St Martin Of Tours Housing Association Limited

Chalkhill Road

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 19 February 2016 and was unannounced. There were no breaches of the regulations at our previous inspection on 17 June 2014.

Chalkhill Road is registered to provide personal care and accommodation for up to 19 people with complex mental health needs.

The home did not have a registered manager in place at the time of this inspection. 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 this inspection an existing deputy manager had been assigned to temporarily manage the service. A new manager had been appointed and was due to commence work in April 2016.

People receiving care confirmed they felt safe and secure around the staff and with each other. Risks to people were assessed and well managed. There were procedures in place for monitoring and managing risks to people. When there were changes in the level of risk, the risk management strategies changed to reflect this.

Safeguarding procedures were in place to keep people safe from harm. People felt safe living at the home. The staff understood their responsibility to recognise and report safeguarding concerns and to use the whistle blowing procedures. They had received training on how to identify abuse and understood both the providers and local authorities' procedures for safeguarding people.

The service took an effective approach in managing risks, accidents and incidents. Risk assessments for the environment had been drawn up and were regularly reviewed with the changing needs of the people who lived at the home in mind. There was a comprehensive business continuity plan. Robust arrangements were in place to respond to emergencies and major incidents. Safety checks were done regularly throughout the building and there were regular fire drills so people knew how to leave the building safely.

People were protected from the risks associated with the recruitment of new staff. There were robust recruitment procedures in place. New staff had induction training until they were competent to work on their own.

People were safe because staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. There was a rota system in place to ensure that enough staff were on duty. Staffing levels were flexible so that if people needed extra support due to illness or to take part in their particular interests there were staff available for this.

There were appropriate arrangements for obtaining medicines. The acting manager and senior staff regularly reviewed and audited medicines to ensure they met people's current needs.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs, preferences and choices. The deputy manager and her staff team knew people well and understood their specific care needs.

People were supported to maintain good health. They were referred to relevant health professionals when they needed specialist care and treatment. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

There was a strong emphasis on the importance of good nutrition and hydration. People were supported to eat and drink enough and maintain a balanced diet.

Staff sought people's' consent to care and treatment in line with legislation and guidance. They understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Staff were kind and caring. They had respectful relationships with people. People's privacy and dignity were respected. The service's philosophy ensured people were supported and empowered to be as independent as possible in all aspects of their lives.

The management team demonstrated strong values and a desire to implement evidence based practice throughout the service. The philosophy of the service was to support people to recovery and to be as independent as possible. The service's model of care was consistent with this belief.

The service had a strong quality assurance system in place. Where improvements were needed, plans were put in place to achieve these.

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.

People receiving care confirmed they felt safe and secure around the staff and with each other.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority and others if they had any concerns.

Risks had been appropriately assessed as part of the care planning process and staff had been provided with clear guidance on the management of identified risks.

Appropriate recruitment and selection processes were carried out to make sure only suitable staff were employed to care for people and there were sufficient staff available to meet people's assessed care needs.

There were appropriate arrangements for the management of medicines.

Is the service effective?

Good

The service was effective.

Staff received induction, training and supervision to support them in their roles.

People were supported to maintain good health. They had access to a range of healthcare services to make sure they received effective healthcare and treatment.

People's choices were respected and staff understood the requirements of the Mental Capacity Act.

People were provided with a suitable range of nutritious food and drink.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect.

Staff understood people's individual needs and respected their right to privacy. Their views were respected and acted on.

Is the service responsive?

Good

The service was responsive to people's needs.

People received individualised and personalised care which had been discussed and planned with them.

People were listened to and encouraged to express any concerns or complaints they might have.

Is the service well-led?

Good

The service was well-led.

The acting manager and the chief executive directors had provided staff with appropriate leadership and support.

People were asked for their views of the service and had the opportunity to provide feedback about the service during residents' meetings and issues raised were addressed appropriately.

There was a thorough and effective quality assurance system in place. The acting manager, the chief executive and staff team were proactive in seeking out ways to improve.

Chalkhill Road

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 19 February 2016 and was carried out by one adult social care inspector. It was unannounced.

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 also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

At this inspection we spoke with seven people who lived at the home, the acting manager, chief executive, and four members of staff. After the inspection we also received feedback from healthcare professionals and social care professionals about the service.

We spent time observing the interaction between people who lived at the home and staff.

We also spent time looking at records, which included the care records for five people. We looked at the recruitment, supervision and appraisal records of four members of staff, a full staff training matrix and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People receiving care confirmed they felt safe and secure around the staff and with each other. In a 'service user' survey that was carried out in 2015, all respondents from Chalkhill Road felt save receiving care at the home. One person told us, "Staff are very helpful. We are very safe here." Another person said, "The manager always makes sure we are okay. We are well looked after. I do not have any concerns about my safety at all."

People were protected from abuse and avoidable harm. There were appropriate procedures in place to help ensure people were protected from all forms of abuse. Staff had received training on how to identify abuse and understood both the service and local authorities' procedures for safeguarding people. They described the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. Posters displayed in the manager's office and staff room provided staff with immediate access to information and guidance on how to report any concerns about people's safety. Staff told us they were confident that any concerns reported to managers would be treated seriously and appropriately investigated. They told us they could report allegations of abuse to the local authority safeguarding team and the Commission if management staff had taken no action in response to relevant information.

People felt that their risks were managed appropriately and that they were involved in making decisions about any risks they may take. Each person had an up to date risk assessment which was linked to a care plan. The assessments focussed on such areas as harm to others, harm from others, self-harm and harm to staff. The risk assessments were detailed and managed thoughtfully, to take into consideration the least restrictive approaches and interventions. The senior management were aware a balance needed to be struck between risk and the preservation of rights, particularly as all people living at the home had capacity. There was an emphasis on positive risk management and a collaborative approach which focussed on recovery, recognition of a person's strengths, and the need for organisational level support. Thus, risk management was more proactive than reactive. There was an emphasis on anticipating situations and planning ahead to prevent potential problems. For example, the service ensured people were engaged in purposeful activities to help create structure and routine and to help enhance mental wellbeing. This was an effective proactive intervention for people who required meaningful daily activities as part of their recovery.

The service managed accidents and incidents effectively. Accident forms had been completed and these had been checked and signed off by a senior member of staff. Records were then sent to a health and safety officer of the organisation so they could be analysed to identify any themes or trends which might be helpful in mitigating future risk. When patterns were found, prompt action was taken and outcomes were monitored. This included referral to health professionals, such as the GP, occupational therapist, psychiatrist and psychologist.

Risk assessments for the environment had been drawn up and were regularly reviewed with the changing needs of the people who lived at the home in mind. People could be confident that there were plans to respond to any emergencies and that these were understood by all staff. The service had adequate arrangements in place to respond to emergencies and major incidents. The service had a comprehensive

business continuity plan in place for major incidents. This was designed to prepare Chalkhill Home to cope with effects of an emergency situation or threat that was likely to affect the health and safety of people. The plan considered a wide range of possible threats or incidents, including, power or water supply failure, flooding, loss of data and major incidents involving significant harm to people. Each likely incident was assigned a risk score with a corresponding action plan that gave staff guidance of appropriate steps to be taken for dealing with the situation in question.

The service had an up to date fire risk assessment. The London Fire and Emergency Planning Authority had also carried out an inspection of the premises on 9 February 2016, and at that time no significant failure to comply with the Regulatory Reform (Fire Safety) Order 2005 was noted in the parts of the premises or relevant documents viewed. Each person had a personal emergency evacuation plan (PEEP) in their plan of care. This gave guidance to staff to ensure people's safety was protected during the evacuation of the building in the event of fire or other emergency.

People were protected from the recruitment of unsuitable staff. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check, evidence of identity, right to work in the country, and a minimum of two references to ensure that staff were suitable and not barred from working with people who used the service. This helped to ensure people employed were of good character and had been assessed as suitable to work with people.

People were safe because staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. There was a rota system in place to ensure that enough staff were on duty. Staffing levels were flexible so that if people needed extra support due to illness or to take part in their particular interests there were staff available for this. We saw an example on one rota where staffing levels had increased beyond the usual ratio to support staff to care for a person who needed temporary extra care.

There were appropriate arrangements for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. The medicines administration records (MARs) showed people were normally getting their medicines when they needed them. The MAR charts were found to be clear and tidy; each person had a medication care plan with supporting documentation and information. Items added or hands transcribed were clearly legible.

The service managed risks associated with people administering their own medicines to ensure people had a full and meaningful life. Before people could administer their own medicines the service carried out a risk assessment to ensure this was safe and people were competent to do so. Training involved observing people administering their own medicines in order to weigh up the risks and benefits of self-administration.

The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The deputy manager was the infection prevention and control (IPC) lead who liaised with the local IPC teams to keep up to date with best practice. There was an IPC protocol in place and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence action was taken to address any improvements identified as a result. During this inspection we saw the service was clean and odour free.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff that had the necessary skills and knowledge. Staff had received training in all mandatory areas of care and this was kept up to date. This included, safeguarding adults, medicines management, health and safety and the Mental Capacity Act 2005. In addition, staff had also received specific training in relevant areas of their work, which included mental health and substance misuse. Staff were positive about the training they received, and confirmed they regularly had refresher training in several essential areas. One staff member told us, "The manager is very supportive. We are up to date with all our training" and another said "[The service] will be supporting me to enrol for my doctorate degree."

New staff were supported to complete induction training. The service recruited staff who either had qualifications in social and health care or psychology graduates. They were introduced to relevant areas of the organisation; including, policies and procedures and other core areas where they shadowed experienced staff until they felt confident to care for people unsupervised. Since December 2015, the service was liaising with one of its training partners to review staff induction and the annual training programme to ensure that they were aligned to the Care Certificate, which is the benchmark that has been set in April 2015 for the induction of new care workers.

The service provided a regular structured one to one meeting between staff and their line manager every six weeks. The agenda items included, the wellbeing of staff, people's medicines, people receiving care, training, and safeguarding. Staff confirmed the meetings were helpful. We read from supervision notes that arrangements were made for supporting staff in areas they were not confident in.

There was a strong emphasis on the importance of good nutrition and hydration. People were supported to eat and drink enough and maintain a balanced diet. Care plans included information about how people were involved in decisions about their meals and drinks. People had been involved in drawing up the menu and their choices were regularly adapted in line with their preferences. Those people who did not choose from the menu were offered alternatives. One person told us, "Staff support us with shopping and meals", and another told us, "If there is a dish I am not able to cook, staff will always come and help me."

People were supported to have a balanced diet that promoted healthy eating. They were encouraged to participate in regular healthy cooking sessions, which were aimed to demonstrate healthy eating. Care plans showed how staff encouraged people with their eating and drinking when needed. One to one cooking sessions were arranged for those who required a higher level of support in this area. For example, one person's care plan highlighted a programme of support he required. The plan instructed staff to encourage the person to budget money for meals, and to join healthy cooking classes on Friday and Sundays. The person had also requested staff to accompany him for shopping to buy healthy meals. This had been a self-identified need on the part of the person and demonstrated co-production in care planning.

Staff were aware of people who needed more assistance with their cooking and nutrition. The service organized for 10 people to attend Jamie Oliver cooking sessions. The courses were funded by Well London

to improve the health of the community. At the end of the course, people cooked for 200 people in their local community at Chalkhill Community Centre demonstrating what they had achieved in cooking sessions. People who attended the class told us that they had enjoyed the sessions. People spoke highly about the course. One person said, "When l came here I did not know how to cook well. They put us on a cooking course. Now l can cook" and another said, "I attended every Jamie Oliver session. I learnt food preparation and recipes."

Where there were concerns people were at risk of not receiving sufficient fluids or food, staff completed charts to monitor progress in this area. For example, the acting manager told us about one person who had been monitored by his GP because of weight loss. The care plan for this person gave instructions for staff to create meal plans and working alongside him to ensure he ate three times a day, and to be weighed weekly. The acting manager could evidence to us that staff were working with the person; and keeping a food diary to document his food intake. The acting manager could also evidence a weekly weight chart.

People's nutritional needs, including those relating to culture and religion, were identified, monitored and managed. We observed preparations for the healthy cooking group that was held on Fridays. We saw staff ensured that cultural dietary preferences were met, giving as much individual choice as possible. For example, purchasing halal meat, vegetarian options and giving a choice of fish on Fridays.

There were good links with health services. People were supported to maintain good health, had access to healthcare services and received on-going healthcare support. Care plans contained detailed information from healthcare professionals involved. These included mental health specialists, occupational therapists, and their GP. The home had followed expert guidance and had maintained detailed records in relation to the effects of treatment interventions at the request of clinical professionals.

We checked whether the service was working within the principles of the Mental Capacity Act 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's consent to care and treatment was sought in line with legislation. Although everyone in the home had capacity to make decisions for themselves, the acting manager and staff had knowledge of the Mental Capacity Act 2005 (MCA). Staff had completed training in the MCA and Deprivation of Liberty Safeguards (DoLS). Staff were able to discuss how the MCA might be used to protect people's rights or how it had been used with the people they supported. Where required, the service had considered people's mental capacity to make decisions and there was information about this in their care plans. For example, we saw evidence of mental capacity assessments being carried out before people received certain interventions such as surgery.

People's individual needs were also met by the adaptation, design and decoration of the service. Chalkhill Road was well maintained and decorated in a homely manner. People's bedrooms were personalised and included pictures, furniture and other personal items people had brought with them when they had moved in. There were appropriate maintenance schedules in place. There was an accessible garden with raised beds and covered seating area, spacious accessible communal areas, spacious ground floor kitchen with additional kitchens on each floor, so that people had enough space to socialise together, or spent time alone.

Good

Is the service caring?

Our findings

We asked people how they felt they were cared for. Their comments included, "Staff are very helpful. They genuinely want to help us", "The [acting manager is very kind to us. At Christmas she came and cooked food for us", "The [acting manager] is very friendly. She is very supportive with activities" and "Staff support us with shopping and meals." Professionals were equally complimentary.

The service took a proactive approach by encouraging behaviours that promoted the wellbeing of people. The service understood the importance of relationships as a major factor in promoting wellbeing and preventing mental health problems. We saw many examples where the service had facilitated activities to promote people's well-being, including targeted interventions to build social relationships between people receiving care and other isolated groups. For instance, the community football team, which was composed of people using the service, allowed the service to bring together people from different parts of the community, which allowed service users to meet new people and integrate into their local community. The service also utilised interventions that encouraged social connections between people with similar experiences to provide peer support. An example of this was the Men's group. This group was run by people receiving care and independent of Chalkhill Road. It enabled people to discuss about their lives and the challenges they faced.

Staff knew people well. Care plans included guidance for staff on how to approach people with care and compassion and these were regularly reviewed, to ensure staff understood when people may need more support and attention. Care plans included guidance for staff on how to approach people with care and compassion and these were regularly reviewed, to ensure staff understood when people may need more support and attention.

We spent time with people in the communal areas observing care. Staff knew people well. The atmosphere was calm, friendly and inclusive. The interactions between staff and people were caring and respectful. Staff were familiar with people's backgrounds, wishes and preferences. They had relevant knowledge regarding people's routines, and their likes and dislikes. It was clear people were at the centre of care and the service valued the contribution of peer support and the importance of family in supporting the individual. We observed that people were treated with great respect and regard to their dignity. Staff asked people's permission before entering their bedrooms. We saw that when people decided to spend time alone in their bedroom their decision was respected.

The service had a policy and procedures to guide staff around ensuring people were not discriminated against on the grounds of a wide range of diverse needs. Staff had received training in equality and diversity. The majority of staff had attended the training, which was delivered by the British Institute of Human Rights. A smaller group of staff have had extra training to prepare them for the role of being Human Rights Champions.

The acting manager told us 'Human Rights Champions' have lead roles for identifying Human Rights

concerns and reporting these as 'incidents', which can then be followed up with action points and reviewed. We saw that St Martins had included Human Rights concerns within its incident classification coding system. This meant staff were empowered through education to use human rights as a tool to make positive changes in people's lives.

Good

Is the service responsive?

Our findings

Before people moved to Chalkhill Road, they were supported to have care plans that reflected how they would like to receive their care, treatment and support. A team of experienced assessors that included a forensic psychologist and an occupational therapist carried out a comprehensive assessment to make sure their needs could be met. People told us, "They have been good to me since I came here. Before I came, they asked me about all the support I would need" and a social care professional said, "The good thing about this service is their understanding and meeting the needs of their service users."

Peoples care and support were planned proactively in partnership with them. As part of the assessment, a transition period was arranged, which involved the person visiting Chalkhill Road before moving in. This gave the person a chance to meet other people receiving care, get to know staff and gain an understanding of how the service operated. Equally, staff got to know as much as possible about the person; their life history, likes, preferences and interests, care needs and mental health condition, in order to establish that the home was able to meet their care needs. The acting manager told us trials were person-centred, and could range from one month to nine months depending on the needs of the individual. The managers and staff observed how people got on during the visits and spoke with other people at the service afterwards. In consequence, the service did everything possible to help ensure people were happy with the service before they eventually moved in.

The service used effective care planning systems which provided person centred care based on well-established systems used for the recovery and support for people with mental health problems. The care plans were underpinned by a model of care called 'Resilience and Recovery'. This is an evidence-based model for supporting people who are stepping down from secure hospitals, prisons and mental health services. The model is used to enable recovery and to maximise people's independence and safety in the community. We examined people's care plans to check if they were designed to support their recovery and independence.

The care planning process provided practical examples of person centred care. People receiving care were involved in the assessment and planning of their care as much as they were able to. The organisation's model of care utilised two types of care planning frameworks; Wellness Recovery Action Plan and the Recovery Stars. Which plan was used for any person was a question of people's individual choice. The Wellness Recovery Action Plan was designed to help people to gain insight into previous unhelpful behaviour patterns, and to develop new and healthier coping mechanisms. Conversely, people who did not want to think about distressing times in the past, preferred to use the Recovery Stars plan. This was used to acknowledge the person's current progress and for planning future progress.

The care plans were comprehensive and reflected people's needs, choices and preferences. They contained clear guidance and sufficient information on each person's individual care needs to enable staff to support them effectively. This is because they were informed by the information people provided during the assessment and transitioning process and had been updated regularly to help ensure they remained current. There were arrangements for people to have their individual needs regularly assessed, recorded

and reviewed.

The service supported people flexibly and responsive to their needs to enable them to achieve their full potential. This was accomplished by supporting people to pursue their social interests, and activities. This included meeting peoples educational, social and where appropriate employment needs. For instance, several people had expressed a wish to access driving lessons. The acting manager sourced funding from a scheme by 'Upper Room'; a charity working with socially and economically disadvantaged people, supported by a lottery grant. Under this scheme people who completed 80 hours community service were eligible to access free driving lessons. One person had completed his driving test and another two had recently joined the scheme.

People were listened to and actively encouraged to express any concerns or complaints they might have. When they did, they were taken seriously and every effort was taken to resolve the issue quickly. All complaints received were audited by the acting manager, and passed through to senior service managers to make sure they were investigated, responded to and resolved appropriately. The complaints procedure was displayed around the service and each person was given their own copy. This showed that the service sees concerns and complaints as part of driving improvements.

The service ensured people had reasonable adjustments made to make sure they received the support they need to stay independent. There were provisions for disabled access bedrooms and a disabled bathroom. Each room was fitted with en-suite bathroom which was easily accessible. There was a disabled access to the building, people with mobility issues were placed on ground floor rooms. This helped maintain peoples' independence.

Good

Is the service well-led?

Our findings

People told us how satisfied they were with the care they received and that they enjoyed living at Chalkhill Road. One person told us, "The [acting manager] is excellent."

Staff were also complimentary. A member of staff told us, "[The acting manager] has stepped up. [The previous manager] built the service in such a way that [it was seamless] when she left", and another staff said, "The chief executive makes time to see you. He knows our names." The healthcare and social care professionals also complimented the service on the quality of care and support it provided.

The service had a robust strategy and supporting business plans which reflected its vision and values and this was regularly monitored. The most recent strategy review was carried out in October 2015. This had highlighted the need for the organisation to build capacity in response to changes in the referral system, which had entailed the service was receiving more complex referrals than before. Accordingly, the service had responded to this by improving the way it managed new referrals. The service had recruited experienced assessors (forensic psychologist and occupational therapist), to ensure the service collected detailed information about people's needs before they moved to Chalkhill Road. The service had also improved how it managed incidents, risk assessments and support planning. We saw these changes were supported by current service business plans.

There was a clear leadership structure in place and staff felt supported by management. The registered manager of the service had resigned a few weeks prior to this inspection and we had been notified. We saw evidence a new manager had been appointed and was due to commence work in April 2016. In the interim, arrangements had been put in place for an existing deputy manager to temporarily manage the service. The deputy manager had the experience, capacity and capability to run the service. She had worked at the service as a deputy manager for three years and had previous experience of working as a general nurse. She continued to receive support from the chief executive of St. Martins who had a visible presence at Chalkhill Road. Staff told us the deputy manager was approachable and always took the time to listen them. Likewise, people receiving care were as complimentary. One person told us, "The manager is brilliant. She gives us incentives to do good things. She helps us with all our activities." Another person said, "On weekends, when she is not working she comes to watch us play football." Equally, the chief executive was described by staff and people in matching terms, including 'approachable' and 'very visible'; referring to his regular presence at the Chalkhill Road.

The chief executive carried out a formal quality assurance visits every month to monitor the quality of care provided and to identify any areas where improvements could be made. People receiving care and staff were always asked of their opinions of the quality of service provided. When we spoke with the chief executive he had a clear understanding of the organisation's vision, model of care, organisational values and priorities. His passion about improving the service was also shared by the acting manager. Both told us and had high expectations of the recently introduced evidence based 'psychologically informed environments', citing its relevance to the people they supported. This showed us that people benefited from a management team that had a positive sense of direction.

There were detailed records of regular checks and audits. We looked at the audits that were carried out in the last eight months by the chief executive. These focussed on accuracy of records and whether they were suited for their designed purpose. This included medicines records, nutrition records, fire log, accident book, record of incidents, complaints, minutes of 'residents' meetings' and health and safety risk assessments. The audits also examined the processes for service delivery; whether these were fit for purpose. Care plans were also examined to ensure they were up to date and contained complete information; including their relevance and benefit to the person concerned. Staff performance processes were checked to see if they were well calibrated. Audits questions covered staff supervision, appraisal, training, sickness and absence, rota and general staffing issues. Plans were put in place where shortfalls were identified. Other audits were conducted by the acting manager and senior project workers on a weekly, monthly and quarterly basis. By having regular audits, managers had a good understanding of everything happening at the service and therefore were well positioned to focus on continuous improvement.

There was an open and positive culture within the service. The service held regular monthly team meetings. We noted from the minutes that staff had the opportunity to raise any issues. They felt confident in doing so and felt supported if they did. We also noted staff participated in a regular annual survey. In the most recent survey, staff were asked to comment on a range of issues, including, ''there are adequate opportunities for me to feed my views, concerns and ideas up the organisation', 'if I need to I am able to challenge the way things are done in this organisation'. We saw mixed responses from staff, but in each case, their feedback was valued and acted upon so that the service could work to constantly improve.