Mrs Carol Barkwell

Lyndridge Care & Support

Inspection report

Barowe House, Beardown Road
Exeter Road Industrial Estate
Okehampton
Devon
EX20 1UA

Tel: 0183754782
Website: www.lyndridgecare.co.uk

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20 February 2018
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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

Lyndridge mainly provides care and support for older people and people with a learning disability living in 'supported living' settings in Crediton, Okehampton and surrounding areas, so that they can live as independently as possible. People live in houses which they share with other people. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. As the housing and care arrangements are entirely separate, people can choose to change their care provider without losing their home. Lyndridge Care and Support also provide personal care and support to people living in their own homes in Okehampton and the surrounding areas.

The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care', which is help with tasks related to personal hygiene and eating. Where they do receive personal care we also take into account any wider social care provided

Some people supported by Lyndridge Care and Support did not require support with personal care, but did need support with enabling activities such going out and shopping. We do not inspect this aspect of service provision.

Lyndridge Care and Support provide personal care to older people living in 10 supported living houses. At the time of inspection there were around 60 people living in these houses. People had their own bedroom or in the case of couples, shared a bedroom. People in each house shared communal areas including sitting rooms and dining rooms. Staff were present in all the houses throughout the day and night, although in six houses staff slept in while on duty at night. Some houses had an office where staff were able to work and store records related to the service. On this inspection we visited seven of the 10 houses where older people lived.

Lyndridge Care and Support also provide personal care to people with a learning disability living in six supported living houses. We did not visit any of these houses on this inspection. We also did not visit any people receiving personal care who lived in their own homes.

The inspection took place over six days; two inspectors visited the offices of the provider and one supported living house on 20 February 2018. One of the inspectors visited five supported living houses on the 8, 13 and 22 March 2018. A pharmacy inspector visited five supported living houses where some or all of the people received personal care on 28 March 2018. On the 4 April 2018 the inspector returned to the provider's offices to meet with senior staff and the provider.

The inspection was prompted in part by notification of an incident where a person sustained a serious injury and died later in hospital. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, we also received information after the incident which indicated there may be possible risks to other people. There were potential concerns about staffing levels, poor care, staff training, the privacy and dignity afforded to people. This inspection examined those risks. We did not find evidence to support these allegations at the time of our inspection.

The first day of inspection was unannounced. All subsequent days were announced as we needed the provider to check with people whether they were happy for us to visit and talk with them. Where people did not have capacity to make that decision, the provider checked with the person's legal representatives whether they agreed, on the person's behalf, for inspectors to visit the person's home, speak with them and review their care records.

At the last inspection in July 2016, the service was rated Good. At this inspection, we found the service remains Good in all five key areas.

The provider of Lyndridge Care and Support had also registered with the CQC as the manager of the service. A registered manager is a person who has registered with the CQC 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.

The registered manager was supported by a team of senior managers called development managers. Development managers were responsible for overseeing the work in three or more supported living houses. Each house had a manager. House managers were responsible for the day to day running of the house, ensuring there were sufficient staff; supervising the staff and monitoring the quality and safety of the service provided. This information was fed back to development managers and the registered manager as part of the quality assurance and governance systems. The service had a service improvement plan. There was evidence that actions on the plan had been completed; the plan was monitored and updated at regular intervals.

Where incidents and accidents occurred, these were investigated and, where necessary action was taken to reduce the risk of similar incidents or accidents occurring again.

People living in the supported living houses said they were happy with the care they received. Comments included "Really good"; "Very happy here" and "Staff are lovely, they help me whenever I need it." Our observations of interactions between staff and people confirmed this. Care plans were person centred and included background information provided by the person and their family. Staff knew people well and were able to describe the care and support each person needed.

Staff had been recruited safely and underwent a comprehensive induction which provided them with the knowledge and skills required to deliver effective care. Staff refreshed their training at regular intervals to ensure they remained up to date. Staff were supervised and appraised by managers and supported to undertake qualifications and additional training to meet people's individual needs.

There were sufficient staff to meet people's needs. Staff said they had enough time to work with people without rushing. Staff sought advice from health and social care professionals appropriately. Where a change in a person's care was recommended, care plans were updated accordingly. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

There was a complaints policy and procedures. No complaints had been received in the previous 12 months.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Lyndridge Care & Support

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 was prompted in part by notification of an incident where a person sustained a serious injury and died later in hospital. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, information shared with Care Quality Commission (CQC) about the incident also indicated there may be possible risks to other people. There were potential concerns about staffing, staff training particularly in respect of the management of risk of falls. This inspection examined those risks.

At the time of inspection, the CQC was made aware of concerns about the care provided at some supported living houses where personal care was provided by Lyndridge Care and Support. These concerns related to the care provided to people at night, the staffing levels, medicine administration and staff knowledge and experience. These concerns had triggered safeguarding meetings for individuals and the service as a whole. Safeguarding meeting had been attended by provider, members of staff from Lyndridge Care and Support, members of the safeguarding team, commissioners of care, staff from the local authority's Quality Assurance and Improvement Team (QAIT), the police, health professionals including community nurses and CQC inspectors Relatives of people receiving care have been informed of the safeguarding concerns.

The first day of this inspection took place on 20 February 2018 and was unannounced. On this date, two inspectors visited the office location to meet with office staff and arrange visits to people living in supported living houses who received personal care from the provider. We also visited one supported living house on this date. Further inspection dates were carried out by one of the inspectors on 13 and 22 March; these were all announced.

A pharmacy inspector also visited five houses where Lyndridge Care provided personal care to people living there on 28 March 2018. We gave the service notice of the inspection visits to the houses as we needed

people's consent to visit them.

The lead inspector visited the offices of Lyndridge Care and Support on 4 April 2018; during this visit we inspected paperwork relating to staff recruitment and training, the service improvement plan as well as other records. We also gave feedback to the provider and senior managers of the organisation.

During our visits to seven supported living houses, we met many of the people living in these houses. We spoke with 21 people using the service; we also spent time in communal areas observing the care and support provided to people. We met and spoke with one relative. We interviewed and spoke to 19 staff on duty including senior staff. We met with the provider who was also the registered manager as well as the operations manager and an external consultant who was undertaking work to support the registered manager. We reviewed ten care records including care plans, risk assessments and daily notes. We reviewed sixteen medicine administration records. We also looked at four staff records including recruitment information, incident and accident logs, policies and procedures, audits and checks carried out in the last 12 months, the service improvement plan, minutes of staff meetings, quality assurance surveys and feedback.

Prior to the inspection, we contacted the local Healthwatch team to ask if they had received any feedback from the general public about the service. They responded to say they had not received any feedback about Lyndridge Care and Support. We contacted 10 health and social care professionals during the inspection. We contacted three GP surgeries and a team of district nurses. We received feedback from five GPs. During the course of inspection we also met five health and social care professionals at meetings where feedback was provided.

Good

Is the service safe?

Our findings

We had received concerns about the care provided to people at night, the staffing arrangements to support people and medicine administration. We did not find evidence to support these allegations. However, during the inspection, the provider decided, that because of some staffing issues, that they were unable to provide adequate support for four people living in one of the supported living houses. They worked with each person, their families and the local authority to ensure each person was offered alternative arrangements. People were supported to consider whether another provider could support them in the house. People were also offered the opportunity to move to a different house where Lyndridge Care staff could continue to provide their care and support.

At the time of inspection, there were sufficient staff to support people safely. Senior staff calculated the number of hours support each person needed for personal care from Lyndridge staff. This information was used to determine the staffing required at each supported living house. When necessary, staffing levels were increased to take into account changes in people's needs. For example, in one house we visited, a senior member of staff said additional night-time staff were working as one person needed more support at night. A senior manager explained that they had some flexibility to increase hours within a house when needed. Where the increase was more than they had authority to provide, they would discuss with the registered manager how the staffing levels could be maintained to keep people safe. At all the houses we visited, staff were working calmly and without rushing. Many of the staff worked flexibly and would work at different houses; this meant that staffing levels could be adjusted to ensure people's needs were met. People said there were enough staff to support them. For example one person said "Really good staff, always there when I need help."

People said they felt safe and happy being supported by Lyndridge Care and Support. During our visits to supported living houses where care was provided by staff from Lyndridge Care and support, we observed people were relaxed and happy with staff as well as with other people they lived with. Comments included "I am very happy"; "Staff are really nice" And "I feel safe and cared for."

There were policies and procedures to support people to take to take medicines safely. The medicine policy and procedure for the service had been updated in January 2018; it contained sufficient information for medicines to be handled safely.

Most people in the houses we visited had signed to show they agreed to have their medicines managed by the service; this included the service holding the keys to the medicines storage so people did not have access to them. There was a clear agreement and risk assessment for each person which stated the level of support provided for medicines administration. When people were self-administering medicines, for example inhalers and creams, there were risk assessments in place to ensure that this was safe.

Medicines were stored safely in service user's own bedrooms, with access controlled by the staff when it had been agreed that the staff were responsible for the administration of the medicines. Staff monitored and recorded temperatures of medicine refrigerators to make sure the medicines were fit for use. Medicines that

had a reduced expiry date once opened were dated on the day of opening to ensure that they were fit for use.

Medicines which required extra security were stored separately. Staff made regular checks on these medicines and they had not identified any issues. The service's medicines policy stated that this was required.

Medicines were administered in a caring way and encouraging manner. The care worker checked that the person was ready to take their medicines before administering them. Staff completed the MARs to show what medicines people had received.

Some information in care records about the medicines a person was prescribed had not been updated when changes had taken place; this meant that the care record did not contain the same information as the MAR. Staff said they always referred to the MAR when administering medicines as this would always show the latest prescribed medicines. People's allergies or sensitivities to medicines were recorded on their MARs. However for one person, their care folder stated that there were no known allergies but the MAR stated that there was. We discussed this with a senior member of staff, who took action to ensure the record was corrected.

Systems were in place to ensure that medicines that were to be given 'when required' were administered at the correct time intervals. There were protocols in place for the use of these medicines.

The service did not hold a stock of 'homely remedies' such as cough syrup or painkillers in the houses. Where people chose to buy 'over the counter' medicines, staff encouraged the person to alert them to this. Staff recorded these on 'homely remedy' sheets, and encouraged the person to discuss it with the GP and get them prescribed if possible.

The service checked MARs to ensure that there were no unsigned sections in the medicine administration. Any gaps were followed up to ensure that medicines had been given as prescribed. Audits were carried out weekly, three monthly and annually which looked at differing aspects of medicines administration and the safe handling of medicines.

Staff were trained to administer medicines safely. This included senior staff carrying out competency assessments and signing staff as fit to practice following training.

Staff generally followed these policies and procedures; however, there were occasions when staff had not followed the guidance fully. For example, in one house, some medicine administration records (MAR) had not been signed when topical medicines, such as creams, had been administered.

Where a medicine administration error occurred, staff competency was reassessed and staff then underwent refresher training and competency checks. Where agency staff were used, they were only authorised to administer medicines if the agency provided evidence that they were trained and assessed as competent. A professional fed back that staff had altered the way they gave one person their medicines as there were concerns about them. The professional commented ""Good communication with GP to let them know what had happened and review of how medicines given – MAR sheet amended etc."

Staff were encouraged to report medicine errors or near misses. Trends from medicine incidents and audits were analysed and used to support improvements.

Staff were recruited safely. Checks were carried out to ensure that people were suitable to work in care with vulnerable people. These checks included an interview process, references from previous employers, checks on any gaps in employment, as well as Disclosure and Barring Service (DBS) checks. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were protected from the risk of abuse as staff had been trained to understand what to do if they had a concern. Staff were able to describe the types of abuse that people may be subject to, for example, financial, physical or institutional abuse. They also knew what actions they should take if they thought someone was being abused. For example, one member of staff said that if they had a concern, they would "make the person safe and phone [a manager]." They also said they would contact the local authority safeguarding team and the Care Quality Commission if they felt it was not being addressed by senior staff. Managers were aware of their responsibilities if there was a safeguarding concern. The registered manager and senior staff had worked with the local authority when safeguarding concerns had arisen.

Risks to people were recorded in risk assessments and care plans described how to address the risks. For example, one person's care plan described how they were at risk of urine infections as they had a catheter. The care plan described how to support the person to reduce these risks. Staff were able to describe what they did when supporting the person. Their descriptions reflected the information in the care plan.

Care plans were generally well-maintained and kept up to date when risks changed. However there were some daily records where changes in the person's presentation had been noted by the member of staff. However there were no indications as to what action had taken place to address the changes. The house manager said they would ensure that this was fed back to the member of staff to reduce the risk of recurrence. Later in the records, there was evidence that action had occurred.

Staff ensured they reported any concerns about building maintenance to the landlord. Where necessary, staff ensured there were safety precautions put in place until remedial action by the landlord had taken place.

Staff understood the importance of protecting people from the risks of infection. Staff used personal protective equipment such as disposable gloves and aprons when supporting people with personal care. Staff followed good hand hygiene practice. When preparing food, staff followed the correct food safety and hygiene procedures.

Where something went wrong, the incident was reviewed to see what learning could be gained to help avoid recurrences. For example, where a person had had a fall, the incident was reviewed and where necessary staff were retrained.

Good

Is the service effective?

Our findings

We had received concerns about staff being asked to undertake care without the necessary knowledge and skills. We did not find evidence to support these allegations. Staff had been trained to support people safely and effectively. Where staff had not followed the correct procedures as outlined in their training, action had been taken to address this. The actions included additional training and supervision for staff until they demonstrated they were competent to work alone.

Staff underwent an induction when they first joined Lyndridge Care and Support. The induction introduced staff to the provider organisation, explaining its ethos, aims and objectives. Staff also undertook training to ensure they were able to fulfil their role satisfactorily. The training covered areas including moving and handling, safeguarding vulnerable adults, fire safety and the Mental Capacity Act (2005). The induction was in line with the national standard outlined in the Care Certificate. The Care Certificate is a set of 15 standards defined by Skills for Care that health and social care workers stick to in their daily working life.

Staff were supported to refresh their knowledge and skill on a regular basis. The provider had systems to monitor when staff were due to refresh training and alert the staff member and their manager. This helped to ensure that staff remained up to date with the necessary knowledge and skills to enable them to undertake their role effectively.

Staff were also supported to complete relevant national qualifications as well as undertake specific training to meet the needs of people. For example some staff had completed training in dementia awareness, diabetes and catheter care. Staff were not allowed to provide particular elements of personal care, such as catheter care until they had undertaken training to support people with this.

There were systems in place to support staff with supervision and appraisals. Supervision provide opportunities for staff to reflect on their performance; discuss with their manager what they think they are doing well and identify support or training they might need. There were systems in place to monitor when staff had received supervision and training.

People's physical, personal and social needs had been assessed by staff prior to them receiving personal care from the provider. It was normal practice for a senior care worker to visit the person before they started receiving care to assess their needs and agree a package of care for them.

Where people's risks or needs changed, records showed that their risk assessments and care plans had been reviewed and, where necessary, updated to take account of the changes.

People were supported to maintain good health. Records showed that health professionals had been contacted and consulted when needed. For example, one person's care records showed there was contact with the person's GP, a district nursing team, as well as the person's optician and dentist. Where a person's needs had escalated, records showed that emergency services had been contacted for advice and when needed admission to hospital. A manager described how they would visit the hospital before a person was

discharged. During the visit, they would assess the person to ensure that Lyndridge Care and Support were still able to meet the person's needs. They said that if they felt that this was not possible, they would alert the commissioners so they could consider other alternatives for the person's care.

A health professional commented "I have seen patients in the surgery accompanied by their carers, I can see their concern and worries about their residents. They are well followed up. When doing visits… there is a professional environment and I have felt the concern of the staff and managers in the homes."

One health professional raised some concerns about the knowledge and attitude of one care worker, but also commented that other care workers were helpful and knew the people they supported well. This was discussed with the provider who said they had been aware of the issue and action taken.

Each person's nutritional and hydration needs were met by staff who took into account the individual person's preferences when preparing food and drink. For example, when we visited one house where three people were receiving personal care, staff asked each person what they would like for a tea-time meal. Each person specified a different meal which was prepared for them. Where necessary, people were supported to eat and drink by staff who spent time engaging with the person, encouraging them to eat and helping them to be as independent as possible. For example prompting the person to help themselves to the food. One person said "Really good food."

Records were kept and meals prepared to support people with specialist dietary needs such as diabetes and coeliac disease. Where people were at risk of choking, soft diets were prepared and given to them.

The Mental Capacity Act 2005 (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.

People's ability to make decisions for themselves was assessed by staff. Wherever possible, people were encouraged to be independent. Where concerns were identified about a person's capacity to make a decision, staff involved health and social care professionals as well as the person' family and/or friends.

Staff had undergone training and understood their responsibilities in terms of the requirements of the MCA. When necessary, they worked with social care professionals to have applications made to the Court of Protection on the person's behalf.

A health professional fed back "I would like to comment that the staff from [house] are highly rated by one of my service users and enable him to maintain his independence and support him. They accompany him (with his consent) to appointments at the surgery. The staff from [house] also contact us if they have concerns about their clients and do respect the individual's dignity and privacy."

Good

Is the service caring?

Our findings

Everyone we spoke with said they were happy with the care received from Lyndridge Care and Support. Comments included "Very happy, lovely staff. They really are so kind."; "Very kind staff, they really know what I like."; "I like living here." Relatives also commented how kind and caring staff were.

A health professional commented "In very few words, I would be happy for my mum to be looked after by Lyndridge Care.

The atmosphere in all the houses we visited was comfortable, relaxed and homely. Throughout the inspection, staff showed affection and concern for people, asking how they felt and whether there was anything they wanted. Where people appeared distressed, staff took time to find out if anything was the matter and then tried to remedy the problem. For example, where one person appeared unhappy, staff sat down beside them and held their hand whilst speaking reassuringly to them.

Staff were aware of people's history, background and family and used these as references when talking to each person. For example, one person had spent many happy holidays abroad; staff talked to them about these holidays which the person clearly enjoyed.

Staff were good at understanding people's different communication methods. For example one person who had a long term condition had poor sight and hearing. Staff made sure they knelt beside the person and held their hand so the person was aware of the staff presence. The staff member then made sure they spoke slowly and clearly to the person to help them understand. Staff used objects of reference to help another person understand what they were trying to convey.

People, and where appropriate, their family members, were encouraged to be involved in making decisions about their care and support. For example people were encouraged to develop their care plans so that the help they received was personalised. People's care plans reflected their preferences, for example what time and how they liked to be woken in the morning; what time they preferred to go to bed; social activities they enjoyed and personal care preferences. One person said "They do everything for me, but sometimes I like to help, such as I like to wash myself."

People were afforded privacy and staff maintained people's dignity when providing personal care. Staff understood the importance of keeping information about people secure and confidential. Care records were stored in people's rooms.

People were supported to be as independent as they were able. For example in some houses we visited, people were able to go out independently, while others needed closer supervision. Staff took this into account when working with the person. People's religious and social preferences were discussed with them to ensure the service promoted their individuality and rights as defined by the Equality (Act 2010). For example several people had specific religious preferences which included remaining in touch with local officiates as well as observing specific religious practices. Staff were aware of these preferences and

supported each person to maintain these.

Although most people supported by Lyndridge Care and Support had tenancy agreements with an external organisation, Lyndridge staff 'managed' the house on a day to day basis, opening the door to visitors and welcoming them in. Visitors were welcomed without any unnecessary restrictions and were made to feel welcome when they were in the house. In one house, staff had provided some toys for visiting children to be available. People said their relatives felt free to visit whenever they liked. One relative said "I pop in often and tend to just turn up. Staff are always very welcoming.

Good

Is the service responsive?

Our findings

People were involved in planning their care and support by staff who recognised the need to help people stay independent. For example one person said "Staff are very good, but they always ask me. Sometimes I want to do things for myself."

People's care plans reflected their different needs including their physical, social, mental, and emotional needs and how these should be met. Care plans included some information about people's background and history. Details about their family and other loved ones were in the care records. Married couples were also supported to remain together.

People were supported to follow their religious preferences. For example, because attending chapel was no longer possible for two people, there were arrangements for a church elder to visit each week and read the bible to them.

Staff understood how to support people with physical disabilities. For example, staff were able to describe how to move people safely when using moving and standing aids.

Staff were able to describe people's different communication needs. For example one person who had poor eyesight had been supported to keep abreast with current events by having a staff member read the newspaper to them. Staff described how another person was unable to communicate verbally. Staff explained the methods they used to ensure the person's needs and wants were understood.

There was a complaints policy and procedures. We discussed with senior managers that the policy referred people to the Care Quality Commission (CQC) if they wished to escalate their complaint. The CQC do not deal with or investigate individual complaints; this role is undertaken by the Local Government Ombudsman. A senior manager said they would ensure their complaints policy reflected this.

There had been no formal complaints received by the service in the previous 12 months. People and their families were advised of how they could make a complaint if they were not satisfied with the care they received. Details were given to people when they started receiving care from Lyndridge Care and Support. Copies of complaints forms were available for people to easily access. People said that they knew how to complain and felt their complaints would be dealt with appropriately. One person said "No complaints here – its lovely." Another said "I have never had to complain in a big way, if there is a niggle it is always dealt with by staff very efficiently."

Staff had supported some people using the service at the end of their life. Care plans described people's end of life wishes where people had chosen to consider this. This included copies of treatment escalation plans (TEP) signed by the person (where they had capacity to make a decision about their preferences) and the person's GP. A TEP is a form that describe people's wishes about the interventions they want if they become very unwell.

A house manager explained that they worked with health professionals including the person's GP, district nurses and palliative care nurses to support people nearing the end of their life. Wherever possible, they said they tried to support the person if they wished to remain at house they were residing in and be supported by Lyndridge Care and Support staff.

Good

Is the service well-led?

Our findings

There was a management structure in place which supported staff to deliver good quality care in all areas of work. Although care was delivered to some people living in their own homes, most people receiving personal care from Lyndridge Care lived in supported living houses where they had tenancy agreements.

There was a clear vision of the service to deliver continued independent living for people to enable them to lead a full and active life according to their personal preferences. The website describes this as 'Your life, your way.' Staff were able to describe this vision and how they were involved in delivering it. For example one member of staff said "The standard of care is really good; we look at the whole person including their personal preferences. This might be something as simple as their choice about when to get up or whether to shave; it's all about what makes people tick; what's important to them."

There was a registered manager in post, who was also the provider. They were knowledgeable about the people cared for and their individual needs. Each of these supported living houses had a 'house manager'. House managers were supervised by 'development managers' who oversaw the delivery of care in a number of houses. Development managers reported to the registered manager who was also the provider. The managers were supported by an administrative team based at the provider's office headquarters in Okehampton. Managers met with each other regularly to exchange ideas and support improvements and development in the service.

The registered manager had links with the local community. They kept up to date with the latest guidance and were involved in regional groups for the development and innovation of the care sector. The service submitted information to the Care Quality Commission when required. This included statutory notifications when notifiable incidents had occurred.

A governance framework had been developed to monitor the quality and safety of the care provided. This framework was fed in part by audits and reports which were completed by house and development managers. Following identification of issues and concerns related to medicines management; care planning and record keeping, the provider had worked with the local authority's Quality Assurance and Improvement Team (QAIT) to create a service improvement plan (SIP). This SIP included a number of actions to improve the delivery of care, recording systems and audit systems for the service as well as improvements to the overall quality assurance framework. Development managers and house managers were involved implementing these actions. Progress on these actions was monitored by the registered manager and her management team. Staff from QAIT said the provider and staff at Lyndridge had been positive about the improvement processes and had worked well with them.

A health professional commented "…over the past few months the management team have been willing to engage and work with us to try to improve communication and patient safety. I have had meetings with [Registered manager] and we both encourage communication from her local managers when things are not clear, smooth or do not work well with medication or home visit requests and with improving the audit trail and information available to carers. When things don't work perfectly they seem willing to work with us to

improve them and are keen to engage."

There were policies and procedures in place which were reviewed at regular intervals. Regular checks and audits were undertaken. For example there were audits of care records including risk assessments and care plans.

The service checked the medicine administration records to ensure that there were no unsigned sections. Any gaps were followed up to ensure that medicines had been given as prescribed. There were also audits at weekly, three monthly and annually which looked at differing aspects of medicines administration and the safe handling of medicines. Staff were encouraged to report medicine errors or near misses. An analysis of the log showed that there had been 48 medicine incidents in the last three months. Of these on 12 occasions the MAR sheets had not been signed, on 16 occasions medicines had not been given, on three occasions the wrong medicine had been given and on five occasions an incorrect dose had been given. In the event of an error staff were required to complete refresher training and their competency was re-assessed. Trends from medicine incidents and audits were used to design a service improvement plan.

People, their families, health and social care professionals were asked for feedback about the services provided and what improvements could be made. Surveys were carried out on an annual basis. There were systems in place to investigate and learn from incidents and accidents. There were regular staff meetings in each of the houses where teams supported people. Managers of each of the houses also said they had systems to support staff who worked across different houses, this included ensuring that staff were updated about changes to people's care as well as hand-over meetings at the end of a shift. Staff said they were able to contact house managers as well as development managers when necessary.