Care Quality Commission

Beth Ezra Trust

Beth Ezra

Inspection report

52 Smitham Bottom Lane
Purley
Surrey
CR8 3DB
Tel: 020 8668 7116
Website: www.bethezra.org

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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

Overall summary

This inspection took place on 10 February 2015 and was unannounced. At our last inspection in October 2013 the provider met the regulations we inspected.

Beth Ezra is a residential care home that provides accommodation and personal care support for up to 18 older adults. People living at the home have a range of needs and some people are living with dementia. 18 people were using the service at the time of our inspection.

A new manager was in post at the time of our inspection and was in the process of completing their registration. They successfully registered with us shortly after our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service and their representatives told us they felt safe and well cared for at Beth Ezra. Staff were trained in safeguarding adults and the service had

Summary of findings

policies and procedures in place to ensure that the service responded appropriately to allegations or suspicions of abuse. The manager and staff team understood their role and responsibilities to protect people from harm. Risks were assessed and appropriate action was taken to reduce or eliminate the risk.

People's rights were protected because the provider acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff understood people's rights to make choices about their care and support and their responsibilities where people lacked capacity to consent or make decisions.

The provider's recruitment procedures helped ensure that people were protected from unsafe care. There were enough staff on duty day and night to make sure people's needs were met in a safe and timely way. Most of the staff had worked at the home for several years which meant that people experienced consistent care.

People lived in a safely maintained service and the quality of the environment was regularly checked. Medicines were managed safely and people had their medicines at the times they needed them.

People were able to take part in activities of their choice and were supported to maintain relationships with family and friends who were important to them. People spoke positively about the quality of the food and choices available and were provided with homemade, freshly cooked meals each day.

There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. Staff treated people who used the service and their guests with respect and courtesy. Staff maintained people's privacy and dignity at all times and interacted with individuals in a caring and professional manner.

Care plans contained information about the health and social care support people needed and they were involved in making decisions about their care. Arrangements were made for them to see their GP and other healthcare professionals as and when they needed to do so. Where people's needs changed, the provider responded and reviewed the care provided.

Staff told us that they had the training and information they needed to care for people and that the manager was always available to offer guidance and support.

People who lived in the home and their relatives said they felt involved in the way the home was run and were encouraged to express their views and opinions about the services provided.

The provider carried out regular audits to monitor the quality and health and safety of the service and to plan improvements. Where improvements were needed, action was taken.

There was an open and inclusive atmosphere in the service and the manager led by example. Staff had a good understanding of the ethos of the home and told us they were clear about their roles and responsibilities.

Summary of findings

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 in the service felt safe and able to raise any concerns. Staff had received training about how to prevent abuse and knew how to act to keep people safe.

Risks to people's safety had been assessed and staff were provided with guidance in actions they should take to reduce the risk of harm occurring.

The environment was safe and maintenance took place when needed.

Staff were recruited safely because the appropriate checks were undertaken. The provider ensured there were enough staff on duty to meet the needs of people living at Beth Ezra.

People's medicines were managed safely and they received them as prescribed.

Is the service effective?

Good

The service was effective. Staff understood the importance of gaining consent to care and giving people choice. The provider acted in accordance with the Mental Capacity Act (2005) Code of Practice to help protect people's rights. Staff understood their responsibilities on how to protect people who lack capacity to make their own decisions.

There was an ongoing programme of training and supervision to ensure that staff were provided with opportunities to keep up to date and develop their skills and competence.

People were supported to have enough to eat and drink. Where a person was at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

People received the support and care they needed to maintain their health and wellbeing. People had access to appropriate health care professionals when required.

Is the service caring?

Good

The service was caring. People felt well cared for and were involved in planning and decision making about their care.

Staff supported people in a caring and compassionate way. Staff were polite, kind and took time to listen or explain things to people.

Is the service responsive?

Good

The service was responsive. People's needs had been assessed and appropriate care plans were prepared with the involvement of people and their representatives.

Staff understood people needs. They knew the people they cared for well and supported people to maintain their independence and to get involved in daily activities of their choice.

People and their relatives were encouraged to complete surveys to give their views about the quality of the service.

Summary of findings

Is the service well-led?

Good

The service was well led and promoted a positive and open culture. People who lived in the home and their relatives were asked for their opinions of the service and their comments were acted on.

Staff told us that the manager was approachable and supportive. There was open communication within the staff team and staff felt comfortable discussing any concerns.

There were systems in place to monitor the quality of the service through audits and feedback from people, relatives and staff. Where improvements were needed, action was taken.

Beth Ezra

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.

Prior to our visit we reviewed the information we held about the service. This included notifications we had received from the provider and other information we hold about the service. A notification is information about important events which the service is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR).The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 10 February 2015 and was unannounced.

The inspection was carried out by two inspectors. We spoke with eight people who use the service and five of their relatives. Due to their needs, some people living at Beth Ezra were unable to share their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the registered manager, the deputy, five members of staff and a chef. We observed care and support in communal areas, spoke with people in private and looked at the care records for five people. We reviewed how medicines were managed and the records relating to this. We checked four staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

Good

Is the service safe?

Our findings

People living at Beth Ezra were kept safe from the risk of abuse and avoidable harm. One person said, “I feel safe with the staff here.” Another told us, “I trust the staff do the right thing.” A family member told us they “could relax, knowing my relative is being kept safe here.”

There were notices in the home with contact numbers that staff, people who used the service or visitors could use to report any concerns regarding abuse.

Staff knew who to report any concerns to, how to respond to any allegations of abuse or other serious incidents and what to expect as a result of reporting any such concerns. Staff also undertook regular training relevant to keeping people safe and free from harm. One staff told us they had recently done training. When asked whether this was of benefit to their work, they replied, “Yes, it opens your eyes up.” They showed a good understanding of the different types of abuse and how they would look out for signs. For example, they told us, “When doing personal care, we can see how the person is and if they have any bruises.” They also told us, “Most service users would recognise poor care or rough treatment and complain about it; they know they must not accept rude or rough behaviour.”

Risk assessments formed part of the person’s agreed care plan and covered risks that staff needed to be aware of to help keep people safe. Staff showed an understanding of the risks people faced. One explained how they checked people’s rooms daily for trip hazards and made sure people had appropriate footwear when walking. The assessments were reviewed every month and adjusted if a person's needs had changed. However they were generic, included a score rating and as a result, lacked personalisation. Examples included, “mobility- requires the hoist” and “mental health- can be in a low mood.” We noted how a person had been scored as high risk; using the Waterlow assessment (this gives an indication of the risk of pressure sores). Although staff recognised the risks and there was information about equipment the person needed it was not recorded clearly within the person’s risk assessment. We discussed this with the registered manager and senior staff who agreed to revise the format and include more details. The manager explained she was in the process of reviewing all records and exploring further ways to involve people in their care planning. We saw records to support this.

Records of accidents and incidents we reviewed included an analysis of what had happened and improvements that could be made to prevent reoccurrence. People's weight and falls were monitored and action had been taken to address any changes identified. For example, the staff had contacted the falls clinic when needed.

Beth Ezra was well presented and clean and tidy. An area of the home was being renovated at the time of our visit due to relocating the manager’s office. There were general risk assessments for the premises and for health and safety working practices which contributed to people’s safety. This included appropriate maintenance contracts concerning fire, gas and electrical safety. Servicing and routine maintenance records were up to date and evidenced that equipment was regularly checked and safe for people to use. Fire alarms and equipment had been serviced and practice evacuation drills held regularly involving both people using the service and staff.

Staff records showed that the provider had safe systems in place for the recruitment and selection of staff. The required checks had been carried out before staff started working at the service. This ensured that staff employed were of good character and had the right skills and experience to support people. We discussed the recruitment process with a new member of staff. They told us they had been asked to provide references and a criminal records check had been undertaken before they were allowed to work. The provider had policies and procedures for when concerns were raised about the conduct or performance of staff. This helped to ensure that people were protected from unsafe care.

People received appropriate staff support to meet their needs. They did not have to wait for attention and staff responded promptly when people needed assistance. One person told us “I press my bell when I need help and the nurse is there within minutes.” Another told us how “staff come as quick as they can when I ring.” We saw how the call bell was accessible to each person in three rooms we visited. Staff told us there was enough of them to meet people’s needs and said they did not feel under pressure. One told us, “There is enough, we have time to sit and talk with people.”

We checked a sample of rotas and saw that staffing levels were consistently maintained. There were between three and four staff throughout the day with two staff on duty throughout the night. There were additional ancillary staff

Good

Is the service safe?

that included cleaners, two cooks and an activities co-ordinator. Staffing levels were organised flexibly and according to people's individual needs, routines and occupancy. The manager told us that the service had a full complement of staff. Where necessary the provider had systems in place to cover staff absence at short notice and on call management arrangements in the event of an emergency.

People's medicines were appropriately managed and were administered in a safe manner by staff. The home used a 'Bio dose' system and records showed that all staff handling medicines had received relevant training and had been assessed as competent to manage medicines by a senior member of staff. There were effective procedures in place for recording the administration and disposal of medicines. People we spoke with told us they received their medicines on time. Care records contained a personal profile which recorded medicines prescribed and guidance for staff in administration of these items and identified any allergies and side effects. The sample of records we checked showed that people were receiving their medicines as prescribed.

Where people were prescribed medicines on an 'as required' basis, for example, for pain relief, there was sufficient information for staff about the circumstances when these medicines were to be used. Regular visits by health care professionals ensured people had regular medicines reviews.

All medicines were stored securely. People had individual medicine cabinets in their rooms and there was an additional locked cupboard to store controlled medicines and those prescribed when needed (PRN). A named member of staff had responsibility for the auditing of medicines every month. This helped ensure there was accountability for any errors and that records could be audited by the provider to determine whether people received their medicines as prescribed.

Good

Is the service effective?

Our findings

People were supported by staff with appropriate skills and experience. The staff told us they received training and support to help them carry out their work role. For example, all new staff worked alongside experienced senior care staff for up to six weeks, depending on experience. New staff completed a comprehensive induction and one member of staff spoke highly of the support, training and guidance given to them. They said their induction was "managed well" and they had a book to complete their learning. The staff member told us they had completed a practical moving and handling course and they had "loads of training courses coming up."

Staff felt they had received appropriate training to support people with their care needs. This included training on using hoists and caring for people living with dementia. There was an electronic training record which enabled the manager to monitor the training staff received and ensure they were up to date. Certificates were also held on individual staff files. The majority of training was available through the provider and other courses were arranged through liaison with the local authority.

Staff told us they had regular supervision from senior staff and we saw records to support this. Discussions were held about staff welfare, training and development needs and where appropriate, work performance. Yearly appraisals were also arranged for staff and the manager was in the process of reviewing these.

People we spoke with told us how they were asked for their consent before, for example, staff undertook personal care. One told us, "They always ask me if it is ok [before assisting with a shower]." Another person said, "They are quite cooperative with all my wishes."

The manager and staff demonstrated a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). A DoLS application is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests. Staff told us about recent MCA and DoLS refresher training they had undertaken. We saw that relevant policies were available to staff. The manager told us they had not needed to make any applications to restrict anyone's liberty but systems were in place to do so if needed. We noticed how there was a key pad on the front door, which could mean that a person was prevented from leaving. One staff told us, "All those service users who can and want to go out do so; they all know the code." Two people told us they knew the code and used it accordingly. We asked how those less independent managed to leave the premises and were told how they asked staff to accompany them. One person told us, "I only have to ask and someone will take me out."

Staff told us they made sure they had consent before performing a task "by asking the question in many different ways and taking note of body language." They also told us where a person lacked capacity they "consulted and engaged with family members to reach the best possible outcome for their relative," for example, "if we are planning an outing." Another staff said it was important to, "always tell people what you are going to do."

People using the service had care planning records that were signed by themselves or a relative. There were appropriately completed DNAR forms on the care records we looked at. These were completed by the GP and witnessed by a member of management staff, in consultation with the person (and their relative in one instance). It was clearly noted how one person had full capacity to make such a decision at that time. A member of staff told us how these were the expressed wishes of a person who had capacity at the time of completing the DNAR form and as such, did not require a review. This demonstrated that the service considered and recorded the wishes of people using the service in regard to medical intervention and their consent was sought and documented.

People all commented favourably on the menu and choices available. Their comments included, "The food is super, the only problem is, I have gained weight because it is so delicious" and "if the food is something I cannot eat, then the chef will give me what I want." One person told us they had asked for a particular dish, and said, "it was served later that same week."

People were involved in planning the weekly menu. A staff member told us they discussed food choices with people in the morning and relayed this information to the chef. The chef told us, "The menus are planned a week in advance, after feedback from the residents meeting, where people make suggestions." Menus provided two choices of meal at

Good

Is the service effective?

lunchtime and three at suppertime. The options included a meat and a vegetarian option, with vegetables and a choice of desserts. The chef also told us, “Whatever people want, they get; we want them to feel they are at home.”

We joined people in the dining room for lunch. The food served was well balanced, of a good temperature and well presented. There was a member of staff available for each person who needed assistance with eating at lunchtime. The staff supported them sensitively. The lunchtime experience was calm and unhurried. Staff asked people if they needed any assistance and made sure that they were comfortable. People were asked if they wanted further helpings and were offered a choice of desserts. Hot and cold drinks were offered to people throughout the day.

We discussed peoples’ special dietary needs and how these were met. The chef told us how special needs were recorded in their care plan and the senior staff passed on this information. One care record we looked at emphasised the person’s dietary requirements and we saw how this was reflected in the food offered to the person. The chef prepared food according to individual needs and requests, for example, where a person did not like pureed food; they adapted this into a soup.

Where people were at risk of poor dietary and fluid intake, appropriate records were completed. We saw on care records how people were weighed each month, or “more frequently if recommended by the GP”. Staff told us that they would use food record charts if they were concerned about a person’s appetite. A care plan we reviewed showed that one person had been at risk of malnutrition in the past. Charts showed this person's dietary intake had been monitored and their weight had been checked on a regular basis. Another person was referred to the Speech and Language Therapist [SaLT] and their care records recorded how appropriate actions were taken on the recommendation of the SaLT.

People were supported to keep well and had access to the health care services they needed. Advice from other healthcare professionals was incorporated in to care plans to ensure that people received appropriate care and treatment. Records showed that staff recognised when people became unwell and that appropriate action was taken such as requesting a visit from the GP or making a referral to other healthcare professionals involved in their care. For example, records confirmed people had seen an optician, chiropodist, and district nurse where appropriate as well as other specialists for specific medical problems. The manager and staff had begun to write hospital passports for people and planned to complete these within the next two months. This is a document which contains important information about a person’s health and helps ensure all professionals are aware of a person’s needs. For example, when attending health care appointments or if people require a hospital stay.

We found the premises to be homely and well-furnished in the communal areas. Whilst those bedrooms were not fully en suite, they each had a separate room with a toilet and hand basin in it. There were accessible toilets and bathrooms situated throughout the building. Facilities were equipped with sufficient aids and adaptations to meet people's physical needs such as raised toilet seats and hand rails for support. People had mobility aids and other specialist equipment to promote their independence and there was passenger lift access to the first floor.

Good

Is the service caring?

Our findings

People told us the home was a friendly and happy place. One person told us, "This is a good care home, we get good care." A relative told us, "The staff are a cheerful bunch. The beauty of this place is that you get to spend time with lots of others." One person who used the service spoke about the kindness of staff and said, "They bought a book especially for me because they knew I was interested in that subject." Another person told us, "The staff are nice, they get put things right for me – they mended my coat."

We saw how staff interacted with those who used the service in a kind and respectful way. For example, each time staff passed close to a person, they were greeted using their name and asked how they were and what they were doing. One person who used the service told us, "I feel really consulted about things here; you can put your opinions across and feel they are listened to." Another person commented, "Staff are splendid and kind, they arrange all sorts of nice things for us to do."

During the structured observation at lunch, the staff frequently checked if people were comfortable and engaged them in conversation. They responded to people's body language such as offering a drink when one person pointed at their cup. Staff supported people to eat and drink at a pace that suited them and provided encouragement to eat their meal. One staff member cut food into smaller pieces for one person and asked them to try again. The person smiled, touched the staff's hand and continued to eat their meal. People received support in a dignified manner and staff guided individuals to hold their cup or cutlery independently. Throughout lunch, staff asked people if they were enjoying their food and whether they would like more.

We observed how one staff member engaged with a person by reading to them and this interaction generated an animated response from the person. At another time, a member of staff demonstrated good knowledge about a person by asking appropriate questions relating to their personal history, thus enabling this person to engage in familiar conversation.

People using the service were supported to maintain relationships with their family and friends. Visitors said that they were able to visit freely and were made to feel welcome. We saw how visitors were welcomed and given hospitality, including morning coffee and lunch.

People told us that they were treated with respect and that their privacy and dignity was upheld at all times. This was also confirmed by visiting family members. We saw how doors were closed when personal care was given. One person said, "My privacy is respected, people knock before coming in and are always discreet when helping me to shower." Staff gave us examples of how they respected people's dignity by making sure they were covered during personal care activities and that clothes were stored and labelled individually. People's private and personal information was stored securely and staff spoke in confidence about people's care needs.

Although staff knew people well, care documentation did not always provide information about the person's interests or details about their life history. We discussed this with the manager who agreed to review these records. She explained that staff were due to complete further training on person centred care later in the month and a representative from the local authority was due to visit and discuss other training needs.

People told us that they had comfortable bedrooms and we saw that they had been able to bring in items from home to personalise them. We looked at two of the communal bathrooms and saw attention had been given to make them comfortable. For example, one bath had a painting and a saying over it to aid relaxation and the other had the bath positioned so that it looked out over the back garden.

Good

Is the service responsive?

Our findings

Care files showed that people's needs were assessed before moving in to the service, with relatives and health professionals supporting the process where possible. The assessments took account of a range of needs relating to physical health and care, and activities of daily living. People had 'personal care plans' which identified people's assessed needs and how to support them. Staff had a good understanding of people's individual needs and told us they were expected to read the care plans. One new member of staff described the plans as "very informative."

Care records were regularly reviewed and reflected where there had been any changes to people's care or support needs. There were monthly reviews of people's needs and a more in-depth review held every six months with family participation. Review meetings were signed by all present, including the person who used the service and their relative. One family member told us, "It is a chance to relook at things, in case something needs to be added." Another relative told us, "my relative has been transformed since being here; I can sleep at night now, knowing how safe and happy they are." Another commented that the reviews were "very useful and not just lip service."

People told us the staff were supporting them well and that staff responded if they needed anything. One person said, "They bath me when I want" and "staff are cooperative about the time I like to get up [very early]." A family member told us, "Staff have managed to build up my relative's confidence and helped her to become more independent – the difference is remarkable." Staff adopted a person centred approach and supported people to be independent. One staff told us how they encouraged people to do as much as they could for themselves, "to keep their skills for as long as possible."

Staff wrote daily records about each person's experiences, activities, health and well-being and other relevant events such as medical appointments. This helped staff to monitor if the planned care and support met people's needs. They told us they shared information at each shift change to keep up to date with any changes. We asked how staff responded to fluctuations in people's weight. One staff member told us they notified the GP and requested a referral to the dietician or SaLT. We looked at one care record and saw how a visit was made to the dietician in response to weight loss. There was frequent contact with other professionals such as the GP and district nurses, which ensured people's health was maintained.

People's diverse needs were understood and supported. The care plans included information about their needs in relation to age, disability, gender, race, religion and belief and sexual orientation. A communication board had been devised to meet the needs of one person. This board enabled staff to engage with the person and offer them choices about aspects of daily living.

There was written information about the programme of activities displayed on the lounge noticeboard. Relatives told us this was posted to them each week. One told us, "This keeps us up to date on what our relative is doing." People told us they were happy with the activities provided. One person told us they frequently made suggestions for "nice outings, and staff always seem to listen to me." Another person said they were looking forward to the weather improving and going out more.

Preferences for entertainment and activities were a regular topic discussed at the residents' meetings, and included suggestions for trips out. Prayer services were part of the weekly activities; most people in the home were practising Christians and had chosen the home based on its religious ethos.

People were encouraged to express their views and opinions of the service by taking part in surveys, regular meetings and through daily discussions with staff and management. People told us they felt part of the decision-making in the home. Staff told us there were residents meetings held every two months at which a range of subjects were discussed. Minutes of each meeting were distributed to every person who used the service. One person told us they were very pleased that their recent suggestion of new chairs for the lounge seemed to be taken seriously. We later saw the deputy and a senior staff discussing colour and material samples of chairs from a brochure with several people.

We asked people if they knew how to raise a complaint. One person told us, "I know where it is and what to do but I could not imagine a situation where I would need to make a complaint about anything here." This view was echoed by other people we spoke with as well as visitors. We looked at the complaints procedure which was visibly displayed. This

Good

Is the service responsive?

was clearly set out and gave information on who to make a complaint to, including details about the Care Quality Commission. We saw people had a copy of the complaints procedure in their bedrooms.

Good

Is the service well-led?

Our findings

The 'open door' policy of the home meant that anyone living in the home, family members and staff could discuss openly their views or requirements with the manager. People using the service and their relatives were confident to speak with the manager and felt listened to.

The culture of the home was open and welcoming. We observed that the registered manager engaged with people, relatives and staff throughout the day. Staff spoke positively about the manager. One told us, "We can talk to her anytime" and also said, "Any issues are always dealt with, she is the most honest person I've met." A newer member of staff said they felt "very much supported."

The new manager had been working at the service since September 2014 and had spent time reviewing all aspects of the service and how it was run. She was able to tell us about the key challenges, such as reviewing records to improve people's care and support and developing the skills and knowledge of the staff team. The PIR also gave us information about how the service performed and what improvements were planned. The manager was making efforts to address the improvements and knew what was required to develop the service. For example, she had reviewed fire safety awareness and had organised more fire practice drills and training for staff. The manager was also studying for a level 5 diploma in leadership and management in health and social care.

Staff meetings took place every two months and the minutes of these meetings were shared with staff for discussion and learning. In a recent meeting staff were reminded about the bullying policy and how to raise concerns. Staff also told us they talked about the ethos of the home and how it should be run. They felt valued by the provider. One told us, "They are very appreciative; they recognise we work hard and tell us." Staff knew of the whistle blowing policy and said there was an expectation that they would report any poor practice.

The provider had a quality assurance group who were independent of the charity that ran the home. We were shown the most recent survey report from July to December 2014 which reflected the responses and comments of people who used the service and their representatives. The results were very positive about the care and support provided at Beth Ezra. The report identified the few issues raised by some respondents and detailed the recommendations for improvement. The manager wrote about how these recommendations were progressing. For example, it was recommended that the complaints process and the role of the keyworker staff be reinforced with people using the service. In response, these issues were discussed at residents meetings and people were provided with a copy of the complaint form in their rooms. Other examples included ensuring there was regular consultation about the catering arrangements and laundry service with people. Similarly, the manager had taken action to address these recommendations.

The manager completed a monthly report for the Trustees who also carried out a monthly audit. We checked the latest reports which provided information about how the service was running and any identified actions. Areas checked included care issues, activities, staffing, complaints, premises, health and safety and finances.

Any incidents or accidents were investigated, recorded and dealt with appropriately. Where any learning was taken from accidents or incidents, this was shared through regular supervision, training and relevant meetings. CQC records showed that the manager had sent us notification forms when necessary and kept us promptly informed of any reportable events.

Evidence showed us that the provider used a range of resources to continually review their practice and place the interests of the people using services at the centre of what they do. The various ongoing audits, both internally and externally, ensured that the quality of care was regularly assessed and evaluated.