Loxwood House Ltd

Acorn Hove

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

We inspected Acorn Hove on 24 April 2018. Acorn Hove is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Acorn Hove is registered to accommodate up to 12 people, some of whom were living with dementia, a learning disability and other long standing conditions. Acorn Hove is comprised over three floors, with a kitchen, lounge and dining area. There were 11 people living at the service during our inspection.

At the last inspection on 17 & 18 June 2015, we rated the service as good, However, we identified some concerns in relation to the way medicines were managed. We asked the provider to take action to make improvements and this action has been completed. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

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

We have made a recommendation about systems being implemented to comply with the Accessible Information Standards (AIS).

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights.

Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including managing behaviour that may challenge others and awareness of autism. Staff had received both supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People's end of life care was discussed and planned and their wishes had been respected.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people could give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People were encouraged to express their views and they said they felt listened to and any concerns or issues they raised were addressed. People's individual needs were met by the adaptation of the premises.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people in their rooms, visits from external entertainers and watching films. People were also supported by staff to attend day centres. People were encouraged to stay in touch with their families and receive visitors.

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

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 has improved to 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**

Acorn Hove

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 comprehensive inspection took place on 24 April 2018 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounge and dining area of the service. Some people could not fully communicate with us due to their conditions, however, we spoke with eight people, one relatives, the activities co-ordinator and two care staff. We spent time observing how people were cared for and their interactions with staff and visitors in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At the last inspection on 17 & 18 June 2015, we identified an area of practice that required improvement. This was because we identified some concerns in relation to the way medicines were managed. We saw that Improvements had been made.

At the previous inspection we saw that on person had not received their prescribed medication for a significant period of time. The provider told us at the time that improvements would be made and we saw that this was the case. Specific protocols were now in place to ensure that people's medicine was recorded accurately to ensure that they received it in a timely manner. Care staff were trained in the administration of medicines, and a member of staff described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed a member of staff giving medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "They remind me I have my pills and make sure I take them". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "Yes, I feel safe. To be honest I don't even think of it". Another person said, "I love it here. Yes, safe". A relative added, "[My relative] is definitely safe".

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that agency staff were used when required. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "The staff are alright. I get on with them. Yes, enough of them. I can press my bell and call and someone will come quickly". Staff agreed with this, and a member of staff said, "There's definitely enough staff, we cover for each other and we rarely use agency staff. We're quite a good team". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were a number of policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if

people witnessed or suspected abuse was displayed around the service for staff and people.

People continued to be cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. One person told us, "I think they're quite thorough. It's cleaned all the time and if anything is spilt it's mopped up straight away". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves was readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan (PEEP). There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Good

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "None of the staff would do anything without my permission if they needed it". Another person said, "I get treated as I expect to be treated. They do everything as they should do". A relative added, "The staff are very good with [my relative], they know what they are doing".

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 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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Staff understood when an application should be made and the process of submitting one. DoLS updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessments were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. Staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. One person told us, "I'm quite satisfied with the food. It's nice to have it cooked for you. There's no shortage". Another person said, "The food is nice. Spag bol is my favourite. I don't like baked beans and they don't give them to me. If it was something I didn't like they'd give me something else". We saw people were offered drinks and snacks throughout the day, they could

have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Specialist diets were catered for, such as pureed and staff had been in contact with Speech and Language Therapists (SALT) to obtain guidance around this. However, staff stated that any specific diet would be accommodated should it be required.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's and social workers. Access was also provided to more specialist services, such as visits to the local polyclinic. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. A relative told us, "They are very good at calling the GP for [my relative] when she needs it". Staff told us that they knew people well and could recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured when people were referred for treatment they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them. We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

Staff had received training in looking after people, including safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around managing behaviour that may challenge others and awareness of autism. Staff told us that training was encouraged and was of good quality. Staff also told us they could complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

Staff had a good understanding of equality and diversity, which was reinforced through training. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. A member of staff told us, "There is support from management for anybody who suffers discrimination".

People's individual needs were met by the adaptation of the premises and there were adapted bathrooms and toilets.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "The staff are kind, they will always talk to me and if I just wanted someone to speak to on my own they will come in and chat. I think they like being with us". A relative added, "[My relative] has been a lot happier since she moved here, she is always dressed nicely in clean clothes and looking well".

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. One person told us, "There's always someone here and they're very good. I like to see to myself. We all know each other here". We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food and drink. Most staff also knew about peoples' families and some of their interests.

Throughout the day, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. One person told us, "They're all nice. I like [name] best. She's my keyworker. I can speak to her. They're all my friends". A member of staff added, "It's like home from home, we have a good bond with the residents".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do what they wanted to do throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "I like to stay in and watch my films and television. I love 'Carry On' films. I get up and go to bed when I want. I like it that way, because I get nervous sometimes, not with the staff, I don't tell them, I work through it. They bring my breakfast up to me". Another person said, "I can take all the time I want to get up. They'll bring me up a hot drink if I'm still in bed, but I don't normally stay too long. I can have a bath whenever I want. It's next door, so not far to go. I have my own toilet. I don't get told what to do. They ask me if I want to do something".
Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "They get a lot of choice. Daily choices, like what to drink and what to eat". Another added, "We offer lots of choice, it's up to the people who live here to tell us what they want".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. For example, we saw people assisting to

make lunch for the day and carrying out chores within the service. One person told us, "They staff are thoughtful. They encourage me to be independent. I like to do drawings and all that". Another person said, "The food is good. I help to cook, I like to help". Care staff also informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "I always encourage people to do things for themselves and help make lunch". Another said, "I encourage people to cook for themselves and make their beds".

People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "The staff are good, they don't bother me and they wouldn't come in here unless I wanted them to". A member of staff sad, "We always ask first before we do anything and we knock on doors before we enter".

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences. Staff told us how they adapted their approach to sharing information with some people with communication difficulties. A member of staff told us, "We use pictorials to communicate with one resident". People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. Staff engaged with visitors in a positive way and supported them to join in the communal activities in the lounge, or have private time together. One relative told us, "We are in here visiting all the time and the staff are always nice to us".

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "They speak to me if I want to speak to someone, they're okay". Another person said, "I've no complaints about anything. I think it's quite alright. It's as nice as you'd expect it to be". A relative added, "They are in communication with us all the time about any changes".

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff ensured that the communication needs of people who required it were assessed and met. For example, we saw that a writing board was used for a person who was hard of hearing and staff understood the best way to communicate with people. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. However, none of the staff at the service were aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. A relative told us, "We were involved with the care plan when [my relative] moved in". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. People were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plan. Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes regarding their care at the end of their life, had been respected.

Keeping occupied and stimulated can improve the quality of life for a person. We saw a varied range of activities on offer, which included, visits from external entertainers, music nights and movie nights. People were also supported by staff to attend day centres. People told us that they enjoyed the activities. One person told us, "They are kind to me, I don't get bored". Another person said, "I like it here. I go out most days and I come up to my room when I want to. I've got a nice room with a comfortable bed. All my friends are here". A further person added, "I like to go into the dining room and watch what's going on. We all meet in there and chat and drink tea and do puzzles and play music". However, if people chose not to be involved,

this was respected also and one person told us, "I like that I've got my own room and privacy and can do my own thing. I don't really like to go to mix with the others. I stay here [in her room] and watch my films". Staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff set aside time to sit with people on a one to one basis in their rooms. One person told us, "They come to me in my room and chat, I like to get to know them [staff]". Another person said, "The staff know I like to be on my own. They don't tell me what I have to do". Staff also supported people to maintain their hobbies and interests, for example one person had been supported to follow their football team, another had an interest in a particular singer and others were supported to go to nightclubs and out for meals with their friends. One person told us, "I like Elvis music and jigsaws".

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "I've had no complaints but would speak out if I had to, I wouldn't be frightened to say something". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Good

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the management of the service and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. One person told us, "[Registered manager] is very good. She speaks to me a lot. It's good here, it's my home". Another person said, "[Registered manger] is lovely. I do the washing up for her. I like to help". A member of staff added, "The new managers have done amazingly well since they have come in, they have really transformed the place". Another said, "I can approach the [registered] manager about anything. She listens and makes changes".

We discussed the culture and ethos of the service with people and staff. One person told us, "I love it here". A relative said, "It's good here. [My relative] is always nicely fed and warm, with plenty to drink and the staff get on great with her". A further person added, "I feel it is just like living at home". A member of staff said, "They get amazing care here and we treat the visitors well too".

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. Meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided. Feedback from the surveys was positive overall.

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management, including any issues in relation to equality, diversity and human rights. A member of staff told us, "We always get support from the managers". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff told us, "We work well together as a team, we're flexible and support each other". This was echoed by people and one person told us, "My keyworker makes me feel safe. She told me I can always speak to her when I need to". Another person said, "I find everyone okay. They're very good and professional".

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety, infection control and medication. The results of which were analysed to determine trends and introduce preventative measures. Up to date sector specific information was also made available around topics such as the MCA, DoLS and effective communication. Staff had also liaised regularly with the Local Authority, the Dementia In-reach Team and the Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing

to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice for both people and staff living and working at the service.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.