Home from Home Care Limited

The Old Hall

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

The inspection took place on 1 December 2016 and was announced.

The Old Hall is registered to provide accommodation and personal care for up to 13 people who have a learning disability or autistic spectrum disorder.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Nine people living at the service had their freedom lawfully restricted under a DoLS authorisation and a further two were waiting on assessment.

Staff undertook appropriate risk assessments for all aspects of a person's care to keep them safe from harm inside and outside of the service. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were supported to have a nutritious and balanced diet and hot and cold drinks and snacks were available throughout the day. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. Relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and advance skills to enable them to perform their roles and responsibilities.

People were supported to have an active life and were encouraged to take part in hobbies and interests of their choice. Relatives commented that their loved ones were well looked after and their wellbeing had improved since moving into the service.

People where able were supported to make decisions about their care and treatment and maintain their independence. People had access to information in an easy read format about how to make a complaint. Relatives told us that they could approach staff with concerns and knew how to make a formal complaint to the provider.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

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 had their risk of harm assessed and staff knew how to keep them safe.

Staff were aware of safeguarding issues and knew how to raise concerns.

Medicines were ordered, stored and administered as the provider's guidelines and unwanted medicines were disposed of safely.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities competently.

People were supported to have a healthy lifestyle and received support from healthcare professionals when the need was identified.

Is the service caring?

Good

The service was caring.

People were supported by caring staff that treated with kindness.

Staff communicated with people in a way that helped them to understand their care they received.

People were treated with dignity and staff respected their choices, needs and preferences

Is the service responsive?

Good

The service was responsive.

People received personalised care, specific to their individual needs.

People took part in hobbies and pastimes of their choice.

A complaints policy and procedure was in place in a format that was accessible to people.

Is the service well-led?

Good

The service was well-led.

There were systems and processes in place to check the quality of care to improve the service.

Staff felt able to raise concerns with the registered manager. Staff were aware of the whistleblowing policy and procedure.

The registered manager created an open culture and supported staff.

The Old Hall

Detailed findings

Background to this inspection

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

The inspection took place on 1 December 2016 and was announced. The inspection team was made up of one inspector.

We gave 48 hours notice of our inspection because people who live at the service are often out of the service taking part in recreational activities. We needed to be sure that they would be in so as we could speak with them.

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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the locality manager, the registered manager, an assistant manager, the communication and compliance manager and one member of care staff. Following our inspection we spoke with three relatives by telephone. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included staff training information, staff recruitment safety checks and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care records and support plans for five people and medicine administration records for four people.

Good

Is the service safe?

Our findings

Most people who lived in the service had verbal communication difficulties and were unable to tell us if they felt safe living there. However, we watched people interact with staff and saw that they were at ease with staff. We observed that people had put their trust in the staff to keep them safe.

We spoke with relatives of three people who lived at the service who told us that the provider had processes in place to ensure people were as safe as they could be. The relative of one person who had moved into the service in the last year told us, "Staff keep [name of person] safe. I feel better for him being there. It's safe and friendly." Another relative said, "You can't be a fly on the wall. You have to trust them."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of harm and abuse and who to report any concerns to. The registered manager was the safe guarding lead for the service and the safeguarding protocol was on display in the
main office. One member of staff said, "We have a safeguarding rota in the office so as we know who is on call if we need advice about an issue. We can also contact HR for guidance if staff are involved." Furthermore, staff were aware to contact the local safeguarding authority, the police and CQC with concerns.

There were systems in place to support staff when the registered manager was not on duty, such as access to on-call senior staff out of hours for support and guidance. There was a business continuity plan to guide and support staff in an emergency situation such as a power failure. If the service needed to be evacuated in an emergency, procedures were in place to relocate people to a service run by the provider in a nearby village.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care, such as the safe use of a wheelchair and hoist for a person who was unable to mobilise independently. A detailed care plan was in place to enable staff to reduce risks and maintain a person's safety when transferring from their bed to their wheelchair by hoist.

There were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. All new staff undertook a four week induction where they followed a structured learning programme and shadowed experienced staff. New starters also completed the care certificate. This is a training scheme supported by the government to give staff the skills needed to care for people. One member of staff was the nominated mentor to support new starters through the induction programme and care certificate to maintain a continuous approach to the induction process.

We found that the provider employed sufficient numbers of staff to keep people safe and each person had a support worker allocated to them to assist with assessing, planning and delivering their care and social

needs. The registered manager explained that the service used a layering system of staffing to ensure people had the right support to undertake hobbies and interests and keep them safe inside and outside of the service. Having a layering system meant that staffing levels were increased to cover periods of high activity. Relatives we spoke with said that the previous high turnover of staff had recently improved and the staff team had settled down. One person's relative said, "It's a worry when they change staff. There has been a big turnaround, it's settled, got better, more settled, a lot calmer. They've got the right staff now. Most people have complex needs and need a lot of understanding. It's much better now."

People received their medicine from staff that had received training in medicines management and had been assessed as competent to administer them. We observed medicines being administered at lunchtime by two members of staff to reduce the risk of errors. We looked at medicine administration records (MAR) for four people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a recent photograph of the person for identification purposes and any allergies and special instructions for the storage and how to administer the medicines were recorded. We saw that robust safety checks had been implemented by the provider. For example, in addition to signing the MAR chart when a medicine had been administered, staff also recorded this electronically. If a medicine was not given at the prescribed time this was picked up by the provider and the service received a phone call to ask why the medicine had not been given.

We found that one person was unable to take their medicine in tablet or capsule form. Therefore, they took their medicines crushed and mixed with peanut butter, chocolate spread or yoghurt. The person was made aware that their medicine was in their food. However, to ensure that their medicine was effective when administered this way staff had liaised with their GP and dispensing pharmacist and a protocol had been agreed.

All medicines were stored in accordance with legal requirements, such as locked cupboards and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines, the medicines policy and a system that identified when medicines needed to be reordered. Furthermore, individual fact sheets were available for each medicine a person was prescribed. We noted that some of this information was in an easy read format.

Good

Is the service effective?

Our findings

Most people were unable to tell us if staff had the knowledge and skills to look after them. Therefore we observed staff deliver care to people and saw that they understood people's individual needs and they acted in a responsible and confident manner. All staff undertook mandatory training in key areas such as safeguarding, deprivation of liberty safeguards and health and safety. In addition, staff were provided with training in areas relevant to the care needs of people who lived in the service such the care of a person living with epilepsy and autistic spectrum disorder and safe hold and breakaway techniques. The provider had their own training facility that staff attended for most of their training needs. We saw a copy of the staff training matrix that identified refresher training for staff over the next three years.

We saw an example were training staff to meet a person's individual needs had a positive outcome for the person and enhanced their overall wellbeing. Staff had received training from an independent psychologist to understand and identify the triggers that caused one person to have emotional outbursts as much as three times a day. With improved insight into the person's care needs, incidents had been reduced dramatically in the last year to four in total. The registered manager told us that the person's relatives were happy because the person was now able to go on family holidays and have regular weekend breaks at the family home.

All of the staff we spoke with were positive and enthusiastic about the training that was provided and told us that the training programme was always being added to. For example, one member of staff said, "We now have a trainer for Makaton, so that will be included in the induction programme." Makaton is a sign language often used by people with limited verbal communication. Staff received an annual appraisal and regular supervision sessions, called one to one sessions. Staff were expected to attend 10 sessions a year. In addition, the registered manager received regular supervision and an annual appraisal from their line manager. The responsibility for undertaking staff appraisals was shared by the registered manager, assistant managers and team leaders.

Most people who lived in the service were unable to give consent to their care and treatment and we saw that staff followed the guidance in the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. For example, we saw that people had their mental capacity assessed and best interest decision were made so as they could receive their medicines safely. However, we saw where a person had the capacity to make decisions about their care and treatment that there was a record that they had been involved in the development of their risk assessments and care plans and had given their consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and eleven applications had been submitted to the relevant local authority and nine had been authorised and two were waiting on assessment. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and staff knew that people who lived in the service were subject to a DoLS authorisation and how to support them.

The service did not employ cooks and all staff had been trained in the safe handling of food. People who lived at the service met with staff on a Sunday to plan the menus for the following week. For example, we saw from the minutes of the previous meeting that menu planning was person centred. People were supported to make their choices from pictures of food. One person said they would like chicken on the menu and staff showed them pictures of the various meals they could make with chicken. The person chose chicken curry with rice and prawn crackers. We found that where able, people were supported to access food shops in the local community with a member of support staff. Two people were empowered to plan their own menus and were supported to buy, prepare and cook their own food. Mealtimes were flexible and were planned around the times that people were coming and going from their different activities and trips out.

A member of staff told us that they directed people towards healthy options including fresh fruit and vegetables. One person's relative told us that they were concerned about their loved one's food intake as they liked to eat takeaway food or pub meals and they had recently gained weight. The person had the mental capacity to decide what they wanted to eat and were supported by a member of staff to shop for their own food. We saw that staff were working with the person and their wider healthcare support team to modify their eating habits.

We saw that people were supported to access healthcare services such as their GP and dentist. Staff kept a record of all consultations with information on advice given and treatment offered. The relatives we spoke with told us that staff informed them if their loved one was unwell and kept them up to date with their recovery. We found that although people no longer lived with their relatives; that their relatives were encouraged to attend clinic appointments with their loved one. Members of staff told us that they had a good relationship with the local doctor's surgery. The GP dedicated time on a Monday to a telephone conversation with staff at the service. Each person was discussed at length. We were told this had a positive outcome for people as some got distressed and anxious when they visited the doctor's surgery and early intervention reduced their need to visit the doctor's surgery.

We found that staff at the service had built a good relationship with other health and social care professionals. For example, one of the consultant psychiatrists that most people had seen as an outpatient had recently moved to another part of the country. However, the transition to the new psychiatric team was smooth and unproblematic and people received continuity of care.

Staff supported people to take regular exercise to maintain their physical fitness. We saw that a wide range of physical activities were enjoyed outside the service such as swimming, football and one person regularly attend a gym and another took part in martial arts. People were also supported to exercise inside the service or grounds. We saw that one person had a treadmill in the communal lounge and all had access to the local play park. In addition, we saw that people were provided with different relaxation techniques to help them stay calm and reduce their anxieties. For example, there was a snoezelen; a multi-sensory environment where people could go to relax and some people had sensory lights and music in their bedrooms.

Good

Is the service caring?

Our findings

We observed staff interacting with people who lived at the service. People and staff had a good relationship and there was evidence of mutual respect and trust. Each person was cared for by a core team, which included their key worker and three support staff. We were informed that this provided continuity of care for the person and helped relatives to relate to the staff who cared for their loved one. Members of the core team attended annual reviews and any outpatient appointments. In order to support continuity of care across different care settings people had an "accident and emergency" grab sheet that went with them if they were admitted to hospital as an emergency. The grab sheet provided hospital staff with information that the person would be unable to share them.

We found that a person centred approach was taken with people who had difficulty communicating their needs verbally. For example, one person with a limited vocabulary used a sign language technique called Makaton, had a range of picture cards with familiar activities on them and pointed at everyday objects to communicate their needs. Their communication care plan clearly recorded how the person felt if staff did not speak to them directly and read, "I do not like it when staff talk about issues regarding me or talking about me in front of me, this can make me feel un-involved and cause me to become anxious." We observed this person interact with their key worker and the registered manager, Makaton was used effectively and the person was involved.

People were enabled to maintain contact with family and friends and supported to develop new friendships with their peers. A few days before our inspection one person had a birthday and invited another resident to join them on their birthday treat to London to see the sights; supported by care staff. Relatives spoke about the contact they had with their loved ones and informed us that they could phone, Skype and visit at any time. Furthermore, staff supported people on visits to the family home or to go on family holidays. One relative who found the transition from the family home into The Old Hall traumatic spoke of the support they had received, "There are lots more staff [at The Old Hall] than at the last home. He perceives things differently, but the staff here can support him. At first I felt I was giving away my child. I can tell by the way he talks he misses me and the wider family. But he is not unhappy; he is as happy as I can hope he can be away from home." We found that staff enabled the person to maintain daily telephone contact with their family and supported them to visit the family home every couple of weeks. The registered manager told us that they initially had daily contact with the relatives to reassure them that their loved one was settling into their new home.

We observed how staff enabled people to develop and maintain their skills to be as independent as possible. As we mentioned earlier, the service did not employ ancillary staff such as a cook or housekeeper. People who lived at the service were supported by staff to undertake a range of general housekeeping duties where physically able. We saw that one person cared for the garden.

We saw that staff respected people's culture and beliefs. For example, one person had been brought up in The United States of America. The week before our inspection staff put on a celebration for Thanksgiving day with an American themed dinner and party. A Halloween party had been put on for people from all of

the provider's services. One person told us that everyone had dressed up and said, "I was a werewolf." The registered manager told us, "It was nice to see everyone get together. They have friends in other homes, it's important to bring them together."

People who lived at the service were also enabled to help others less fortunate than themselves. For example, one person assisted their friend in a wheelchair to complete a five kilometre fun run and raised £250 for a local charity. When we spoke with this person they were full of enthusiasm for the event and were proud of their achievement.

Staff were aware that some people who lived at the service found it difficult to cope with disappointment when plans were changed at short notice. For example, most people went to a regular social event once a week where they danced to disco music and met up with friends from other services. However, people were unable to attend a few weeks ago due to a sickness bug. Rather than disappoint people, staff put on their own event in the activity room with disco lights, music and soft drinks and snacks. One person said, "It was good fun."

We saw that people's right to their privacy and personal space was respected. People kept their bedrooms door closed when they did not want anyone else to enter and we noted that other people and staff respected this.

People and their relatives were made aware of the lay advocacy service. Lay advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. One person's relative told us that they had appointed a lay advocate on behalf of their loved one, but they no longer needed their services.

Good

Is the service responsive?

Our findings

Each person had their own bedroom and en-suite bathroom or shower room. Some people were happy for us to see their rooms. We saw that their decoration, furniture and personal items were relevant to their needs, preferences and personality. Shared areas including the lounge and kitchens were spacious and there was ample room to manoeuvre a wheelchair.

The provider had a discussion group called "our voices" for people who lived in their services. Two people who lived at the service represented their peers at the monthly meetings. We saw that minutes of the meetings held on 1 September and 6 October 2016 were accessible to all and were recorded in word and picture format. People had shared what events had worked well and what they would like to plan for the future. They had also recorded that they were looking forward to catch up with friends from other services at the annual Halloween party. In addition, the service held internal "our voices" meetings twice a month. The purpose of "our voices" was to empower people who lived in the provider's services to have a say in the running of their service and give their feedback on areas for improvement. We looked at the minutes from the meetings held on 28 October and 16 November and noted that one person had suggested that they had a blackboard wall to draw on in the recently developed activity room.

The registered manager told us that each day was different and structured around the people who lived in the service and was influenced by their planned activities and individual moods and behaviours. We observed and care records recorded that people lived busy and active lives and were encouraged to take part in hobbies and interests of their choice and live a fulfilled life. Two people had work experience placements at the provider's training and administration centre. One of them was a trained fire marshal and also taught staff how to communicate using Makaton.

Another person worked three days a week in a café in a neighbouring village and was made to feel part of their team. The person had been invited to the staff Christmas celebration; a visit to the pantomime followed by dinner. The manager of the café had also invited all the people who lived at The Old Hall and their support staff for a Christmas meal at the café.

People were enabled to take part in a diverse range of activities. For example, on the day of our inspection two people had gone to a themed farm and adventure park, three people had made a packed lunch and travelled to the coast to visit new-born seals and one person who looked after recycling at the service had gone to the local recycling centre and then on to a popular seaside resort. During the morning we watched people who had chosen to remain in the service either take part in craft work or bake cakes. These people had trips out planned for the afternoon or evening.

We were informed that people who lived at the service and staff had a positive relationship with the local community. We found that they would often walk with staff to the local shop or visit the pub in the evening for a game of pool and a meal.

We found that staff exchanged information about a person's care needs and wellbeing at shift handover to

maintain continuity of care throughout the day. The handover was face to face and also an electronic record was maintained and staff could consult this at any time during their shift. We looked at copies of the handover sheets for the previous 24 hours and saw that an update was provided on each person who lived in the service. In addition staff had access and maintained a "service user" daily diary that recorded all aspects of the person's day. For example, what they had to eat and drink, their involvement in domestic tasks and details of any activities or pastimes they took part in.

People had their care needs assessed and personalised care plans were introduced to outline the care they had received. Care was person centred and people where able and their relatives were involved in planning their care. One person's relative told us, "We attend an annual review with his key worker. We are pleased with his progress."

We saw that individual care plans were written from the person's perspective and focussed on the support and understanding the person required to live well, maintain their independence and develop new skills. For example, we saw written in one person's care plan that they wanted to overcome the things that were problematic to them to develop their independence. Mechanisms were in place to enable the person to achieve their goal. A new care plan system had been introduced across the provider organisation following feedback from CQC inspections undertaken in the last year. We found that the new care plans were person centred, straightforward and we readily found the information we needed.

People and their relatives had access to information on how to make a complaint and we saw it clearly displayed in word and pictorial format. Relatives told us that they had never had to make a formal complaint. One person's relative said, "They [loved one] are very well looked after. I've never had a problem. He has complex needs, but they [staff] are very understanding. I could walk in now and be made to feel welcome. They would offer me refreshments."

Good

Is the service well-led?

Our findings

Staff told us that the service was a good place to work and that they found the registered manager approachable, supportive and knowledgeable and said they could go to them at any time. One staff member said, "This is the nicest place I've worked. I would let my family come here to be cared for. I would feel confident that they were supported and well cared for and not abused." Another member of staff told us, "We have good management. Really know their staff and very approachable."

We read five responses from the 2015 relative's quality assurance questionnaire. Feedback included positive comments such as, "quality of life is good" and "really care for residents and respect their individuality" and "encouraging the residents to develop their abilities to the maximum." However, some relatives responded that communication could be improved upon. In response to this feedback the provider had recently introduced a system called "Parent call". Relatives have the option to receive a regular monthly phone call at a time convenient to them from a member of staff who was not directly involved with providing care to people who lived in the service. We saw that the relatives of four people who lived at the service had signed up to this initiative. One relative who was involved in "Parent call" told us, "I get a contact call from a lady to ask how I feel and about [name of relative] care and they go in every month to check all is ok." We spoke with the recently appointed communication and compliance manager, who led the scheme and they told us, "I am independent from the home. I can help parents talk about how they felt when their child first moved into the home. They often feel guilty. I reassure them that when children reach a certain age it's hard for parents to let go. It's normal to feel like this. We talk about how they can get the most out of visits home." The registered manager told us, "If gives parents the chance to off load if they are anxious." The registered manager received feedback any topics raised that needed to be actioned.

Monthly staff team meetings were held with the registered manager and a member of the human resources department. Human resources attended so as any employment issues would be addressed straightaway. Staff were expected to attend a minimum of ten meetings a year. Topics discussed at team meetings included quality assurance, training and development and health and safety. The registered manager held weekly meeting with the assistant managers to discuss topics relevant to the quality of the care people who lived at the service received. Furthermore, team leaders met once a month and discussed all aspects of life in the service, including care reviews and audits. A member of staff said, "We learn from each other at meetings. We also learn lessons from other homes when there has been an issue." All staff were kept up to date about the wider Home From Home Care community through a regular newsletter from the provider. We saw the latest issue provided training dates for November, current job vacancies and good news stories form different services about events and initiatives that were successful for people living at the services. In addition, staff were provided with the opportunity to give their feedback on the service. Although 89 per cent of the responses were positive, the provider did acknowledge that there were things they needed to do better.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. We

noted that staff had access to confidential helpline set up by the provider. The registered manager shared with us that the whistleblowing processes were robust and went on to explain that a recent whistleblowing alert had been investigated and a member of staff had been dismissed from their post. In addition, several members of staff had key roles in topics such as cleanliness and infection control, dignity and nutrition and acted as a resource to their colleagues.

The registered manager undertook a weekly walk around that included a health and safety audit. We found that the purpose of the walk rounds was to do visual checks on the internal and external environment to ensure that there were no hazards that compromised people's safety. A programme of regular audit was in place that covered key areas such as care plans and medicines. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. In addition, some areas were subject to external audit such as the safe management of medicines by the dispensing pharmacist and local authority quality visits. Furthermore, the service had an unannounced quality audit once a month that was structured on the Health and Social Care Act 2008 regulations. We saw the results of audits undertaken in October and November 2016. Actions were identified with the name of the person responsible and the date to be achieved by.

The provider was kept up to date with events in the service. They had a system were the registered manager reported their staffing levels and skill mix, and accident and incidents to their head office once a week. In addition, the provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about.