, is really important as consistent care delivery and specific routines were central to person centred care. People could choose whether they wished to be cared for by male or female staff. Meal times were flexible to suit people and this could vary on a day to day basis, dependent on how the person was feeling. Staff confirmed that daily life choices were offered and if a person wanted to sleep in, they could. Unless an important meeting was scheduled and then they would find a way to accommodate this without fuss or stress. People were supported to be as independent as possible and supported in a caring and reassuring way. Some people chose to attend a day centre and communication books travelled with people. This enabled staff at either the home or the centre to understand how people were feeling and what they had done during the day. We observed staff accompanying people on trips out whether for a walk or appointment. It was undertaken in a way that stress free and comfortable.

The service supported people to express their views and to be actively involved in making decisions about their care, treatment and support as much as possible. One member of staff described this as a challenge and said that many people were unable to communicate verbally. They referred to, "Research and trying to find out why people are behaving differently." Staff were able to understand people's body language and various signs were used to enable people to understand and communicate effectively. We saw staff sitting with people and communicating by Makaton."

Care plans had been signed by some people to indicate they had been involved in decisions about their care. People were allocated their own keyworker who co-ordinated all aspects of their care. Keyworkers met regularly with people to review their care on a monthly basis and this was confirmed by people and their families. One relative told us, "They (staff) send pictures and reports quite often." Another relative told us they were invited to care plan reviews and felt involved in their relatives care.

People's privacy and dignity were respected and promoted. When staff were asked about this, one said, "It's their home, it's about treating them with respect." Another member of staff said, "I treat our residents in a way I would want my family to be treated, with courtesy and respect." When asked how they would assist someone with their personal care, a member of staff told us, "I always ask them. We try and encourage people to be as independent as possible." They added that they would also give people privacy by making sure that they were covered up, curtains were closed and people's bedroom doors were shut. A member of

staff explained, "I'm proud of the fact that I always try my best and treat them respectfully."

Our observations during the inspection told us that people were calm and confident, we saw staff were gentle but firm when they needed to be. During meal times there was no rush or pressure on people to finish food or drinks. One person took an hour to eat and was allowed to eat at their own pace with no fuss. Staff explained the reasons why and were very supportive. We saw that staff were proactive, engaged and knowledgeable. Their support was evident yet not intrusive or demanding.

People were provided with appropriate information that met their needs and were supported to understand the care and support choices available to them. People were
given a 'service user guide' which provided information about what people could expect from the service. Care plans and assessments were compiled in a format to aid understanding and comprehension. Staff were knowledgeable about people's needs with regards to their disability, race, religion, sexual orientation and gender and supported people appropriately to meet their identified needs and wishes.

Good

Is the service responsive?

Our findings

People received care and treatment in accordance with their identified needs and wishes. one person told us, "I love my room, I chose the wall paper." Detailed assessments of people's needs were completed upon admission to the home to ensure that the home could meet their needs safely and appropriately. Three separate folders were in place for each person, health needs, social needs and financial.

Care plans provided clear guidance for staff about people's varied needs and behaviours and how best to support them. For example one care plan contained detailed information on how staff should support the person to dress and how to manage the person's anxiety and emotional behaviour when wearing certain clothing garments. Another person's care plan documented how staff should support the person when attending health care appointments and undergoing medical tests and screening. Health and social care professional's advice was recorded and included in people's care plans to ensure that their needs were met and contained guidance such as managing epilepsy. Care plans also recorded people's progress that was monitored by staff and as advised by health professionals, such as fluid monitoring, weigh charts and blood sugars.

Care plans detailed people's physical and mental health care needs, risks and preferences and demonstrated people's involvement in the assessment and care planning process. Where people were not able to be fully involved in the planning of their care, relatives and professionals, where appropriate, contributed to the planning of peoples care. A relative told us they had been involved in their relatives care plan and reviews and had attended care meetings when required and felt that they were able to contribute to their loved ones care. We saw that people's care needs had been identified from information gathered about them and consideration was given in relation to peoples past history, preference and choices. Staff were knowledgeable about managing individual behaviours that challenged and distressed. Triggers for these behaviours were documented and known to staff, for example, one person became agitated when people did not understand them, another person disliked negatives in speech and could slap. Management techniques were documented and were updated and reviewed if not successful. Staff demonstrated knowledge and understanding of peoples behaviours and responded appropriately.

Care plans demonstrated people's care needs were regularly assessed and reviewed in line with the provider's policy. We did find that one care plan had not had its annual review but this had been rectified by the second day of inspection. Daily records were kept by staff about people's day to day wellbeing and activities they participated in to ensure that people's planned care met their needs. Staff told us that communication with people was one of the most important areas of their care delivery. One staff member said, "Communication is so important whether its verbal or by sign and body language We saw that staff responded very well to those who were non verbal and interacted in a friendly and caring manner. We saw examples of staff using pad and paper to assist people to communicate.

People's diverse needs, independence and human rights were supported, promoted and respected. People had access to specialist equipment that enabled greater independence and dignity whilst ensuring their physical and emotional needs were met. For example one person had mobility needs and a lift had been

installed to provide level access to all floors. For another who lived with the possibility of sensory overload, staff had assessed their personal environment and decorated to afford low sensory stimulation.

Care plans contained detailed guidance for staff on the use of specialist equipment, such as wheel chairs and we saw equipment was subject to regular checks by staff and servicing when required.

People were supported to engage in a range of activities that met their needs and reflected their interests. The home had access to two cars that were owned by the provider and enabled people to venture out into the community. People had individual activity programmes which detailed their weekly activities. Activities we saw included trips out for lunch, visits to family and friends, shopping trips, attending local community clubs and social events, visits to local attractions and health and leisure activities such as swimming sessions. We saw that people were supported and encouraged to participate in activities they liked, for example one person enjoyed Sudoku word searches and reading books, which staff ensured were available and kept in the persons' room. Craft sessions were held and on one inspection day people were effectively engaged in this activity making cards for Christmas. One person told us, "We do lots, everything is well organised." Another person said, "I love to go shopping, the staff take me." A relative told us they took their relative out on occasions and also visited the home frequently. We were also by one person that "Sometimes I can't get to do outings because there isn't enough staff. But that is okay, I understand." This was referred to the registered manager to investigate.

The service routinely listened and learned from people's experiences, concerns and complaints. People were encouraged to discuss any concerns they had with their keyworker or could talk with the registered manager. Any complaints could then be dealt with promptly and appropriately in line with the provider's complaints policy. people were encouraged to raise their issues or concerns immediately by staff so as deal with it immediately. We were told that, if people had a complaint, "They will tell you immediately and it can often be about food." There was a formal complaint procedure which was adhered to as guided by the policy. Formal complaints had to be recorded in system within 48 hours. The registered manager said she would always check with the complainant to ensure they were happy with the outcome and any action taken as a result of the complaint raised. No formal complaints had been received by the service within the last year.

Good

Is the service well-led?

Our findings

People, visitors and staff we spoke with felt the service was well-led. People told us, "I think it is really good here, we get nice staff and good food." A visitor told us, "The manager is approachable and keeps us informed and involved." Staff said, "I have been welcomed in to the team, really good supportive staff, we are three teams from three different homes and have joined together really well to create a really strong team." The registered manager said, "I'm really proud of the staff here, they are all dedicated and work together to provide a safe and caring service."

The service promoted a positive culture and people were involved in developing the service as much as possible. Residents' meetings were not held regularly as these had been assessed as not being an appropriate method of obtaining some people's views. Instead people met with their keyworker on an individual basis. Any views could then be listened to and addressed. However, the provider did invite friends and families to complete a satisfaction survey on a yearly basis. The last survey, completed in 2014 showed that a high percentage of respondents were either happy or very happy with the service their friend or relatives received. Respondents had also given their views about the accommodation provided, food, laundry, transport and activities provided for people.

Information following investigations into accidents and incidents were used to aid learning and drive quality across the service. Daily handovers, supervisions and meetings were used to reflect on standard practice and challenge current procedures. For example, the care plan system and infection control measures were being improved following review.

The provider had informed the CQC of any issues that might affect the safety of people living in the home. Such as safeguarding concerns raised by the local authority. The manager said she used the notification system to inform the CQC of any accidents, incidents and issues raised under safeguarding and we were able to check this on our system. We found information had been sent to the CQC within an appropriate timescale.

The culture of the home was one of 'homeliness' and we observed this throughout the day. When people returned from their various activities they had been involved with during the day, they were enthusiastic to share with staff what they had done. One member of staff said, "We're kind of like a big family really. We all work well together and the residents are special." The registered manager said she was proud of, "The fact we are three homes in one has been gratifying to set up and people are really happy and settled."

Staff were supported to question practice and there was a whistleblowing policy in place. One member of staff explained, "If I've got a problem I would go to [named registered manager] or her manager or Head Office."

The service demonstrated good management and leadership. One member of staff said, "I just enjoy it. everyday I feel I've achieved something. I can make a difference to them." The registered manager felt well supported by her manager and from head office and had supervisions every month and an annual appraisal.

Staff told us the people were important and they took their responsibility of caring very seriously. They had developed a culture within the service of a desire for all staff at all levels to continually improve. For example they were offered staff training opportunities in areas such as medicine training and diploma in health and social care.

There was a quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised. Where recommendations to improve practice had been suggested, they had been actioned. Such as medicine recording and meals. The provider and registered manager acknowledged that the quality audits had been an area to develop over the past year. The registered manager feels that now the service had been up and running for a year audits were now embedded and were a great help to improvements within the service. Audits were undertaken on a quarterly basis. Where action was required to be taken, the evidence underpinning this was recorded and plans put in place to achieve any improvements required. The provider's operations manager also visited regularly and checked on any audits undertaken, which were submitted to the provider.