Willow Tree Homecare Ltd

Willow Tree (Bournemouth)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Willow Tree (Bournemouth) is a domiciliary care agency. It provides personal care to people living in their own houses and flats. Willow Tree (Bournemouth) provided this service to 106 adults at the time of this inspection. Not everyone using Willow Tree (Bournemouth) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

This announced inspection took place on 14, 15, 16 and 17 May 2018.

There was not a 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. The previous registered manager had left their post in January 2018 and the new manager had started their application process.

Willow Tree (Bournemouth) had entered a period of change when the previous registered manager left and a number of staff had also left. This meant the service was not able to provide visits at regular times with regular staff. There had also been some missed visits and medicines errors during this time. The manager and senior staff had robust and comprehensive plans in place and were working hard to stabilise the staff team.

The whole team were committed to providing a quality personalised service to people and felt close to achieving this.

Oversight structures and ethos of care were clearly communicated and the quality assurance systems had been effective in identifying areas for improvement at location level. The provider had not picked up on developing issues and they had changed their oversight process to address this weakness. People and relatives were listened to and we saw that their views informed improvement work.

Staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected people's wishes and preferences. Staff also knew how to identify and respond to abuse and told us they would whistleblow if it was necessary.

Staff encouraged people to make decisions about their lives. Care plans did not always reflect the care that was being delivered or how it was developed within the framework of the Mental Capacity Act 2005 when people lacked capacity and did not have other people who could make decisions for them legally. This was addressed during our inspection.

People were supported by safely recruited staff who were committed, compassionate and enthusiastic. Staff told us they felt supported in their roles and had taken training that provided them with the necessary

knowledge and skills.

There were systems in place to ensure people had enough to eat and drink and that people were supported safely when eating and drinking.

People, whilst concerned about the reliability of their care, were positive about the care they received from the service and told us the staff were kind. Staff were cheerful and treated people with respect and kindness throughout our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staff were not deployed in a way that ensured people had care when they needed it. There were comprehensive plans in place to address this.

People's medicines were not always administered safely. Systems were being implemented to ensure the safety of medicines administration.

People were supported by staff who had been recruited safely and had the necessary skills and knowledge to support them.

People were supported by staff who understood how to reduce the risks people faced. Staff understood how to protect people from abuse.

Is the service effective?

Requires Improvement

The service was mostly effective. Staff had the knowledge necessary to deliver effective care with the exception of specialist tasks which impacted on a person's care. Training was put ion place to rectify this.

Staff had a good understanding of the principles of the MCA and incorporated these in their work. Records did not always reflect the framework of the MCA. This was being addressed during our inspection.

People, or those who knew them well, were involved in the assessment of their care needs and care planning. This meant their preferences were reflected in their care plans

Is the service caring?

Good

The service was caring.

People received care from staff who cared about them and liked and respected them. Staff developed relationships with people and took the time to get to know them individually.

People and their relatives were listened to and felt involved in making decisions about their day to day care.

Is the service responsive?

Requires Improvement

The service was responsive but could not ensure regular staff would attend visits. This was being addressed as a priority.

People and their relatives were mostly confident they were listened to and knew how to complain if they felt it necessary.

Is the service well-led?

Good

There had been substantial change and a new management team was in post.

The management team was developing and embedding comprehensive systems of oversight and quality improvement. The provider organisation oversight had not picked up on areas that needed improvement at the location.

There were systems in place to monitor and improve quality including seeking the views of people, their relatives and staff

Willow Tree (Bournemouth)

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 inspection took place on 14, 15, 16 and 17 May 2018 and was announced. We announced this inspection to ensure people could be contacted and asked to take part in our inspection. The inspection team was made up of two inspectors and two experts 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 experts by experience made calls to people who used the service.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. We had not received a Provider Information Return (PIR).This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We had last asked for this information in June 2016. We were able to gather relevant up to date information during our inspection.

During our inspection we visited three people receiving care and spoke with a further nine people and four relatives of people who used the service. We spoke with six care workers and the trainer. We also spoke with the deputy manager, the manager and the regional manager of the provider organisation.

We looked at eight people's care records and medicines administration records. We also reviewed records relating to the running of the service. This included four staff records, quality monitoring audits, and accident and incident records. We also spoke with or received feedback from two social care professionals who had worked with the service.

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We requested further information from the manager related to the management of the service and we received this as requested on 24 May 2018.

Requires Improvement

Is the service safe?

Our findings

A recent reduction in staffing had affected how safe people felt. People and relatives told us they usually felt safe with the staff who visited, however they could not be confident in the time of calls or who would be visiting and this made them concerned. Comments were made such as: "Just latterly it has gone a bit haywire. I have been getting different people." Another person told us: "They haven't arrived this morning. We have been waiting for three hours. They are not reliable." A relative told us new carers made their relative feel nervous. Visits had been missed. These were investigated and measures had been put in place to address the issues identified.

We spoke with the manager and they acknowledged the impact of staff changes on the service. They detailed the comprehensive measures they were taking to improve this experience for staff and people. This included scheduling changes informed by people's care needs and staff feedback, staff recruitment, communication with people and relatives and liaison with commissioners to ensure the service was supporting an appropriate number of people. Recruitment was being undertaken safely and induction training of new staff was taking place when we inspected. We discussed the measures of the effectiveness of this work and the manager sent us evidence of improvements following the inspection. We heard office staff communicating with relatives and people about scheduling issues in an honest and transparent manner, acknowledging the impact, apologising and finding solutions that met people's needs.

Staff also commented on deployment difficulties. They told us they were confident that the new management were addressing the root cause of these problems. One member of staff said: "We are short staffed and do extra calls. I do this because I care for the people and don't want them to miss out on what they need. I know new staff have been recruited but it will be some time before they are on board fully." Another member of staff said "It's a lot better since the new manager has been in post, they are very friendly and they make sure I am informed of changes. It has been difficult recently but I can see light at the end of the tunnel."

Staff who supported people with their medicines had undertaken training and had their competency assessed. People were confident in the support they received with their medicines. There had , however, been errors in medicines administration and the administration of time dependent medicines was not robust. This was because staff had not recorded clearly the time of administration and the time of care visits did not always ensure an appropriate gap between medicines. We spoke with the manager about this and they altered schedules immediately to reflect this. They also highlighted the importance of clear recording to staff. The manager's action plan had identified medicines errors and a process was being implemented to ensure trained staff undertook regular checks on people's medicines based on the risks identified. Supervision sessions had also been booked with the trainer to support staff in their delivery of this task.

We observed staff administer medications safely to one person we visited. The member of staff described the process for the medicines being ordered, delivered, and stored in the person's home, as well as any surplus (such as PRN paracetamol) being returned to the pharmacy. Another person explained "I am in total control of my medicines, staff just ask me if I have taken them. They do help put cream on my legs." We saw

Medication Administration Records (MAR) had been completed and daily records included when people had taken their medicines as prescribed. Each person's care plan and risk assessments included clear detail of the person's medicine needs.

Risk assessments were reviewed regularly and took into account people's views and preferences. The level of risk was identified for areas such as moving and handling, falls and mobility, medication, skin integrity, smoking, finances, environment and nutrition. Measures to reduce the risks were identified and people had access to equipment such as walking frame, grab rails and shower chair to enable them to manoeuvre safely and independently. Staff understood the risks people faced and were able to confidently describe the measures in place to address these. For example staff had a very clear understanding about the measures in place to reduce the risk of people falling in between care visits.

There were systems in place to support staff to respond to emerging risk. A member of staff recounted a time a person was at risk due to their mental health and how they had been supported to remain with them until appropriate professionals arrived.

There were procedures in place to support good safeguarding practice. Staff were able to describe signs of abuse and had received training in how to follow the safeguarding process. They told us how they would report any suspected abuse and were confident concerns would be taken seriously by managers. One member of staff told us: "I would report it to the office straight away." Another member of staff highlighted the agencies they could contact." Staff all had access to the telephone number for the safeguarding authority.

Staff understood their responsibilities to ensure infection control was effectively managed. We observed staff using good infection control techniques, such as wearing protective clothing and washing hands regularly before and after tasks. Staff explained they had "ample supply of protective clothing and antibacterial hand gels."

Health and safety procedures were operated and these were reviewed within the quality assurance framework. This meant that equipment used by staff in people's homes was checked. Staff checked equipment before they used it and liaised with health professionals and others to ensure equipment was replaced and serviced appropriately. We saw a person's bed had been replaced to ensure it was safe for the person and the staff. There were systems in place to reduce the risks to staff inherent in lone community based working and the environments staff worked in were checked to ensure health and safety risks such as people smoking, and having pets, were identified and managed.

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report these. Accident and incident reports were reviewed and actions taken as necessary. Staff were encouraged to flag mistakes and concerns and we heard discussions that involved open reflection and commitment to learning from situations that had not gone well. The manager had not been made aware of one incident that included missed visits. The member of staff who was aware of the situation had left the organisation just before our visit. When made aware by an inspector the manager made immediate contact with the safeguarding authority.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People told us that staff checked with them before providing care and staff were able to describe how they promoted choice and responded sensitively and appropriately to people not wanting care. One member of staff told us: "I always try to persuade with gentle reasoning techniques but I respect people and report if they refuse care."

Whilst staff promoted choice we found mixed evidence regarding care plans reflecting the framework of the MCA. For example, one person who could not make decisions about their care did not have an MCA assessment recording this fact or best interests decisions recorded about care decisions. Family were making these decisions on their behalf without the legal authority to do so. There was no indication that these decisions were not in the person's best interests but the legal framework provided by the MCA protects people from unnecessarily restrictive care. Other care plans were clear, for example one had been signed appropriately by the person who held power of attorney and another person's care plan included how decisions would be made in line with the MCA as the person's capacity changed. Legal documents related to power of attorney and their areas of responsibility were held on file. This supported staff to ensure the decisions made were legal and reflected the person's wishes and best interests. The manager told us they were working to review all care plans; we saw this process had started prior to our inspection and included MCA assessments and best interests decisions.

People, who had capacity to do so, had given their consent to restrictions on their movement such as wheelchair lap belts and bed rails. One person said "I see it as an aid to keep me safe and the rails help me move in bed. I have been made aware of the risks, but the benefits outweigh them."

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. No one was being deprived of their liberty at the time of our inspection. The manager and senior staff understood the process involved if this needed to change.

People and those who knew them well were involved in developing their care plans following a detailed assessment process. This meant that care plans reflected the outcomes that mattered to people and ensured that their preferences were met. For example, care plans highlighted the relationships that needed to be supported and the importance of people's physical proximity to family. Detail about people's history and present day preferences and lifestyle, including their work, passions, and relationships helped staff speak with confidence about the details that ensured individual and effective care for people.

Assessments and the resulting care plans included the outcomes people wished to achieve and were written

with respect and promoted people's human rights. This translated into the way staff spoke about people with respect and without judgement. They also detailed information relating to people's beliefs. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. Where health professionals such as physiotherapists, nurses and speech and language therapists had assessed the person their care plans were incorporated into the service care plan. This ensured that care was delivered in a way that reflected current good practice and met individual needs.

Most people told us that staff had the skills they needed, although one person required staff to have specialist training and they told us they were not always competent in this skill. We raised this with the manager and they ensured that update training was scheduled to rectify this person's experience.

Staff felt confident they had the skills they needed and felt able to ask for refreshers whenever they needed to. One member of staff told us: "I have received sufficient training and feel competent in my role." Another said: "Training is brilliant – you can ask anything." We spoke with the trainer who explained changes to the training plan for the service. Staff undertook regular training to enable them to carry out their roles. This training was comprehensive and mostly up to date. The trainer explained that where training was due shortly before the new system that was more linked to staff and people's needs they were deferring this.

Some of the staff who had recently joined the team were new to care work and had started the Care Certificate. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. The induction process covered the knowledge requirements of the Care Certificate and the in house trainer worked through this with all new staff providing theoretical and practical training in a classroom setting. Staff then developed their skills through shadowing and competency checks with senior staff. The provider had developed this process which they called 'on boarding' covering competency, support and organisational values. Staff were positive about their induction process: one member of staff described how they "had shadow days where I worked alongside a member of staff until I was confident to work alone. I had five days induction which involved training such as moving and handling, safeguarding, DoLS, first aid, medication, food safety and dementia."

Staff told us they felt supported by their colleagues. One member of staff said: "I feel 100% supported", and "Colleagues are there to help each other – it is nice." They also commented on the ready availability of support from the manager and senior staff. Staff acknowledged that they had been through an unsettled time with management changes and staff turnover but commented on how they were all working hard to secure the team. One member of staff commented: "The managers are committed. They are positive and we are going to get there." Another member of staff told us they always got a quick and comprehensive response to queries and concerns.

Staff had received regular supervision sessions. This gave them an opportunity to discuss any concerns, reflect on how their values impacted on their work, highlight any training needs and discuss their career. One member of staff commented: "I had a supervision when the manager first started in March." Another member of staff said they received regular spot checks and one to one time with their manager to "talk about what's going well / not so well, training needs and they listen to any ideas I have."

Some staff told us they had not had spot checks on their competence;, one member of staff said: "I have worked here for eight months and I have never had a spot check." We spoke with the manager about the oversight of staff. They explained, and showed us, that all priority checks had been carried out and that senior staff had checked the competence of new staff as part of their induction.

People were supported with their day to day health needs in conjunction with health care professionals. Records showed that people had regular contact from a range of health professionals such as: physiotherapists, district nurses and speech and language therapists. Care plans included detail to support people to maintain their health including guidance about health conditions for staff and specific information about supporting wellbeing. For example one care plan explained: "I need a carer to brush my teeth as I get food stuck in my gums"

Where people were supported by care staff to eat and drink they were involved in decisions about this. This meant that any dietary, cultural or religious needs were respected. People were encouraged to have a balanced diet that supported their health and well-being whilst respecting their rights to make unwise decisions. There were systems in place to ensure staff were aware of safe swallow plans drawn up by a speech therapist, for example where people needed their drinks thickened, to help them swallow safely.

Good

Is the service caring?

Our findings

Relatives and people liked the staff and made comments such as: "They are all very nice and kind." People and relatives highlighted the importance of friendliness, and feeling valued, in people's days and often described the interaction that they had with care staff in these terms. One person told us: "We have a good chat". Some people highlighted that staff, who had mostly left, had not always been guarded about issues associated with organisational change and this led to difficult feelings for the people. We spoke with the manager about this and they told us they planned to start regular newsletters to keep people informed about changes in a direct way.

Kindness, compassion and an enthusiasm to ensure a caring service were evident across the staff team who described people in very positive ways. Another member of staff commented on their colleagues who had provided care for one of their own loved one's saying: "They are all such caring and friendly people" Care plans contained personal detail about likes, preferences, and history that supported staff to develop relationships.

Whilst attentive the staff also respected people's space and autonomy within their homes. We observed carers interact with people. They spoke with people with respect, calling them by their chosen name and by providing the level of care and support the person wanted in a calm and relaxed, but professional way. This approach enabled people to make as many decisions as possible about how they wanted to receive their day to day care.

Staff told us they were not rushed and described the parts of daily life people could undertake themselves. Staff were passionate about the importance of promoting dignity in all situations. One member of care staff told us: "I am proud of how we help people to retain their independence." Staff were supported in this by care plans that promoted independence and reinforced people's human rights. They also sometimes had time to carry out tasks that people described as 'over and above' for example one person told us : "They will always take the rubbish out for me."

Staff in the office spoke with care about their colleagues. They understood the demands of the care staff's role and were supportive , respectful and valued the work they did.

Requires Improvement

Is the service responsive?

Our findings

People's wishes and needs had not always been taken into account in the way their care was organised, and people were not always informed about changes to rotas. People we visited lived in a specific geographic area. They knew who was providing support for them and at the time they were expecting them. Without exception each person said the member of staff stayed the allocated time. They also told us they had regular staff, or if there were changes due to holidays or sickness, they had been introduced to the carer before they started providing their care. These people also knew who to contact if staff hadn't arrived as expected and added the staff at the office were "always polite and reassuring." Other people using the service did not share this experience and universally told us that changes were common and they did not know who would be coming to provide their care. They told us this made life difficult and relatives told us they found it difficult to rely on the service.. A member of staff reflected this, saying: "Last few months the service has been all over the place, last minute changes to rotas, therefore people don't know who to expect and when." The manager was aware of these issues and had instigated changes to ensure a rota could be sent out in advance of care. This was reliant on the new staff taking up post and the team stabilising alongside the development of rostering skills within the team.

Staff described people's needs consistently and confidently; emphasising people's individuality in their discussion with us. Care plans were being reviewed and they contained the detail necessary to enable staff to understand what was important in their lives. For example, one person's care plan stated: "I like to hold a teddy. My glasses go in my case til the morning." This gave staff the detail they needed to ensure the person felt safe and respected as they went to sleep.

Care plans covered a range of areas including personal care, mobility, and communication. Staff were aware of each individual's care plan and had the opportunity to read these and highlight when change was needed. One member of staff highlighted the importance of finding out about people's needs. They told us: "It is up to us as staff to get information on clients who are new to us; I speak with their regular carer to get an oversight before I go to the person." Where staff noted changes in people's needs this was reported to the office and there was evidence in records of professionals being involved at an appropriate stage. This meant people received the right care and support. One person needed a new bed and office staff coordinated this. Reviews were also responsive to small changes informed by personal preference. A person identified they would like a cup of tea in bed in the morning and the care plan did not allow for this due to the time it took. This feedback had led to a new care plan being developed incorporating the person's wishes.

Communication needs were identified and recorded within the care plans with information provide to support staff. For example one person for whom English was their second language had a care plan that stated: "I understand basic English so please speak slowly and clearly." Another person's care plan identified that they needed staff to face them and speak clearly so that they could lip read.

There was a system in place for receiving and investigating complaints. People and relatives knew how to make a complaint. Where concerns and complaints were raised we saw that a sensitive and comprehensive response was initiated. Reviewing what went wrong and considering how to improve the situation. Where

learning needs were identified it was clear that these had been acted on. For example complaints around the time of calls, missed visits and medicines management had led to a review of practice around scheduling and medicines and changes were being instigated. An expert by experience passed on concerns raised by people about staff deployment during our inspection. These were addressed sensitively and immediately. One person was very "touched" when the registered manager visited them over a weekend following a concern they had raised. They said "X (the manager) explained what they had done and if there was anything else they wanted done. This made me feel reassured that they had taken my concern seriously and had done something about it. I trust they would do the same for anyone." During our office visits we saw that concerns raised over the phone were acknowledged, apologies made as appropriate and records kept of communication with people, relatives and staff. Senior staff and the manager considered the implications for people and staff of any concern raised and responded quickly and comprehensively.

At the time of our inspection no one was receiving end of life care. The manager described the way they had provided this support to people. End of life care was discussed with people and their relatives to ensure their wishes were respected and when people were receiving end of life care this was reviewed as often as necessary to ensure that their needs were met with compassion. Some staff had received training to support people at the end of their lives and the manager explained that they had good connections with relevant professionals.

Good

Is the service well-led?

Our findings

Willow Tree (Bournemouth) had been going through an unsettled period at the time of our inspection. These previous registered manager had left their post in January 2018 and some staff had followed them. This had meant it was not possible to ensure all care packages could be covered. The manager in post had started their application to register with the Care Quality Commission. Since their appointment they had been working in partnership with other agencies to ensure that Willow Tree (Bournemouth) could meet expectations and provide a reliable and quality service. At the time of our inspection they had a robust plan in place and were working to deliver this plan with the whole team. The provider understood the challenges facing the service and allocated funding for a full time recruiter during our inspection.

The manager spoke highly of the staff team and told us they were all motivated to do the best for people. They demonstrated that they were introducing more senior roles to reflect the skills in the team and to ensure newer staff received appropriate and timely support. The care staff also spoke highly of each other. One member of staff said: "All the other carers are kind and helpful." They were confident that their colleagues had people's best interests at heart. Staff spoke with pride about their own work and with respect for the rest of the team in ensuring good outcomes for people.

Staff all commented on the availability of the manager who was new in post and felt confident they could come into the office or call with any concerns. One staff member told us: "The managers are quick to get issues resolved they are doing their best." Another member of staff described the manager as being "very approachable", they "listen and act on what I have said".

The registered provider had a quality assurance process that included regular visits to the service. These had not been effective in highlighting issues that had become clear about recording and monitoring concerns at the location. We spoke with the regional manager about this and they acknowledged that they had not checked on any information provided by the location. For example they had identified that training was not recorded appropriately in 2017 and had understood that this had been rectified. They had not checked that this was the case and it had not been done. We also found that some concerns of staff had not been picked up by the provider during this same time frame. They had reviewed their processes and explained that as of April 2018 they were undertaking sampling when they visited locations. This meant that if a manager was struggling or was not providing accurate data this would be picked up in a timely manner.

The manager and senior staff also undertook audits. These had been effective in improving the quality of the service people received. For example, medicine timing errors had been identified and a new training, recording and monitoring system was being implemented. Where training or awareness issues were identified by audits there was a clear follow up with individual staff or the team as a whole as appropriate. Feedback from staff was also used to inform improvements and we were reassured that all deployment issues raised during our inspection were being addressed.
People's feedback was gathered and action plans developed from the results. The manager had visited 45 people since taking up their post and they used the information gathered informally alongside information from quality calls and concerns and complaints to inform their action plan for the service. The manager was

also aware of the individual needs of members of staff, including needs protected by the Equalities Act, and this had informed development plans and actions already taken. Team meeting minutes reflected that staff were involved in discussions about how to improve the service and staff told us that this was the case. One member of staff described how their personal circumstances had been respected in relation to how they contributed to team discussion. They told us: "I feel listened to. Concerns have been listened to."

The provider organisation understood their legal responsibilities and the registered persons had ensured relevant legal requirements, including registration and safety related obligations had been complied with. Learning was shared across the provider organisation. For example the provider was trialling an electronic care planning and recording system and there were plans to start using this system in Bournemouth. This meant that problems with the system would be addressed before it was introduced across the whole provider as a staged rollout.

The management was responsive to the input of other professionals. We saw that they were liaising with other professionals and the manager responded appropriately to concerns identified during our inspection. One professional told us: "The manager and deputy manager have listened to suggestions I have made and are very responsive to any concerns. They listen and act which is very important, especially in these changing times." Another social care professional said the manager was "professional, honest, listened and accepted issues which occurred prior to them starting, however they acted swiftly and took action."

The manager had the skills necessary to prioritise tasks and deal with them in a comprehensive and sensitive way when under pressure. A member of staff who had responsibility for scheduling visits had left the service without notice when we arrived to complete the inspection. The manager and deputy ensured that calls were covered and liaised with people considerately whilst ensuring the inspection could proceed. This approach was leading to improvements. For example a member of staff told us: "I have a regular run now. It is better for the service users. They find it a lot better."

Records were stored tidily and securely and there were systems in place to ensure data security breaches were minimised. Staff had log-ons to access computer based records and records were locked away when not in use. Some records had not been brought into the office from people's homes. The registered manager acknowledged this and arranged to have them collected. They explained how the new system of auditing that was being introduced would ensure this did not happen.