Mr & Mrs L Alexander

Park View Residential Home

Inspection report

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Date of inspection visit: 7 and 8 October 2014
Date of publication: 15/01/2015

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

Overall summary

This inspection took place on 7 and 8 October 2014 and was unannounced.

At our previous inspection on 3 December 2013 the provider was not meeting the requirements of the law in relation to consent to care and treatment. Following the inspection the provider sent us an action plan to tell us they would make improvements by 28 February 2014. During this inspection we looked to see if these improvements had been made to meet the relevant requirement and we found that they had.

Park View Residential Home provides residential care for up to 30 older people who have a mental health diagnosis, such as schizophrenia or bi-polar disorder. Some people may also have a diagnosis of dementia. There were 25 people living at the service when we visited. The service comprised of four houses which were arranged into two sets of adjoining houses. People who lived in one set of houses had a higher level of dependency on staff support and people living in the second set of houses were more independent. The two sets of houses were joined and were part of the same service. Within each set of houses there were two

Summary of findings

communal lounges, a dining room and kitchen, there were some shared bedrooms. There was access between the two sets of houses via a communal rear garden. People were able to mix freely between the houses.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were encouraged and supported to be as independent as they could. Staff understood people's interests and preferences and enabled them to pursue them. Activities within the service and trips into the community were arranged in accordance with people's expressed interests. People were supported by staff who treated them with dignity and demonstrated an interest in their welfare and views. People had a positive experience from the care they received.

Risks to people were identified with them. Plans to manage the identified risks were then agreed with people. The building and premises ensured people were safe from unauthorised people coming in but did not limit people's freedom to come and go. Staff knew who had gone out and when they were expected to return. The impact of this for people was that they were safe but their freedom was not restricted by the service.

There were sufficient staff to support people safely and there was flexibility in staffing levels in the event that people were unwell and needed extra staff support. Staff had received training and supervision to enable them to support people effectively. Staff were encouraged to undertake relevant qualifications to enable them to provide people's care effectively and were supported with career development.

People received their medication safely from trained staff who spoke with people about what medications they were prescribed and why they needed to take them. We identified one issue in relation to the storage of controlled drugs. The manager took prompt action to ensure that controlled drugs were stored in accordance with guidance and people were protected.

Where people lacked the capacity to make decisions for themselves staff had followed the requirements of the Mental Capacity Act 2005. Staff had received relevant training. The manager understood their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLs) and was actively reviewing whether they needed to submit any applications for people to ensure they were not illegally deprived of their liberty.

People were offered a variety of nutritious meals and staff understood their preferences and requirements in relation to food. Where nutritional risks to people had been identified people were referred to the relevant professional and their guidance was followed. People's nutritional needs were met.

People were supported to maintain good health. Risks to their health were identified and managed. The service had links with local services to ensure people's mental health and physical health care needs were met.

Care plans had been written with people and regularly reviewed. Staff understood people's care needs. This ensured written guidance was available to staff about people's care needs.

People's feedback on the service had been sought in different ways. There was a service user representative to represent people's views and feedback in addition to regular resident's meetings. When people identified issues with the service action was taken to address the concerns raised. People's views had been heard and action taken.

People were relaxed in the service and able to speak freely with staff at all levels. The management and provider were visible and accessible to people. There were processes to monitor the quality of the service and evidence that learning took place from incidents. Changes had taken place as a result of this learning. People benefited from the open and clear leadership.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe living in the service; risks to people had been identified with them and were positively managed to ensure their safety.

People were cared for by adequate levels of skilled staff and there was flexibility in the staffing to meet changes in people's needs.

People received their medicines safely as required. The provider took prompt action to ensure all medicines were safely stored in accordance with guidance. This ensured people's medicines were stored safely.

Good

Is the service effective?
The service was effective.

People's care was provided by staff who had received an appropriate induction to their role and relevant ongoing training to enable them to support people effectively.

People's consent had been sought in relation to their care and if they lacked the capacity to consent to a decision then legal requirements had been met.

People's health needs were monitored and had been met promptly. People accessed healthcare professionals when required.

The provider was aware that the design of the buildings was not suitable to meet all people's needs as they became older and plans were in place to carry out the required adaptations.

Good

Is the service caring?
The service was caring.

People told us staff were caring and spent time with them and our observations confirmed this. Staff understood people's care needs and ensured people's these needs were met.

People's independence was promoted; they were encouraged to be active in the local community. People who required additional support to access the community received the level of support they needed.

People were involved in decisions about their care and their wishes were respected.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People had care plans that addressed their interests and preferences. People's care plans were regularly reviewed with them.

Activities at the service and in the community were arranged in response to people's expressed interests.

People's feedback on the service was encouraged and actively sought. Changes were made to the service in response to people's feedback.

Is the service well-led?
The service was well-led.

Good

People told us that there was good communication between staff and people; this was encouraged by the culture of the service. Staff understood that the objective of the service was to empower people and promote their independence.

People and staff felt that the registered manager was supportive and led the service well.

There were processes in place to assess the quality of the service and ensure that learning from incidents took place and changes were implemented.

Park View Residential Home

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 7 and 8 October 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspector who completed this inspection had experience of working with people with mental health needs.

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 improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. No concerns had been raised since our last inspection.

We spoke with two care managers and three healthcare professionals who provided both nursing and mental health nursing services to the service. We also spoke with commissioners of the service.

During the inspection we spoke with seven people using the service, four staff, the registered manager and the providers. A service provider is the legal organisation responsible for carrying on the adult social care services we regulate. We also used pathway tracking, which involved looking in detail at the care received by two people. We observed how staff cared for people across the course of the day including lunch time. We attended two staff handovers. We reviewed records which included six care plans, three staff recruitment records, staff supervision records and records relating to the management of the service.

We last inspected the service on 03 December 2013 and found the provider was not meeting the requirements of the law in relation to consent to care and treatment. Following the inspection the provider submitted an action plan to tell us they would make improvements by 28 February 2014. We checked to see if the provider had made the required improvements to ensure the regulation was met and found they had.

Good

Is the service safe?

Our findings

People told us they felt safe in the service. Their comments included "Staff keep me safe" and "I have confidence in the staff." The building was secure whilst not limiting people's freedom to come and go as they wished. People said they knew staff would come quickly when they called for help. We saw that when people rung their call bell, staff responded promptly. Where people could not use their call bell to raise the alarm staff monitored people and regularly checked on their welfare. People who were at risk due to their physical or mental health needs had been identified by staff and were observed hourly to ensure they were safe.

People were protected from the risks associated with their care and support because risks had been identified and managed appropriately. When people received support to keep their money safe, the manager ensured this was done in line with the provider's money management policy. One person told us "I keep my money safe in the office." We observed that people's money was stored safely but people were able to access it as they wished. People had risk assessments in place that detailed how risks to them were to be managed, for example the risk of suicide or behaviours that challenged staff. Risk management plans detailed what medication staff needed to ensure one person took with them when they went out to ensure their safety.

People told us they had been involved in making decisions about their safety and supported to stay independent. For example, people who wanted to go out had plans in place to enable them to access the local community safely. People received support to understand how to stay safe when out walking and were initially accompanied by staff until they were confident in finding their own way. We observed people going out for a walk alone as documented in their risk management plans. Staff always knew where people were and this was shared at each shift handover meeting. Action was taken to find people and make sure they were safe if they did not return to the home at the time stated. Incidents relating to people in the community were low. Where incidents had occurred action had been taken to minimise the risk of re-occurrence and this had been successful at reducing risks to people.

People were protected from harm and abuse because the provider had systems in place to ensure that any concerns about people's safety were appropriately identified, reported and managed. Staff had received safeguarding adults training and knew how to recognise and report potential signs of abuse. Records showed that incidents had been reported and recorded in line with the provider's incident management and safeguarding policies. Following investigations of incidents safety plans had been developed with people to prevent similar incidents happening to people in the future. For example, following a medication incident action had been taken to understand how the error had occurred and to minimise the risk of future incidents. People told us that these plans had kept them safe.

People were protected during emergencies because staff understood and had implemented the provider's emergency procedures. The service was staffed 24 hours a day and staff were able to contact the providers out of hours if needed. Contact numbers were available to staff in the event of an emergency, records confirmed that staff had taken appropriate action. For example, staff had sought medical advice in the event of a medical emergency.

People were cared for by sufficient staff to keep them safe and meet their individual needs. A senior member of staff was on duty or available for every shift. Staffing was arranged across the two houses. The activities co-ordinator ran activities between the houses and people could attend activities as they wished. We observed a group activity being run whilst other staff spent one to one time with people. Each shift had a senior care worker who worked between the houses during each shift. The senior staff member was observed supporting people and staff in both houses during the shift.

People, staff and stakeholders told us that there was a good level of staffing for the service. We observed people being supported promptly when they requested assistance and staff did not rush people. Staff wanted to prepare the dining room for lunch but people were still finishing their craft activity. People were given time to finish off what they were doing before the tables were laid with people's participation. The provider had a standard staffing level for each shift, and the manager kept this under review so that if a person was unwell or extra staff were required for a trip this was arranged. Shift records confirmed that the level of staffing identified by the manager had been provided. Temporary agency staff were not used and extra staff were

Good

Is the service safe?

sourced as required from the provider's other locations. The provider had undertaken the required recruitment checks to ensure that people were supported by suitable staff.

People were supported to manage their medicines safely and appropriately in line with the provider's medicine management policy. Controlled drugs were kept locked but the container did not meet the legal requirements. This was brought to the attention of the manager and the provider who took immediate action to source an appropriate container which ensured that controlled drugs were securely stored. No other concerns in relation to the management of controlled drugs were identified.

People told us "I get my medicines as I need them" and confirmed that they received 'as required' medication if needed. People had a medication record which stated what medications they had been prescribed, why, when and how. Records showed that people had received their medication as prescribed. People had been made aware by staff of the medicines they were taking and what they were for. Records showed that people's medication had been discussed with them to ensure they understood what medication they were taking and why. Arrangements were in place to ensure that people took their medicines with them when they went out so that they could take the medication they needed. We observed people receiving their medication appropriately. One person was unsure whether they wanted to take their medication. We saw staff supporting them sensitively to understand the need to take their medicines. A care manager and a mental health nurse we spoke with confirmed that staff worked with people in relation to their medication and supported people's choices.

People's medication was managed safely by trained staff. Staff told us they had received medication training which was updated and their competency was assessed. This was supported by training records we looked at. Medications training included external training to administer people's insulin. Medication administration records (MAR) sheets were completed and checked for completion each shift. Regular audits of stocks took place to ensure that the amounts of medications held matched records. Internal and external audits of medications took place.

Good

Is the service effective?

Our findings

At our inspection on 3 December 2013, we were concerned that people had not always been supported to consent to their care in line with legislation and guidance. We asked the provider to send us an action plan outlining how they would make improvements. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found improvements had been made to ensure the principles of the Mental Capacity Act 2005 (MCA) were met.

Staff had received guidance and training to enable them to understand the requirements of the MCA and the Deprivation of Liberty Safeguards (DoLS). CQC is required by law to monitor the operation of the DoLS, and to report on what we find. DoLs requires providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty. The provider had previously submitted a DoLs application and was reviewing whether they should submit further applications to ensure people had not been illegally deprived of their liberty.

One person told us told us "Staff seek my consent." Staff understood their responsibilities under the MCA. We observed people being asked for their consent before they were given medicines or assistance with their personal care. People's consent had been sought to share bedrooms and privacy screens were used to protect people's dignity. We saw evidence of mental capacity assessments and best interest decisions that had been made in consultation with people's families and professionals, for example; in relation to emergency resuscitation.

People were provided with appropriate support to meet their mental health needs. The provider told us that people's care needs were assessed and considered holistically, in terms of their physical, mental health and social care needs. Rather than the focus of their care being based on medication to manage their symptoms of mental illness. A mental health nurse told us that the service did not just ask for people to be prescribed medication to manage behaviours that challenged staff, but psychological and social interventions were used as an alternative. Risks to people's mental health had been assessed and plans to manage identified risks had been agreed with them. Training had been provided for staff on managing challenging behaviour by a mental health nurse from the community mental health team. This enabled staff to support people appropriately with their behaviours. People were supported to identify their wishes and aspirations and staff supported people to achieve their aims. One person told us that they did not feel restricted they said "It's far freer here."

Staff received an induction to ensure they had been sufficiently trained to undertake their role. They received ongoing training to enable them to meet people's needs effectively and this included mental health awareness training. Staff were supported through regular supervision and an annual appraisal, this was confirmed by records. A number of staff had completed social care qualifications and staff were provided with opportunities for career progression including vocational qualifications.

People were supported by staff who were involved in local forums and projects such as the hydration project and the falls project which were run by a specialist community nurse. This ensured that staff were aware of the risks to people from poor hydration and the link with an increase in falls. People were encouraged to stay hydrated across the course of the day, drinks machines were available. Information about the importance of hydration was available for people. The manager was implementing local guidance from the clinical commissioning group in relation to the use of the Malnutrition Universal Screening Tool (MUST). The service was aware of best practice guidance in relation to people's care and it was followed.

People were provided with a choice of nutritious foods. People told us "Food is good". If people did not like the food choices, they were offered alternatives. Staff knew people's food preferences. Lunch was a sociable time with people seated in small groups. Staff chatted with people as they served the meal and were attentive to people who required support. Staff told us that snacks were available to people between meals.

If people were at risk of malnutrition, staff took appropriate action to manage this. Although no-one required a food or fluid monitoring chart people's food and intake was recorded to ensure they were eating enough and discussed during the staff handover. Staff supported people who had difficulty swallowing to eat safely in line with speech and language therapists (SALT) guidance. We observed staff thickening drinks appropriately during lunch time in accordance with people's care plan guidance. People were also given pureed food if required. The cook had been

Good

Is the service effective?

given information about people's food preferences and requirements from care staff. This ensured people received foods they preferred and which were suitable for their needs.

Staff supported people to stay healthy. People's care plans described the support they required to manage their day to day health needs. The plans included information about people's personal routine, interests, communication, diet, mobility, medication, weight, falls, personal care, skin management and end of life care. Care plans were in place to manage the risks to people's physical health. For example, the risk of people's skin breaking down had been identified. One person was receiving wound care from the district nurse and a further two people had been identified as at risk of developing pressure sores. Appropriate equipment was in place and information about how often people required support to manage this risk was shared at the staff handover and documented in records.

People's physical health needs were supported. People and stakeholders told us that people were supported to stay healthy. One person told us "I had an operation and staff attended appointments with me." Records showed that people had regular access to healthcare professionals such as GP's, chiropodists, opticians and dentists. There were good links with the community mental health teams.

The two sets of houses were linked by a communal rear garden, through which people could access either set of houses. People we spoke with did not object to accessing the two sets of houses via the rear garden if they wished to visit people or to attend activities. Adaptations had been made to the buildings to meet people's existing mobility needs, through the provision of stair lifts, ramps and rails. These ensured people could move around safely.

Good

Is the service caring?

Our findings

People told us "Staff are caring" and a mental health nurse confirmed when they visited they found staff were caring towards people. Staff were observed to be considerate of people. For example, we saw one person was moving slowly and a staff member needed to pass by. The staff member waited patiently whilst the person walked to where they wanted to get to.

People told us "Staff talk with us." Staff had time to spend with people and told us "I sit and talk with people. It is encouraged." Staff greeted people as they walked past them and asked them how they were.

People were asked if they would like to participate in activities such as laying the table. People's art work had been used to decorate the dining room. This made the service feel homely and showed the work people produced through their activities was valued by staff and worthy of display. Staff were able to communicate with people and we saw communication materials had been developed to enable staff to meet the communication needs of a particular person.

People were cared for by staff who knew them well and realised when they weren't well or needed support. Staff were observant to the fact that one person appeared tired. They knew how the person normally presented and immediately checked upon their welfare. Staff told us "We can tell if people are a bit low or present differently."

One person told us "I am consulted about decisions about my care," this was confirmed by a care manager. People were supported by their keyworker to express their views about their care. People met monthly with their keyworkers to discuss their care and we saw that where people had asked for changes to be made to their care arrangements, this had been acted on. For example, one person did not want to be checked upon by staff at night. They had discussed their preference with staff and their care had been amended to reflect their wishes. Choices and wishes were respected. We spoke to one person who told us they kept their own tobacco, whilst records showed that another person had chosen for staff to purchase and hold cigarettes for them. People were able to access their cigarettes when they wanted them.

People's wishes were respected. A person had expressed their wish not to have their bed changed that day. Staff on the next shift were made aware of this in order to respect this person's wishes. People could get up at the time they preferred. Staff were made aware that people had chosen to get up late at the staff handover. If people wanted to have a meal in their room then they could rather than dining communally. People were able to stay in their room if they wished to. Although people's wishes were respected staff ensured that they did not become socially isolated by checking on them regularly and offered encouragement to people to come out of their rooms, this was confirmed by a care manager.

People were kept up to date with relevant information which was displayed throughout the service. Examples of information included advocacy services, people's rights, resident meeting minutes and local information. Staff wore identity badges and this ensured people could identify who they were and their role. People were also provided with verbal information. Staff told people when lunch would be ready so that they knew when it was almost lunchtime. Staff told people where they were going whilst they supported them. Staff warned people of any hazards such as the ramp into another part of the service, to ensure that they had information to mobilise safely.

People told us that their privacy and dignity were respected, this was confirmed by a care manager. Staff knocked on people's bedroom doors and waited for a response before entering. People were asked if they wished to come to the table for lunch. Staff communicated respectfully and appropriately with people and with each other.

People told us "My independence is promoted." Promoting people's independence was a value in the provider's mission statement and reflected in practice. During the inspection people went out for walks, visit a club and go to the shops independently. People used their local community facilities such as the library and cafes. People who could not go out alone were supported to go out by staff if required. When a planned activity had to be cancelled at short notice the activity co-ordinator took some people out for a coffee in a local shop, so they were provided with an alternative activity outside the service instead.

Good

Is the service responsive?

Our findings

People were able to express their views about their care and told us "Staff seek our views" and "Staff listen to us." People's needs had been assessed before they moved into the service. This was confirmed by a care manager. Care plans had been developed in consultation with people using the information gathered at their pre-assessment. People's views were taken into account in planning their care.

People's specific needs, requirements and interests, had been identified and recorded. One person's interest was walking. This person went out for a walk on both days of the inspection. We spoke with them and they confirmed that they went for a daily walk. One person had their own chair provided for lunch. Staff were able to tell us why this had been provided for the person and the benefits of them using it. Arrangements had been made for people to be supported to attend church if they wished. We spoke with one person who confirmed they attended church weekly; staff understood the support this person required to attend this activity.

People's care was planned in response to their expressed preferences and interests rather than focusing on practical tasks that had to be completed in relation to their care. One person told us that they liked music and we heard them expressing themselves by playing their music in their room. Another person told us "I like to go to the newsagent a couple of times a day. Staff encourage me." People told us "They take us out" and stakeholders told us that that people had been supported to follow their interests, for example, visits to the coast.

People told us "We have care reviews." We saw evidence that people's care plans had been reviewed with them monthly and amendments made to their care plans in response to their feedback. One person had expressed a wish to have a shower rather than a bath. Their views had been noted and their care plan amended accordingly. Staff told us they spent time reading people's care plans and demonstrated a good knowledge of individual's needs. Changes to people's care had been made following their feedback at their keyworker meetings and this showed in their records. One person had expressed their preference not to receive support with an appointment and it had been documented that they would attend this appointment alone.

People participated in a varied activities schedule which included activities within the service and the community both during the week, and at weekends. The activities co-ordinator supported a person with cooking as they did not wish to join in with the main craft activity. People said that their views had been sought about their interests and that they could spend their time as they wished. People had been provided with a range of reading materials; DVD's and games. One person was supported by staff to read the newspaper. A hairdresser visited twice a week and health professionals visited the service to see people where required. Some people were very independent and active but other people had more complex care needs. We observed that although a person was in bed the radio was on and the door was left ajar so that they were not isolated. Their care plan recorded an interest in books and staff had ensured that they had a book to look at. Consideration had been given to how this person's particular needs could be met to ensure they received stimulation and were not isolated.

The provider was aware that as people mobility decreased the existing environment may not continue to be suitable to meet their needs. The corridors were too narrow to easily manoeuvre wheelchairs. Plans were in place for the building to be adapted. People had been consulted about the work which had been approved and was scheduled for 2015. People's future mobility needs had been planned for.

People were aware of how they could make a complaint and relevant guidance was available to enable them to do so. They told us that they felt confident that if they made a complaint they would be listened to. People said "Yes I can make a complaint. Complaints are responded to." The service user representative told us that the manager responded promptly to issues they raised on people's behalf and this was confirmed by one person's care manager.

The manager told us that although no formal complaints had been received, they had identified some negative feedback from one person from the last resident feedback questionnaire. We saw evidence that the manager had met with the person to discuss their feedback and what changes they would like to see. Changes had been made as a result of the person's feedback, as their key worker had been changed.

People's views on the service were sought. People had been consulted about and involved in developing the

Good

Is the service responsive?

service improvement plan. As a result of people's feedback changes to the service had been made. The activities co-ordinator was on planned leave and people expressed a desire to have their post covered during their absence. Arrangements had been made to provide an interim activities co-ordinator rather than other staff covering their absence. People were invited to participate in the monthly residents meetings. The cook met with people at the residents meeting to seek their feedback and there was evidence that changes had taken place to menus as a result of feedback. For example, people wanted more soup and this had been provided.

Staff told us that they could raise any concerns either directly with the manager or at staff meetings. The manager told us that staff had requested mental health awareness training and records confirmed this had been provided. When staff raised issues that could impact on people's care action had been taken.

Good

Is the service well-led?

Our findings

People told us that the service was well led by the registered manager; this was confirmed by a person's care manager. Staff said that they felt well supported by the manager. People told us that the providers visited regularly. We observed the arrival of one of the providers at the service and saw people greeted them warmly and were relaxed in their company. The provider told us that these visits enabled them to observe the quality of the service provided and to speak with people and staff. Management was visible in the service and people felt managers and the provider were accessible to them.

The culture of the service supported communication and people felt able to express their views freely. People said that staff morale was good and they felt that "Service users have a voice." People told us "The manager talks with us often." The manager confirmed that they worked shifts alongside staff which enabled them to speak with people, observe staff interactions with people and to seek staff feedback. A community nurse told us that there was an open and transparent culture in the service.

People told us that when staff applied for a post at the service they visited before their interview. During this visit they met with people and the manager who then asked for people's feedback on applicants. The provider told us that when staff were recruited they explored whether applicants displayed the values they were seeking. Values were the behaviours the provider sought in staff to enable them to work effectively with people to promote their independence and empower them. The values of the service were embedded in the service mission statement and then discussed with staff during induction, supervision and staff meetings; this was confirmed by staff. Staff demonstrated an understanding of the vision of the service. Staff were aware that the purpose of the service was to empower and enable people to live fulfilling lives.

People were cared for by staff who felt safe to raise issues that might impact on people's safety or quality of care. Staff were encouraged to express their views through talking with the manager, supervision, staff meetings and feedback to the provider. This was confirmed in the records. Staff told us that they felt able to speak freely with management. Staff understood the procedures to follow if they needed to whistleblow and raise a concern outside the service. The records confirmed that whistleblowing had been discussed in staff meetings.

People's views were sought through the annual survey in addition to the resident meetings, service user representative, provider visits and informal contact with the manager. The role of the service user representative was to raise any issues with the management that people wanted addressed. Annual surveys were also sent to staff and professionals. Actions had been taken as a result of people's feedback.

Incidents that had impacted on people's safety had been recorded and analysed. For example, staff had documented when people had experienced falls. Details of falls had been collated, analysed and plans implemented to reduce the risk of reoccurrence. The outcome of the analysis had been discussed at the bi-monthly senior management meeting.

Staff understood their responsibility to report incidents. Following one incident, staff had reported the incident and accounted for their actions. As a result of the investigation into the incident changes to processes had occurred and staff had been supported with additional training. Staff had been immediately informed of what action and changes to practice were required to learn from the incident.

There was evidence that the provider learnt from incidents and applied this across their services for people's benefit. Following an incident in another location changes had been made to the provider's internal medication audit tool and the revised medication audit tool was being implemented across services.

The service had a registered manager in place; there had been no changes in the management of the service during the past year. The registered manager had ensured that they had informed the Care Quality Commission (CQC) as required of notifiable events, to enable CQC to monitor the quality of the service people received. Notifications had been submitted as required in relation to incidents such as safeguarding, police incidents, serious injuries and deaths.