Bridging the Gap Ltd

Bridging the Gap Limited - Oldham

Inspection report

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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

This inspection took place on 14 and 15 February 2017 and was announced. We gave the provider 48 hours' notice of the inspection to ensure that the people we needed to speak with were available.

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.

At the time of this inspection the service was providing the regulated activity of personal care to 44 people who lived in their own homes. This included some people who were supported over 24 hours in supported accommodation. The service supported older people, people with learning disabilities and people with physical disabilities.

The service was last inspected in July 2015 when we found the service to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection the service had submitted an action plan and when we returned for this inspection we saw that the actions had been followed up. At this inspection we found that the service was meeting all the requirements.

There were systems in place to ensure that risks to people's safety and wellbeing were identified and addressed. Staff were aware of their responsibilities in protecting people from harm and knew how to report any concerns about people's safety or wellbeing. We saw that safe recruitment processes were followed, and staff worked in small teams which helped to maintain consistency of care. People who used the service told us that they always knew the people who were visiting them. We saw that staff had enough time with people to meet their needs.

Care records identified specific risks to people, and care plans directed staff on how to minimise these risks. Where people required assistance with their medicines we saw that this was given safely by staff who had undertaken medicines competency training.

Staff employment records showed that checks had been made to determine their suitability to work with vulnerable people. Staff told us that they received good training which enabled them to meet the needs of the people who used the service. They were fully supported by the registered manager and a programme of training and supervision enabled them to provide a good quality service. People told us that they were supported by staff who could communicate with them in a way they understood, knew how to do their job, and who knew how they preferred to be supported.

We saw peoples choices were respected, and care staff did not use their role to impose their own values on people. Where people lacked capacity to make choices, decisions were made in the best interest of the person, but we noticed that decisions were not always clearly documented.

The service had established good links with healthcare professionals and ensured that people who used the service maintained good access to healthcare, including yearly health checks.

People received a service that was based on their personal needs and wishes. Changes in people's needs were quickly identified and their care package amended to meet their changing needs. The service was flexible and responded positively to people's requests. People who used the service felt able to make requests and express their opinions and views.

We saw that care provided was person centred, and recognised the individuality, culture and values of the people being supported. Care was delivered by kind and caring staff who had a relaxed and comfortable rapport with the people we visited, treating them with dignity and respect and encouraging people to maintain their independence.
People told us that staff encouraged them to do as much for themselves as they could and had helped them to maintain their independence where possible. One person told us "They have supported me and help and encourage me to do more for myself, so I am getting stronger".

People who used the service felt that the management was good and told us that they were able to contact someone in the office when they needed to. There was a system in place to manage complaints, and people were aware how to contact somebody if they wanted to make a complaint.

Staff felt valued in their role, and were encouraged to raise issues with the manager. They received regular supervision and yearly appraisal of performance, and attended team meetings where issues and practice could be discussed.

The service had good quality assurance systems. Information received through audits, complaints, surveys and spot checks was used to identify trends, including good practice and areas for development.

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 in safeguarding so they would recognise abuse and know what to do if they had any concerns.

Risks had been appropriately assessed and the service encouraged a positive approach to risk, to allow people to build independence.

The service supported people to measure and achieve their desired goals.

People were protected through the service's recruitment procedures. These procedures helped ensure staff were suitable to work with vulnerable people.

People were protected against the risks associated with unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received sufficient training to meet their individual needs, and received regular and effective supervision.

Staff promoted and respected people's choices and decisions.

The registered manager and senior staff had a good understanding of the Mental Capacity Act 2005 (MCA).

Where necessary people were provided with a healthy diet which promoted their health and well-being and took into account their nutritional requirements and personal preferences.

Is the service caring?

Good

The service was caring.

People were supported by staff who understood and often shared their cultural and religious beliefs.

The registered manager and staff were committed to providing care that was kind, respectful, and dignified.

People received care from people who knew them well. People who used the service valued the relationships they had with staff and expressed satisfaction with the care they received.

Is the service responsive?

Good

The service was responsive.

Care plans indicated people's interests and activities, and were reviewed on a regular basis.

Changes in people's needs were quickly recognised and appropriate prompt action taken to address the identified changes.

People felt the service was very flexible and based on their personal needs, wishes and preferences.

People knew what to do if they wished to raise a concern and the service viewed concerns and complaints as part of driving improvement.

Is the service well-led?

Good

The service was well led.

The registered manager promoted good values and a person centred culture.

The provider had systems in place to monitor the quality of the service.

We saw that regular audits/checks were undertaken on all aspects of the running of the service.

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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 14 and 15 February 2017. We gave the provider 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection team consisted of one adult social care inspector, who was accompanied on the first day by a translator to assist with conversation with people for whom English was not their first language. Before this inspection we reviewed the previous inspection report and notifications that we had received from the service. The provider had also completed and returned their 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.

During this inspection we visited people in their own homes, and spoke with seven people who used the service and the relatives of another four people. We spoke to the registered manager, care manager and other office staff and interviewed five members of care staff.

We looked at six people's care records, together with other records relating to their care and the running of the service. This included the employment and training records of five staff, policies and procedures relating to the delivery and management of the service, staff rotas and audits and quality assurance reports.

Good

Is the service safe?

Our findings

People we spoke with who used the service told us they were safe. One person said, "I know the staff very well. I have never felt fearful when the staff are with me, I am always safe with them. The staff are very good". A relative also commented, "They make sure [my relative] is safe. They take care with washing, dressing and moving or transferring, and they always check and use the equipment properly".

The service had a safeguarding policy which was in line with current legislation and the local authority safeguarding guidelines. The Care Manager informed us that she sat on the local authority Adult Safeguarding Board and was keen to ensure that staff understood their role and responsibility to protect vulnerable adults and children from harm. We saw the safeguarding policy linked to training and when we spoke with staff they were able to tell us the signs that would alert them to potential abuse and the actions they would take. We looked at the service's safeguarding records and saw that where alerts or concerns had been raised, appropriate action was taken to protect the individuals concerned.

Staff knew how to keep people safe and were aware of their responsibilities for reporting accidents, incidents or concerns. Written accident and incident documentation contained a good level of detail, including the lead up to events; what had happened and what action had been taken. There was evidence of learning from incidents that took place and where appropriate risks were reviewed and prevention plans put in place. The service had a whistleblowing policy and staff were able to tell us how they would respond if they observed poor practice with reference to this policy.

Assessments were undertaken to assess any risks to people who received a service and to the care workers who supported them. This included generic risk assessments, for example, around the environment, or hazards within the home, and any specific risks arising from the health and support needs of the person. Risk assessments included recorded action to be taken to minimise the chance of harm occurring. When we spoke to the Care Manager, she informed us that the service encouraged a positive approach to risk, and said, "Risk assessments help us to help the person to take measured and reasonable risks". This helps to build independence and support for the person to measure and achieve their desired goals.

When we looked at the staffing rota we saw that there were enough staff to meet the identified needs of the people who used the service. We saw staff would work in two or three teams, and each team would work with four or five people. This meant that people received care and support from people they were familiar with and who had got to know them well. The registered manager told us that rotas were sent to all staff by email with a check that they had been received. This minimised risk of missed calls. Staff told us that they were allowed sufficient time to travel between visits and did not feel rushed. One person who used the service told us that they were always introduced to new members of their team, and that the staff would call to say they were on their way. They told us, "They always let me know beforehand. That way I am safe. I won't open the door unless I know who is coming". However, when we spoke to another person, they informed us that, although the number of people who called was limited to four or five familiar faces, they never knew which member of staff would be coming for each visit.

People confirmed that staff general arrived when they were expected, and that they would be contacted if there were any delays. They told us that the service was responsive to their needs and gave examples of when their daily routines varied, the service would respond to the change, so if they wanted a later or earlier visit the service would accommodate this. For example one person told us how they would sometimes attend mass on Sundays, and the service would arrange a later lunchtime call. Another person who used the service told us, "They are very flexible. If I ring them and ask to come at a different time, they will do that. I am very happy with my support".

We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of residents. We looked at five staff records. These contained proof of identity and eligibility to work in the United Kingdom; an application form that documented a full employment history and accounts for any gaps in employment; a job description, and two references. Checks had been carried out with the Disclosure and Barring Service (DBS) before the member of staff began work. The DBS identifies residents who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed by Bridging The Gap.

People were responsible for their own medicines where possible, although some required prompting to take their medicines. This was reflected in the care plans. One person told us, "I can take my own tablets, but I need a reminder and the staff do that. They will bring me a glass of water to wash it down". If people needed support with their medicines the systems in place were safe. All staff completed safe medicine administration training before they were able to support people with their medicines. This meant where people required greater assistance to take their medicines they were supported by staff who had been trained to help them. The managers also completed practical competency reviews with all staff to ensure best practice was being followed.

Staff had received training and guidance on safe hygiene and infection control procedures. Staff were provided with protective equipment such as disposable gloves and aprons. Spot checks were conducted to ensure staff were wearing the correct uniform. Long finger nails, nail varnish and unsuitable jewellery were not allowed. This was not only because they could cause injury to people but also because long finger nails and items of jewellery could harbour germs.

Good

Is the service effective?

Our findings

People told us that they felt staff were competent. We asked people if they thought the staff who supported them had the necessary skills and training to support them. One person replied, "Yes, they have the skills. They know me, what I want and need, and how to provide care. They help me, but encourage me to do things for myself and they have helped me to develop. They respond when I am having an off day, and they talk in a way I can understand".

We saw that the service set clear expectations for the staff and provided on-going training to ensure that staff had the skills to carry out their role. We looked at the training matrix which mapped out the training staff had completed, and helped to identify any training requirements. This included dates when this training would need to be refreshed and reviewed. It showed that staff had completed mandatory training as a part of their induction; all staff had been enrolled on the Care Certificate, which is a nationally recognised qualification and provides staff with the knowledge to ensure they provide compassionate, safe and high quality care and support. Staff rotas allowed time for staff to complete training, and after working for six months they were encouraged to enrol in the National Vocational Certificate (NVQ) level 2 in Care. The training matrix showed that all staff had completed mandatory training at the commencement of their employment including safeguarding adults and children; whistleblowing; capacity and consent; moving and handling and health and safety. Where specific needs for people who used the service were identified, the service commissioned further training, for example, where individuals had a percutaneous endoscopic gastrostomy (PEG), the staff who supported them were provided with training on effective use and care of the site PEG site. PEG is a medical procedure in which a tube (PEG tube) is passed into the person's stomach to provide a means of feeding when the person cannot take food orally. The service recognised that for some staff English was not their first language and these people were supported to enrol in basic courses in written English at a local college.

During our inspection some staff were receiving training around Infection control and control of substances which might be a health hazard. We spoke with staff after this training session and they were able to tell us how they would apply their learning in practice.

During their induction to the service all new staff were provided with a mentor and worked alongside a more experienced member of staff for a period of between three and six months during which time their performance would be reviewed and checked before they were ready to work alone. Regular supervision included on the job observations and off the job simulation to determine their abilities to work with people who used the service. Staff were matched with people with regard to their culture and lifestyle in order to reflect their needs, wishes and cultural lifestyle.

People told us that they were supported by care staff who knew them well. The registered manager told us that there was very little staff turnover, and when people left it was generally for personal reasons. There was a low level of sickness and absenteeism, and the registered manager explained that by employing people to work in overlapping teams staff supported one another, and would cover for any gaps in the rota. This allowed for people to receive care from staff who knew them.

All staff received regular supervision either with the registered manager, care manager or senior carer. Staff told us that they found supervision useful and that they were encouraged discuss what was going well and where things could improve, including any issues or concerns about the people they cared for. We saw this was reflected in supervision notes which also included any professional development and training they would like to explore. Everyone attended staff meetings as an additional support, where they shared their knowledge, ideas, views and experiences.

Bridging The Gap had policies and procedures on the Mental Capacity Act 2005 (MCA). The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack capacity to make some decisions. Information in people's care records showed the service had assessed people in relation to their mental capacity. The registered manager and senior care staff had a good understanding of the MCA. Staff understood their responsibilities with respect to people's choices. Staff were clear when people had the mental capacity to make their own choices, and respected those decisions.

We saw peoples choices were respected, and that care staff did not use their role to impose their own values on people. One person who used the service said, "They respect my views and always offer choice." When we visited a supported tenancy, (these are houses where people were supported in their own homes throughout a 24 hour period), a person told us, "They [staff] always give me choices, like when to get up or what I want for breakfast, and I always have the remote [control] for the TV". We saw that where people lacked capacity to make choices, decisions were made in the best interest of the person, and a relative told us that they were consulted and involved in decisions about the care their relative received. However decisions were not always clearly documented, for example, relatives told us that they had been consulted about measures to maintain security but there was no record of a best interest meeting. When we spoke to the registered manager about this they agreed to review the processes for making best interest decisions for people who may lack capacity.

People were provided with support to eat and drink where this had been identified as a care and support need during the assessment process. Care plans reflected the level of support people may require, and cultural requirements such as diet or attendance at religious ceremonies were respected. Where people required specific diets, such as pureed meals or thickened fluids care plans noted this, and a food diary recorded the amount people had eaten.

Staff were available to support people to access healthcare appointments if needed and, liaised with health and social care professionals involved in their care if their health or support needs changed. People's care records included evidence that the agency had supported them to access district nurses, occupational therapists, dieticians and other health and social care professionals based on their individual needs.

Good

Is the service caring?

Our findings

People told us that they felt genuinely cared for; one person said, "I get on well with the carers. They really think about me and what I might need. They will ring to say they are on their way and check if there is anything I need fetching from the shops. They are really considerate". Another told us, "They respect me and they listen to me I am very satisfied with the staff and with Bridging the Gap".

When we asked people about their relationship with staff, they told us they got on well with them. One person said, "I get on well with all my care staff, we have a lot of banter. Some are really chatty, and are interested in me". A relative said, "They are right loving girls. I can't fault them. They'll have a laugh with [my relative] it really cheers her up". When we spoke with care staff they showed empathy and understanding for the people they worked with. For example, one care worker told us that she noticed a person who was cared for in bed did not always wear appropriate nightclothes and liaised with the family to obtain suitable clothing for them. We saw that care was delivered with patience and compassion and there was an affinity between the support workers and people who used the service.

The care manager told us that when they recruited staff they looked for people who shared the same values, and looked to support individuals who shared the same interests and where possible the same background and culture. Staff worked in small teams which helped them to get to know the specific needs and wishes of the people they worked with. The care manager believed this had paid dividends telling us, "Knowing the people, and being close matters, and helps staff to go the extra mile".

In order to respect the dignity of people who may require personal care, the service looked to provide gender specific care. This was not an absolute, and all people who used the service were asked if they wanted to be supported by people of the same gender. The relative of one person we spoke with told us that the personality and character of the care giver was more important than their gender, and that the person required support from people who responded in a calm and sensitive manner. We saw their support team was made up with people who met this criteria.

The cultural and religious backgrounds of people were always respected. Many of the people who used the service were from the Asian sub-continent, and staff were recruited to communicate with them in language they understood. We saw that where people were supported by staff form a different ethnic background to their own, their views and cultural beliefs were respected. One person who used the service told us how being supported by people from a different culture to their own had helped challenge some of their own pre-conceived ideas, and that by continuing to provide a consistently good quality of care staff gained the respect of people who used the service and helped to overcome their prejudices.

Support workers felt that they were given enough time to provide the right support and that they were not rushed to complete tasks. A relative told us that care workers were never rushed. Due to the changing condition of their relatives the time taken to complete tasks such as washing or dressing could vary considerably. They told us that carers always had time and were considerate and patient.

People told us that they were offered choice in the delivery of their care and support. We asked if people felt that they were involved in planning their care and the responses we received were mainly positive. One person told us that care workers helped them to consider what was in their best long term interests and told us that they welcomed the advice given. They told us that their care plans and the way their care was delivered helped them to maintain their independence. They told us that the care workers would always spend some time encouraging them with mobility, and checked that appointments were made and kept.

Care records for people documented their interests and what they enjoyed doing. We saw that the service was revising the format and the way care plans were written. Older care plans focussed on the tasks to be completed rather than the person, but the newer plans were more person centred, for instance, they asked the author to consider "Ways [person] would like their needs to be met". This helped to ensure that the person who used the service was central to the planning and delivery of their care.

The service supported people when receiving end of life care. We saw that staff had received training in the Six Steps programme to increase knowledge and skills to care for people at the end of their lives. Staff often received heartfelt thanks from relatives following the death of their loved ones and we were shown letters of gratitude from relatives of people who had been supported by Bridging the Gap at the end of life.

Staff told us about how they supported the 'whole family' when providing care and support to an individual, particularly those living with the person. They had built positive relationships based on trust and mutual respect. This helped to support sensitive, emotional situations when people were receiving end of life care. Bonds were built between staff, spouses and family members and staff genuinely cared about them all. A relative told us, "I couldn't wish for a better set of girls, even when [my relative] isn't here they ring to see how I am. I feel safe and loved. I've been blessed."

Good

Is the service responsive?

Our findings

Bridging The Gap supported people in their own homes with a variety of tasks including personal support, meal preparation, and supporting people to take their medicine. In addition, they also supported people in supported tenancies where staff were available throughout the day to support people to maintain their independence. One person told us, "They do a lot for us, but don't take over. They go at our pace. The staff are diligent and patient with me." All the people we spoke with told us that the carers understood not only their needs, but also their preferences and how they liked their needs to be met. People we spoke with were positive and praised the quality of care. A person who used the service had extremely complex physical needs. We spoke with their carer who was extremely positive about the care provided by the service, and told us that when their relative was admitted into respite care, they believed the care there was not as good as that provided by Bridging The Gap, so they brought them back and reintroduced the care package.

Before people started with the service they received an assessment of their needs in their own home, and the managers of the service would plan delivery of support mindful not only of their personal care and needs or support with activities of daily living, but also to their cultural needs. The registered manager told us that they were aware of the service's limitations, and would not accept a new person into the service if they did not believe that they could provide a good quality of support. As they received care, the new team would be introduced to them and a full care plan would be drawn up to include their needs, likes and preferences.

Staff developed care plans detailing how people wanted to be supported. The care plans were informative, and reflected different routines, such as morning and night-time routines. They showed that people had been fully involved in developing their plans and outlined personal preferences, likes and dislikes. They provided staff with step by step guidance about what to do each visit, the person's preferred daily routines and what level of assistance was required. Where there were specific needs, for instance where people's physical disabilities required specific handling guidance, these were highlighted in the care plans. Sections within the care plans provided detail on activities, cognition, and eating and drinking. Personal care needs were identified and detailed instruction provided. However, we found some of the identified needs suggested vague responses, for example, "dependent on others to maintain a healthy social life", rather than considering interventions to minimise the risk of social isolation. When we spoke to the management team about this they agreed to review the documentation to assist staff to consider ways of meeting identified needs

People told us that staff encouraged them to do as much for themselves as they could and had helped them to maintain their independence where possible. One person told us that their care had reduced from four to two visits per day, "They have supported me and help and encourage me to do more for myself, so I am getting stronger. They assist with mobility and movement; they spend time assisting me to walk." They told us that the help they received was encouraging and reassuring, and had helped to build their confidence.

Where people's needs changed the service responded quickly and appropriately. For example, if people were unwell any concerns were reported and followed up. Examples included treatment for infections, review of medicines and assessment for equipment in their homes. We saw in one care file that where a

person's health had deteriorated there was clear evidence of consultation with the person's GP, district nurse and dietician. We saw that daily logs recorded the person's food and fluid intake, elimination and turning, or changing position to ensure that the risk of pressure sores developing was kept to a minimum. The care plan for this person had been reviewed to give further instruction, for example, around oral hygiene, as the person had greater difficulty with this area of personal care. Where care staff noticed that another person who used the service was losing weight, we saw that appropriate action was taken; notes demonstrated regular liaison with the doctor, and a referral to the dietician, who had recommended build up drinks. A number of flavours had been tried and the person had settled on one particular flavour which was noted in the care plan. The person's weight was charted on a weekly basis, and this showed that the loss of weight had been reversed.

The service had a complaints policy and we saw that where complaints had been made they were investigated thoroughly and dealt with appropriately, with investigation notes and actions recorded. Copies of the complaint, and copies of the outcome letter were stored on file. When we spoke with people who used the service and their relatives, they told us they felt confident to express their views and could always talk to a staff member or a member of the management team if they had any problems. They told us that they had seen the complaints policy and knew how to make a complaint. A relative of a person who used the service they told us that that the registered manager and care manager kept in regular contact with them and informed them if there were any concerns. If they wanted to raise a concern of their own then they were confident that the issues would be addressed. The registered manager told us that by identifying smaller issues at an early stage they looked to respond before the concern developed into a formal complaint. We saw that the managers would conduct monthly spot checks with all the people who used the service, and kept in contact with people who used the service or their relatives by phoning them every fortnight.

At the time of our inspection the service was planning a customer satisfaction survey which was in the process of being put into an easy read format so that all stakeholders would be able to contribute.

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Bridging The Gap is registered with the Care Quality Commission. When we visited the service had a registered manager who has been registered since August 2014. The registered manager was present throughout the inspection.

The management team of Bridging The Gap told us that they had set up the service to provide a person centred response to people's care needs. Their aim was to promote independence by responding to people on a day to day basis, for staff to evaluate and respond to presenting need, and recognise that people who are elderly, have physical disabilities or learning disabilities can have needs which vary from day to day. They wanted to provide a flexible approach to meeting people's needs, so their response was sometimes at variance with traditional packages commissioned by the local authority for personal care. One person who used the service told us that due to the nature of their physical disability the staff would spend either less or more time than their allotted hours. However, the people who used the service told us that they were happy with the company and felt it was well managed, and that the flexible nature of the care offered meant that people received safe and supportive care. They told us that they had regular contact with the central office and that managers would frequently visit to check on the care and ensure that service was delivered according to need.

People who used the service and staff told us that the office were helpful and they were able to contact someone out of hours if needed. The management team operated a duty rota to ensure that management cover was always available. We were told that the registered manager and senior staff were supportive. One person told us, "They keep in regular contact and want to know how I'm doing. They are interested in me". Staff comments were positive. One care worker told us, "The managers here are really supportive and listen to us. I think there are good lines of communication, I feel able to speak my mind if necessary".

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure people received safe and effective care. We were told that regular audits/checks were undertaken on all aspects of the running of the service. These included regular monthly spot checks of care as it was delivered and managers would visit people in their own homes to monitor the quality of care. Visits would review the case notes as they were recorded, and check risk assessments, recording sheets and any charts such as food intake or weight charts. Additionally regular audits were carried out including health and safety, environmental factors, care documentation, staffing levels, training, and staff supervision, and action plans were developed which identified improvements or changes that were required.

We reviewed an audit of medication procedures. This included an analysis of medicine administration records, which was completed on a monthly basis for each person. This checked dosage and medication type, and noted any changes were appropriately recorded. Where errors had occurred these were followed up and action taken to minimise any risk occurring. A yearly analysis identified any emerging trends or patterns. We also reviewed similar checks for written records including daily record sheets, and monthly risk measures such as Waterlow scores (which measure the risk of people developing pressure ulcers) and

MUST, which helps to identify if a person is at risk of malnutrition or obesity.

We spoke to the registered manager and care manager about the management of the service. They told us that they were consistently looking to improve, and used information to help identify gaps and issues with service provision. For example, accidents, incidents, and safeguarding concerns were recorded, and used to analyse any issues in the delivery of the service. Where incidents had occurred there was a clear investigation trail including analysis of events before the incident, and lessons learnt had been put into practice.

We were shown a record in the main office which provided a track of all care as it was being delivered and assisted the management team to monitor progress with each person who used the service. This matrix highlighted for each person who used the service the date the support plan was commissioned, all risk assessments in place, interim reviews, upcoming events and dates for scheduled reviews. This provided an 'at a glance' snapshot of the service, and allowed the registered manager to prioritise and schedule work with people who used the service. This matrix also indicated whether or not people had any family involvement, and where they did not this highlighted prompts for full yearly health checks and local authority reviews.

To ensure the service keeps up to date with relevant changes relating to good practice, the managers attended regular forums with other registered managers. The care manager was also a member of the local authority adult safeguarding board. They ensured they had effective working relationships with outside agencies such as the local authority (Oldham MBC), district nursing teams, and GP practices.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.