Caring Consultancy Limited

Whitefriars Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 20 and 22 February 2018. Whitefriars Nursing and Residential Home 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. Whitefriars Nursing and Residential Home accommodates 24 people in one adapted building and there were 23 people using the service at the time of our inspection. The service is registered for 28 people, however shared rooms are only used for people who have made a positive choice to share. All the rooms were single occupancy at the time of our inspection.

The last comprehensive inspection took place in April 2016 and the service was rated good. Following concerns received in February 2017 and again in September 2017, focused inspections were carried out to follow up on each set of concerns raised. At our inspection in February 2017 we did not find shortfalls, however at our inspection in September 2017 we identified shortfalls with the management of medicines and the risk assessments for people using the service and found a breach of regulation in relation to safe care and treatment. Following that inspection we asked the provider to complete an action plan to tell us what they would do and by when to improve the rating of the key question 'Is the service safe? to at least good This was submitted by the provider and they stated they would achieve compliance by 1 February 2018.

The provider's nominated individual is also the registered manager for the service. 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 said they felt safe living at the service. Medicines were being safely managed and risk assessments were in place and being followed to identify and minimise risks to individuals. People were safeguarded from the risk of abuse and staff knew the action to take if they had any concerns. Recruitment procedures were followed to ensure only suitable staff were employed at the service and there were enough staff available to meet people's needs.

Systems and equipment were serviced at the required intervals and were maintained to keep them in good working order. There were processes in place to identify and learn from events and to improve practice in the service.

People were assessed and their needs and wishes identified before being admitted to the service. Staff received the training they needed to provide them with the skills and knowledge to care for people effectively. People's dietary needs and preferences were identified and met, including meals to meet people's religious and cultural needs. People's healthcare needs were identified and they received the input from healthcare professionals that they required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People, relatives, and healthcare professionals were very happy with the care and support people received. Staff showed people respect and maintained their privacy and dignity. Staff had a good knowledge of people's individual care and support needs and met these in a kind and caring way. People's religious and cultural needs were identified and respected.

All the care records had been reviewed and were comprehensive, person centred and up to date. Activities took into account people's interests and abilities and people enjoyed taking part. There was a complaints procedure in place and people and relatives felt able to express any concerns so they could be addressed. People's end of life care wishes were recorded so these were known and could be followed by staff.

The registered manager was approachable and visible so people and relatives knew who they were and staff felt well supported by them. Processes were in place for monitoring the quality of the service and any issues were identified and addressed. The registered manager followed up to date good practice guidance and legislation and people were encouraged to express their views so these could be incorporated into the running of the service.

Further information is in the detailed findings in the main body of the report.

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 said they felt safe living at the service. Medicines were being safely managed and risk assessments were in place and being followed to identify and minimise risks to individuals.

People were safeguarded from the risk of abuse and staff knew the action to take if they had any concerns. Recruitment procedures were followed to ensure only suitable staff were employed at the service and there were enough staff available to meet people's needs.

Systems and equipment were serviced at the required intervals and were maintained to keep them in good working order. There were processes in place to identify and learn from events and to improve practice in the service.

Is the service effective?

Good

The service was effective.

People were assessed and their needs and wishes identified before being admitted to the service. Staff received the training they needed to provide them with the skills and knowledge to care for people effectively.

People's dietary needs and preferences were identified and met, including meals to meet people's religious and cultural needs. People's healthcare needs were identified and they received the input from healthcare professionals that they required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Is the service caring?

Good

The service was caring.

People, relatives, and healthcare professionals were very happy with the care and support people received. Staff showed people

respect and maintained their privacy and dignity.

Staff had a good knowledge of people's individual care and support needs and met these in a kind and caring way. People's religious and cultural needs were identified and respected.

Is the service responsive?

Good

The service was responsive.

Care records had been reviewed and were comprehensive, person centred and up to date. The provision of social and recreational activities took into account people's interests and abilities and people enjoyed taking part.

There was a complaints procedure in place and people and relatives felt able to express any concerns so they could be addressed.

People's end of life care wishes were recorded so these were known and could be followed.

Is the service well-led?

Good

The service was well led.

The registered manager was approachable and visible so people and relatives knew who they were and staff felt well supported by them.

Processes were in place for monitoring the service and any issues were identified and addressed.

The registered manager followed up to date good practice guidance and legislation and people were encouraged to express their views so these could be incorporated into the running of the service.

Whitefriars Nursing and Residential Home

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 was a comprehensive inspection. This inspection took place on 20 and 22 February 2018 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we also reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection was carried out by 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.

During the inspection we looked at a variety of records including three people's care plans and risk assessments, medicines administration record charts for six people, recruitment records for three staff and seven volunteers and students on work experience placements, health and safety audits, monitoring records, policies and procedures, accidents, incidents, safeguarding and complaints records. At lunchtime on the first day of inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interactions between people using the service and staff during the inspection.

We spoke with five people using the service, three relatives, the nominated individual who was also the registered manager, a company director, two nurses, three health care assistants, the activities co-ordinator, the chef, the cleaner and the administrator. After the inspection we requested feedback from four healthcare professionals and received feedback from two of them.

Good

Is the service safe?

Our findings

People and their relatives told us people were safe in the service. One person said, "I couldn't stay at home, it wasn't safe. I'm much better here." Another told us, "I do feel safe from abuse or harm because staff are monitored and others will report it." A relative told us, "There are no problems with safety, my [relative] gets a visitor at least once a week and we've never had any concerns."

At the last inspection we identified shortfalls with the management of medicines. At this inspection we found that these had been addressed. We saw medicines were being safely managed at the service. The nurse took the medicines trolley to each floor in order to administer people's medicines and signed for them at the time of administration. Medicine administration records (MARs) were complete with no gaps in signing. Where there was a variable dose of one or two tablets the actual amount given had been recorded. Handwritten entries were checked and signed by two staff. Records of receipt, administration and disposal were seen and were up to date. The clinical lead said that they checked that the correct dose had been dispensed by the chemist as part of the checking in procedures.

We carried out a stock check of a sample of boxed medicines including controlled drugs (CDs) and these tallied with the amounts given and signed for. Body charts were used to indicate the areas to apply topical creams and lotions and there were clear instructions on their use. CD stocks were checked twice a day and were up to date. Medicines were being securely stored at safe temperatures and daily temperature checks of the clinical room and the medicines fridge were carried out and recorded. Clear protocols were in place for the use of 'as required' medicines and a record maintained of when they were administered and the outcome, so the efficacy of the medicine could be monitored. Where people were on medicines that required monitoring, for example, blood thinning medicines, we saw that regular blood tests were carried out and the results with the daily dose to be given was kept with the MAR so this was clear to the nursing staff. If people required their medicines in a different format, for example a liquid medicine so they could swallow it easily, then this was discussed with the GP and pharmacist to meet the person's needs.

We saw the service's pharmacist had carried out an audit of the provider's medicines management systems in January 2018. The Clinical Commissioning Group's (CCG) pharmacist also visited the service in September 2017 and concluded "Overall the medicines management within the home had been run very well and safe". Feedback from the supplying pharmacist included, "The team at Whitefriars work well and are well trained and informed about medicines management." The nurse in charge carried out a weekly audit of people's medicines records and we saw these were up to date.

At the last inspection risk assessments were not always in place for identified risks and we saw action had been taken to address this. People's care records included assessments of risk and guidance for care staff on how to mitigate these. For example, one person's care plan included risk assessments for continence care, falls and challenging behaviours. Guidance for care staff included, "Gently discuss any task you are carrying out before you carry it out", "If [person's name] is aggressive, staff must give them space to calm down and approach him later". One health care assistant told us that if a person was upset they would speak with them calmly, offer them an activity and ask other staff for support to make sure the person and

others were safe.

Other risk assessments seen included risks associated with manual handling, malnutrition, social isolation and developing pressure ulcers. When people's needs changed the provider updated their risk assessments. For example, when one person stopped using their walking frame to mobilise, the provider instructed staff to provide closer supervision when the person wanted to move from one area to another. The provider had reviewed and updated all of the risk assessments we saw since our last inspection.

All of the staff had a good understanding of the types and indicators of abuse and could tell us what they would do if they had concerns about a person using the service. Their comments included, "I did safeguarding and whistle blowing training recently. People could be at risk of verbal, physical or institutional abuse. I would alert the manager and if she did nothing I will notify the local authority or CQC" and "If I thought someone was being abused I would report to the nurse who is the person in charge. If there was no action I would go to the manager or tell the safeguarding team in the local authority or CQC." Safeguarding and whistle blowing procedures were in place and the provider recorded safeguarding concerns and we saw evidence they worked with the local authority to investigate and resolve any concerns.

Staff were able to tell us how they kept people safe and three care staff mentioned the importance of keeping the environment clear to enable people to walk around safely. One said, "I check for hazards, keep stairs, rooms and corridors clear and lock away cleaning materials". Health care assistants told us they would check people's care plans for risk assessments and they gave examples of falls, pressure care, the use of bed rails and nutrition. One health care assistant told us, "I would look in the person's care plan for risk assessments and I would talk to the other staff".

The provider carried out checks on staff to make sure they were suitable to work with people using the service. Application forms and health questionnaires were completed. We noted gaps in employment records for two staff that had not been explored at the time the staff were recruited. We pointed this to the provider and they addressed this and also reviewed the staff records to ensure this was in place for all employees. Pre-employment checks included two references, one being from the previous employer or place of education, a photograph, proof of identity including copies of passports, evidence of people's right to work in the UK and a Disclosure and Barring Service (DBS) enhanced disclosure. Where staff held a professional qualification and were registered with a regulatory body such as the Nursing and Midwifery Council (NMC) they told us the provider regularly checked their registration to make sure they were able to carry out their role and we saw evidence of this in a nurses file. For the volunteers and high school students on work experience placements we saw they had completed an application form, provided references and a DBS enhanced disclosure.

The provider carried out checks and audits to make sure they provided a safe service. A fire risk assessment had been carried out and action taken to address the recommendations. Monthly fire safety maintenance checks were completed and there was an emergency fire plan in place. Staff had undertaken fire warden training including learning to operate the fire extinguishers. The last fire drill had been carried out in February 2018 and where areas for improvements were identified these were addressed by the registered manager. The day prior to the inspection the provider had noted a smell of gas outside the premises and reported it promptly and we saw the situation was being addressed. There was a business continuity and disaster recovery plan with an agreement with a local school as the place of safety if the service needed to be evacuated.

We saw the provider had a contract for the collection of clinical waste. They had carried out an audit of the kitchen in January 2018, the passenger lift and hoists were serviced regularly, the fire alarm system and

emergency lighting were serviced in November 2017, there were current gas and electrical safety certificates and the cold water system was cleaned and disinfected in December 2017. The chef recorded fridge, freezer and food temperatures daily, they kept a record of people's known allergies and had completed training in food safety, infection control, fire safety and first aid. We saw the kitchen and food storage areas were clean and well organised and the local authority's environmental services had awarded the provider a top score five-star rating for food hygiene in April 2017. The service was clean and fresh throughout and personal protective equipment including gloves and aprons were available for staff to use when providing care.

Accidents and incidents that involved people using the service were recorded and staff were able to tell us how they would respond. For example, the provider recorded an incident where there had been an error with one person's medicines. They discussed the incident with the nurse and ensured they understood the service's procedures for managing medicines. They also ensured the nurse was supervised for a period of time until they were confident they followed the correct procedures. The provider discussed any incidents that identified areas for improvement so everyone working at the service could learn from them to minimise the risk of recurrence.

Good

Is the service effective?

Our findings

Relatives told us they were involved in agreeing the care and support people received in the service. One relative commented, "We have talked about the care plan for [person's name]. The staff fully understand what help he needs." People we spoke with were happy that their relatives were involved with their care plans and felt they received the care and support they wanted. One person said, "The support and care I get are great." Another told us, "Yes, I am very happy with the support and care I receive from the service."

People's care records included an assessment of their care and support needs and guidance for care staff on how to meet these in the service. Care plans covered physical and mental health, personal care, communication, nutrition, mobility, activities and interests and end of life care. Where the provider's needs assessments identified the person needed support, they gave care staff clear guidance. For example, one person needed support and supervision to make sure they mobilised and did not develop pressure ulcers. Their care plan instructed care staff to "Report any redness or marks to the nurse and document".

Staff told us they completed induction training when they started work in the service and regular training to ensure they had the skills and knowledge they needed to care for people using the service. One member of staff said, "The induction was very good. I felt very confident as I shadowed staff who showed me what to do". A second member of staff told us, "The training is very good and we get regular refresher training. I have done safeguarding and health and safety training recently".

Staff undertook training and updates in topics including health and safety, manual handling, fire safety, safeguarding, equality and diversity, first aid, dementia care and food hygiene.

People were provided with food and drink to meet their needs. Drinks and snacks were available throughout the day and fruit was served with the morning tea and coffee round, which people enjoyed. We observed the lunchtime period and we found that people had a positive experience. The atmosphere in the dining room was relaxed and people had the support they needed. Staff offered people choices and where people did not want these they offered alternatives such as soup or sandwiches. A selection of three cold drinks was available and staff ensured that people had enough to drink with their meal. Where people needed support to eat their food we saw staff provided this in a caring way. They sat with people, talked with them while they ate and explained the support they were giving.

For people who experienced any swallowing problems, we saw they had been referred promptly to the speech and language therapist for input and staff followed the instructions to provide people with food and drink to meet their needs. People were weighed each month and were referred to the dietitian if any significant loss occurred, which we saw in a person's care records. Meal supplements were prescribed if necessary and meals were fortified to increase their calorie intake. People's food and fluid intake was recorded so this could be monitored.

People's care plans included details of their health care needs and how the service would meet these. We saw evidence the service liaised with health care professionals including people's GPs, mental health

services, occupational therapists, dentists and opticians. Where people had specific health care needs the service worked with clinicians and hospital clinics to make sure they received the treatment they needed. For example, any skin concerns had been referred to the tissue viability nurse specialist for advice and the service also had input from the palliative care nurse specialist for people's end of life care needs. Feedback from healthcare professionals was that people were referred appropriately and in a timely way for input and any instructions were recorded and followed by staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood their responsibilities under the MCA and DoLS. One member of staff told us, "Some people do not have capacity to make decisions for themselves so we have to act in their best interests". A second member of staff said, "If people can't make decisions we work with their family to make sure they get the care they need. We always offer people choices and respect what they decide." During the inspection we saw people's care plans emphasised the importance of offering choices and respecting decisions people made. We saw care staff offered people choices about the time they got up in the morning, whether or not they took part in activities, where they preferred to spend their time and what they wanted to eat and drink. We saw the provider completed mental capacity assessments and DoLS screening for people on admission and had applied to the relevant supervisory authorities for a DoLS authorisation when indicated. The provider told us they had not received a response from some of the supervisory authorities but we saw evidence they had contacted them on several occasions to check on the progress the applications.

The premises were maintained and the service had a homely atmosphere. People could bring in personal items and the bedrooms we saw were personalised and reflected people's interests and hobbies. There was a passenger lift and wheelchair access throughout the service. The communal lounge was spacious and provided room for people to sit in groups or individually, depending on their wishes. The dining room was used by people for activities and also if people wanted to have some quiet time alone or watch the television. We saw one person enjoying watching the Winter Olympics sitting in the dining room whilst others were doing activities in the lounge. There was a maintained rear garden and we were told people used the garden to sit out during warm weather. The smokers had a designated smoking area in the garden.

Good

Is the service caring?

Our findings

People using the service and their relatives told us staff were kind and caring. One person said, "The staff are very kind and very caring". A second person told us, "The staff are very good, they don't rush and they always have time to talk". A relative commented, "The staff are very good, very flexible and approachable". Another relative said, "We are very happy. We looked at other homes but this was the only place we wanted our [family member] to come to".

During the inspection we saw examples of positive interactions between care staff and people using the service. Staff took the time to sit and talk with individuals. They knew the people using the service well and were able to talk about family members, significant places and events in people's lives. People could choose to get up and go to bed when they wanted to and the staff planned their care and support to fit around their individual patterns. For example, one person chose to get up and go to bed at a late hour and they were happy that their routine was respected by the staff. Staff knew people's wishes in respect of the gender of the staff they wanted for providing personal care and the registered manager took action to record this information at the time of inspection and ensured people's wishes were respected.

We saw staff made sure they asked people if they were happy to have any care or support they provided. For example, we observed staff informing and encouraging people to take part in a planned activity during the afternoon. If people chose not to participate, staff respected this choice and supported them to spend time in other communal areas or their bedroom if they chose to. Staff provided care in a kind, compassionate and sensitive way. They answered people's questions, gave explanations and offered reassurance to people who were anxious.

Staff were attentive and listened to people, and there was a close and supportive relationship between them. People using the service knew the name of the registered manager and responded positively to her. Information about advocacy services was displayed in the service so people could access this if needed. The registered manager explained that for people with deprivation of liberty safeguards authorisations, a qualified advocate could be assigned to them as part of the DoLS process so they had someone independent to speak on their behalf.

People's religious and cultural needs were identified in their care plans and there was contact with religious representatives so that their needs could be met. A representative from the Catholic Church visited regularly and the registered manager said they had contacted representatives from the Jewish and Buddhist faiths to request them to visit people at the service. People's food requirements to meet their religious and cultural needs were identified and known and we saw a variety of meals served to meet these. Several of the staff were able to communicate with people for whom English was not their first language and where this was not possible, then communication books with simple words translated to help staff with communication were provided. People were dressed to reflect individuality and where people had specific clothing for cultural reasons we saw this was facilitated and respected.

People's care plans included their personal histories to help staff gain an understanding of their life histories

and how it affected them today. Care staff demonstrated they were knowledgeable about people's likes, dislikes and the type of activities they enjoyed. Staff told us about information in people's care plans and displayed in their rooms about their likes, dislikes, routines and preferences and we saw examples of the care plans and the displays. This was evidence that care staff understood each person using the service and supported them to receive person-centred care and support.

Good

Is the service responsive?

Our findings

Care plans were comprehensive, person centred and reflected each person's care and support needs and how these were to be met. The provider said all the care plans had been rewritten and updated since our last inspection and we saw that the information in all the care plans we viewed was up to date. Any wounds were recorded and photographs taken with dressing regimes and records of changes. Where someone was going to hospital for treatment this was recorded. Daily records of food and fluid intake, turn charts where required and daily care given were in place and up to date, evidencing the care and support people received.

The service had an activities co-ordinator who told us they worked full-time in the service, including some time at weekends. They told us they met with new people using the service to record their life story and their hobbies and interests. They produced a programme of activities and after each session they recorded the names of people who participated and whether or not they enjoyed the session. They also spent time with people who preferred who stay in their rooms during the day.

During the inspection the activities co-ordinator organised a game of bingo that 14 people took part in. We saw people enjoyed the session and the chocolate prizes they won. The activities co-ordinator told us the provider enabled her to buy materials and resources for activities and they used information from the National Activities Providers' Association (NAPA) to plan new activities for people using the service. They were able to tell us about individual's interests and activities they had arranged for them. For example, they planned to introduce a gardening activity for a person who had expressed this as an interest.

People using the service and their relatives told us they knew how to make a complaint and said they trusted the provider to respond. One person said, "I've no complaints. If I did I'd speak to [the registered manager], she's the boss". A second person told us, "I've no complaints. If I need anything, I just have to ask". A relative also commented, "I do know about the complaints procedure but we've never needed it".

The provider investigated complaints they received and recorded the actions they took to investigate and resolve these. We saw they carried out a detailed investigation and took statements from people involved. Where their complaints investigation showed they needed to make improvements to the service, the provider took appropriate action. For example, they reminded staff of the need to make sure people's clothes were labelled to ensure they did not wear other people's and they increased the frequency of checks on one person who chose to stay in their bedroom to ensure they did not become isolated. Where necessary, the provider reported the findings of their complaints investigations to the local authority.

Some of the staff had undertaken end of life care training at a local hospice and people's end of life care wishes were recorded so they could be met. Care plans for people's end of life care were in place so that people's needs and wishes could be met. 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were seen in people's care records. They had been completed by the GP following consultation with the person or, where appropriate, their representative and were reviewed by the GP to keep the information current.

Good

Is the service well-led?

Our findings

People using the service knew who the registered manager was and said they were responsive. One person said, "Oh, she is very good, so are the carers and staff." A relative commented, "[Registered manager] is very friendly and approachable. I find everyone helpful, approachable and capable." We saw that the registered manager had a good rapport with people using the service, understood their needs and interests and worked with individuals to help them reach their goals. They worked with the clinical lead to ensure people were referred promptly for the health and social care input they required without delay and we saw examples of this during the inspection.

Staff felt the service was well-run and they understood the management structure in the service. Their comments included, "[Registered manager] is in charge but I would report to the nurse in charge of the shift first", "The home is well run. We all know what we have to do and the team work is good. The people living here come first", "I think there is clear leadership. [Registered manager] is very passionate about what we do and she always wants us to do better" and "The manager has an open door policy and we can call her for advice out of hours. The manager doesn't have secrets, she always tells us don't hide mistakes, tell someone and we will use it to improve. The communication and feedback are very good". The registered manager had reviewed their working pattern so they were working on the floor during the mornings, being accessible to staff and people using the service and felt this had improved communication.

The registered manager was clear about the importance of staff training and keeping up to date with current good practice. They were in the process of carrying out staff annual appraisals and said they would be working with each member of staff to create a personalised training programme. She encouraged staff to gain additional qualifications, for example several staff were undertaking diplomas in health and social care and the administrator was studying for a level 5 diploma in leadership and management in health and social care. The registered manager had a recognised management qualification in health and social care and was due to commence a leadership and professional support programme for care home managers in March 2018.

The registered manager attended the care provider forums at the local authority and conferences organised by the Registered Nursing Homes Association. They also accessed publications and newsletters from organisations including the Care Quality Commission (CQC), the National Institute for Clinical Excellence and Skills for Care, to keep up to date with current legislation and good practice guidance.

Satisfaction surveys for people using the service and for staff were carried out twice a year using the National Care Association guidance and forms and then the information was collated and analysed. The results were analysed and an action plan drawn up where areas for improvement were identified. Audits were carried out to monitor aspects of the service and action taken to address any issues identified. The frequency ranged from daily, weekly, monthly and quarterly audits and covered areas including health and safety, fire safety systems and equipment, care records, medicines and premises and equipment. This meant the service was being monitored and action being taken to address any issues identified.

Policies and procedures from a reputable company were accessed and adapted to reflect the service. We saw the registered manager had reviewed these in January 2018 and they demonstrated their knowledge around a sample of documents that were discussed. Where any shortfalls were identified, action was taken to address this promptly, for example, amending the recruitment policy to include exploring any gaps in employment with applicants. The registered manager was aware of their regulatory obligations and sent notifications of significant incidents and events to the CQC to keep us informed of the information we needed to know.