Mears Care Limited

Mears Care Brighton and Hove

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 March 2018 and was announced. This was the first inspection since the service was re-registered following a change in location.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, and younger disabled adults in the Brighton and Hove area. Care was provided predominantly to older people, including people with a physical disability, learning disability, sensory loss, mental health problems or people living with dementia. At the time of our inspection around 81 people were receiving a service of which 58 were receiving the regulated activity of personal care.

The service had a registered manager, who was present for the 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.

Staff told us there had been a significant period of change in the management arrangements and personnel working in the office and of care staff. The registered manager is also the registered manager for another of the provider's services and split their time between both these services offices. However, both services were now located in the same building. Feedback from all staff was this had worked well, they were clear of the management arrangements, the registered manager was accessible and contactable if needed. Systems had been put in place to monitor and review the quality of the care provided.

Staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation. Where people were unable to make decisions for themselves, staff had considered the person's capacity under the Mental Capacity Act 2005 (MCA), and had taken appropriate action to arrange meetings to make a decision within their best interests. People and a relative told us consent was always sought before any care or support was provided. One person told us, "Yes, they check with me before doing things." Another person told us, "We have the same carers for so long that they know how we like things done and they do it that way, but nothing formal." Staff had a good understanding of equality, diversity and human rights.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with dementia. Staff had received both supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

People told us they felt safe with the care and support provided. One person told us, "Yes, perfectly safe," Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Risks associated with the environment and equipment had been

identified and managed.
People told us their care was provided by kind and caring staff. People's comments included, "They are generally lovely, very kind," and "Absolutely, very kind and affable." They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Where required, care staff supported people to eat and drink and maintain a healthy diet. People were supported with their healthcare needs. Medicines were managed safely and people received the support they required from staff.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Care staff had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely.

People were cared for by staff who had been recruited through safe procedures. There were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good

The service was effective.

There was an induction and training plan in place. Care staff had received regular supervision and appraisal.

Care staff had an understanding around obtaining consent from people, and had attended training on the Mental Capacity Act 2005 (MCA).

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed.

Is the service caring?

Good

The service was caring. .

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People told us that they knew how to make a complaint if they were unhappy with the service.

Is the service well-led?

Good

The service was well-led.

There was a registered manager for the service. The leadership and management promoted a caring and inclusive culture.

Systems were in place to audit and quality assure the care provided. Staff had a good understanding of equality, diversity and human rights.

Processes were in place to gain feedback from staff and people.

Mears Care Brighton and Hove

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 13 March 2018 and was announced. We told the provider two days before our inspection that we would be coming. This was because we wanted to make sure that the registered manager and other appropriate staff were available to speak with us on the day of our inspection. An inspector and an inspection manager undertook the inspection, with an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience helped us with the telephone calls to get feedback from people who used the service and their relatives.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law and any concerns we have received. We contacted the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people. We also contacted four health and social care professionals, and received one response. We spoke with nine people and one relative who used the service.

During the inspection we went to the services office and spoke with the registered manager, a visiting officer, a care coordinator, a senior care worker, and three care staff. We spent time reviewing the records of the service, including policies and procedures, five people's care and support plans, the personnel records for five care staff, complaints and compliments recording, accident/incident and safeguarding recording, and

staff rotas. We also looked at the provider's quality assurance audits.

This was the first inspection since a change in location for the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe with the care provided by staff in the service. People's comments received included, "Yes, they are very careful and take things slowly, " and "Yes, they are very safety conscious."

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them, and protect people from harm. Each person's care and support plan had an assessment of the environmental risks and any risks due to the health and support needs of the person, and these had been discussed with them. The assessments detailed what the activity was and the associated risk, and guidance for staff to take to minimise the risk. For example, where people needed help to move, there was clear guidance for staff to ensure this was done safely. Care staff were able to confirm with us they had received training, had detailed guidance in place, and of procedures they were to follow. They told us that the care and support plans and risk assessments reflected the care that was being provided. Senior staff were able to confirm the process of reviewing the risk assessments and the registered manager was monitoring their completion.

There were sufficient numbers of care staff available to keep people safe and meet their care and support needs. When considering new packages of care the registered manager took into consideration the number of hours and staffing available. People told us they now usually got their visit from regular care staff. Care staff told us they usually provided care and support to the same people. Agency staff had not been used to cover care calls. Senior staff showed us how care calls were rostered. They told us, calls were never missed as they were always able to cover any staff absences by allocating other care staff in the team to cover care calls. They showed us the system used highlighted individuals preferences to be considered, such as if a person had specifically requested a male or female member of staff to provide their care. People felt that care staff had sufficient time to deliver their care and stayed the allocated time with them. People's responses as to the timing of their care calls included, "They arrive at all sorts of times, the visit is meant to be 12.00 pm, but they have been as early as 09.30 am, although 10.30 am is more usual. They do provide my care in the time," "The timekeeping is the worst bit, they are very varied and as they help with meals this is a problem," "Timekeeping is a bit variable but it doesn't bother me," "I know what time my regular carer comes but otherwise I really don't know: she is fantastic, sometimes one hour morning visit takes a bit longer and sometimes she logs out for the hour and then stays and finishes off," "Within a reasonable time," and "It is a bit variable, but the morning visit is early and on time which my wife likes." We discussed this with senior staff who acknowledged this was an area in need of improvement. However they were aware of people's concerns and were able to show us how they had worked hard to address this and improve on the timings of the care calls.

Medicines policies and procedures were in place for staff to follow and there were systems to manage medicine safely. Care staff told us they had received medication training to ensure they were following the required policy and procedures and regular checks on their competency to administer medicines. One member of staff told us, "We check the packaging for the name and the date. Count the pills as well. You need to make sure every step is right. They (The senior staff) check you are doing things right." An audit system was in place to check medicines administration and recording had been completed each month. We

looked at a sample of the recording of medicines and staff told us how this had worked and been used to highlight and address with staff where any errors in recording had been identified. The majority of people we spoke with managed their own medicines. For one person who was supported with their medicines, they told us they had been happy with the care provided, "I lay them out in the morning and the morning carer gives them, then I do the rest of the day." Another member of staff told us, "If I get stuck I ring the office."

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen in line with registration requirements, and therefore we could monitor that appropriate action had been taken to safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse. There were procedures in place to help protect people from financial abuse. Where people had support with their shopping they told us this had worked well. People's comments received included, "They do help with shopping and always give me the receipts and write it down," "Carers do my shopping once a week and they always bring back receipts and enter it in the book," and "I have a domestic day and she does my shopping then, always very careful with the receipts and change and so on" If my regular carer does it all is well."

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example, where abuse was suspected. Care staff all demonstrated knowledge of the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Procedures were in place for staff to respond to emergencies. Care staff had guidance to follow in their handbooks and demonstrated they were aware of the procedures to follow. For example, care staff were able to describe the procedures they should follow if they could not gain access to a pre-arranged care call. The care staff told us they would report this to the office straight away and enable senior staff to quickly locate the person and ensure they were safe. There was an on call service available, so care staff had access to information and guidance at all times when they were working. This was run by senior staff in the service who were able to demonstrate how this was run and managed. Care staff were aware of how to access this should they need to. There were policies and procedures which care staff were aware of to support them when lone working. Any incidents and accidents were recorded and the registered manager told us they kept an overview of these, and the provider was also informed and also kept an overview of these to monitor any patterns and the quality of the care provided and provide guidance and support where needed.

People were protected by the prevention of infection control. Staff had attended regular training in this area. PPE (Personal protective equipment) was used when required including aprons and gloves. The provider had detailed policies and procedures in infection control and staff received copies of these in their staff handbooks on induction.

The registered manager told us of the difficulties which had been experienced in trying to recruit new care staff, and of ongoing recruitment to try to address this. They told us they were actively trying to recruit new staff and were only taking on new work if they had the care staff to cover the care calls. Staff they felt there were enough staff to meet the needs of people they were currently providing care to. Comprehensive

recruitment practices were followed for the employment of new care staff. . We looked at the recruitment records for five care staff recruited, and we checked these held the required documentation. New care staff had been through a recruitment process, written references had been sought, and criminal records check had been carried out by the provider to ensure that potential new care staff had no record of offences that could affect their suitability to protect adults. One new member of staff was able to confirm this practice had been followed.

Good

Is the service effective?

Our findings

People told us staff understood their care needs, and provided a good level of care. Comments from people and a relative included," Very much so, we have had a regular carer for the last fourteen years and she and my wife know each other well, they are always chatting," "They know what is needed, we have regulars and that helps," and "I mostly have regulars and they know my needs as well as I do." Care staff told us they always asked for peoples consent before assisting with any support.

Staff demonstrated an understanding of and there were clear policies around the Mental Capacity Act 2005 (MCA.) The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Staff told us they had this training. They all had a good understanding of consent, and where people lacked the capacity to make decisions about their care and welfare. People and a relative told us care staff asked for their consent before any care was given. Their comments included,"I ask them to do things so they don't have to ask as well, they are completely non-intrusive, they never go into a cupboard or the fridge or something unless I have asked them to," "Well they chat as they go along and I am sure my wife's consent is given," and "We manage between us so that consent is given by my actions."

People were supported by care staff who had the knowledge and skills to carry out their roles. The registered manager told us all care staff completed organisation's five day induction. This was confirmed in the sample of recording we looked at. The induction had been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of 'shadowing' a more experienced staff member, before new care staff started to undertake care calls on their own. The length of time new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. Feedback from care staff was that the induction had been good and informative. One member of staff told us, "I learnt a lot." Another member of staff told us their induction was "Informative."

Staff received training to ensure they had the knowledge and skills to meet the care needs of people. Care staff received training that was specific to the needs of people, which included moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, catheter care, dementia care and infection control. Where people had specific care needs, for example moving and handling, using a hoist or where people were living with dementia training had been provided. Care staff told us they were up-to-date with their training, they had received regular training updates and there was good access to training. One member of staff told us, "Our training is pretty good. I will go to anyone for help and information." Another member of staff told us, "It's good when they refresh the training, as there are

new ways of doing things. There are new bits coming in all the time." Staff were being supported to complete a professional qualification and training records we looked at confirmed this. Staff told us they had received supervision and appraisal and the records we looked at confirmed this. Care staff told us they had been able to complete National Vocational Qualifications (NVQ) or Qualifications Credit Framework (QCF) in health and social care. They were kept up-to-date with people's care needs and were informed when they needed to complete refresher training.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and understood. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected.

Where required, care staff supported people to eat and drink and maintain a healthy diet. People were supported at mealtimes to access food and drink of their choice. One person told us, "Carers help and with microwavable meals it isn't too difficult. I can get my porridge in the morning and a sandwich in the evening." Another person told us, "I don't like breakfast, I get a cup of tea and a milkshake and I am grateful for it. They make lunch and supper and it is fine." A third person said, "I can't manage breakfast I am too lightheaded. The carers make my lunch and sometimes go to the chippy if I ask. In the evening I can make myself a sandwich. I told the office at one point that the carers would not go to the chippy and the manager said that the plan says they make me a salad, but I don't always want salad. They do go to the chippy at the moment." Care plans provided information about people's food and nutrition needs. If people had been identified as losing weight, care staff told us there were food and fluid charts they could use, and these were completed to monitor people's intake.

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. Care staff understood the importance of monitoring people's health and wellbeing. Care staff commented how on a daily basis they monitored people and reported any changes or concerns regarding people's health.

Good

Is the service caring?

Our findings

People and a relative told us they were treated with kindness and compassion with their day-to-day care. They were happy and liked the staff. People's comments included, "Couldn't be kinder," "Very kind and caring," and "They are absolutely lovely and they tell me off if they think I am not doing things wrong." A member of staff told us, "I enjoy it. I like being with people who need it. It's nice to give something back. It gives them independence."

People were matched with care staff with whom they were compatible with. Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understanding of the importance of respecting people's privacy and dignity. People told us they felt the care staff treated them with dignity and respect. People's comments included," I can only have a strip wash at the moment because the shower is not working, and they always make sure I am as covered as possible and curtains drawn," "They talk to us nicely and make sure we are not exposed when washing and dressing," and "They do their absolute best and keep me covered when possible. " Care staff had received training on privacy and dignity and had a good understanding of how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they treated them with respect. One member of staff told us, "I would ask them if they want me to provide the care. One gentleman always covers himself up. I talk with them about what is happening."

People and a relative told us they were happy with the arrangements of their care package. They told us their care and support was provided in the way they wanted it to be. They had been involved in drawing up their care plan and with any reviews that had taken place. They felt the care and support they received helped them retain their independence. For older people, independence is about exercising choice and control. People confirmed they felt care staff enabled them to have choice and control whilst promoting their independence. Care staff demonstrated they were knowledgeable about the people they supported. Preferred times to get up with support needed was documented. Care staff told us how they knew the individual needs of the person they were supporting. They told us they looked at people's care and support plans and these contained information about people's care and support needs, including their personal life histories.

Care records were stored securely at the service's office. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all care staff and was also included in the staff handbook. People received information around confidentiality as well. Staff were aware of the importance of maintaining confidentiality and could give examples of how they did this.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the information guide given to people. The registered manager was aware of who they could contact if people needed this support.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns.

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their relatives and staff. The care and support plans were detailed and contained clear instructions about the care and support needs of the individual and the outcomes to be achieved. Individual risk assessments had been completed. Care staff told us that people's care and support plans were up-to-date and gave them the information they needed. They knew people well and had a good understanding of their, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. They could describe to us care and support provided to people with a range of care and support needs. Care and support plans were in the process of being reviewed, but if there were any changes to people's care and support needs care staff would ask for the information to be updated. They also received messages and updates on their work telephones. They told us this worked well and was informative.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Staff ensured that the communication needs of people who required it were assessed and met. For care staff told us how a writing board was used for a person and staff understood the best way to communicate with people. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these.

Technology was used to support people to receive timely care and support. The provider used a system of telephone monitoring. This system required care staff to log in and out of their visits when they arrived and left. This system created information to reflect the time taken with each person and the time to travel in between visits. The registered manager told us that the telephone monitoring system was used by themselves and commissioners of their service to provided information on calls completed, times and where changes to rotas and travel time were required. The information was accessible live through a television screen in the service's office. Senior staff told us how they could use this information to continually monitor and chase up call times. This had also ensured that care calls were not missed. Care staff had also been provided with telephones which they used to log in and out of care calls, and messages and updates could be received. This was to improve call times and enable people to be made aware when staff were running late.

No one was receiving end of life care at the time of the inspection. However, senior staff were able to tell us how peoples' end of life care was discussed and planned and their wishes had been respected. People were able to remain at the service and were supported until the end of their lives. Senior staff were aware of where they could get additional support and guidance if needed to support their care staff in providing this care.

People and their relatives were asked to give their feedback on the care provided through spot checks, reviews of the care provided and through quality assurance questionnaires which were sent out annually.

Where people had concerns they were made aware of how to access the complaints procedure and this was available in the information guide given to people. The complaints policy gave information to people on how to make a complaint, and how this would be responded to. The policy set out the timescales that the representatives of the service would respond in, as well as contact details for outside agencies that people could contact if they were unhappy with the response. The information provided to people encouraged them to raise any concerns that they may have. People told us that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. No formal complaints had been received in the service since the re-registration. However, procedures were in place should a complaint be received and the provider would be informed and monitor any concerns received.

Good

Is the service well-led?

Our findings

The senior staff promoted an open and inclusive culture. People and their relatives were asked for their views about the service and commented they felt heard and respected. Staff acknowledged there had been a period with staff changes when some of the practices required had fallen behind. However, they all spoke positively about the new management team and of the work which had already been completed to address issues highlighted, and told us there had been improvements to the management of the service. People and a relative told us they received a good response from office staff. People's comments included, "They always have the information and they do listen," "They answer their phones," "We only call them if no one has come and they tell us what is happening," and "They give me the information when I call."

There was a management structure with identified leadership roles. This had been changed and the registered manager was now supported by a part-time visiting-officer, a part time co-ordinator, who also worked as care staff for the other half of their role and so knew people well and a senior care worker. Care staff told us they felt the service was well led and that they were well supported. Care staff told us this structure worked well. They had been asked for feedback about the service through supervision, staff meetings and a staff questionnaire. Staff told us this arrangement was working well. The registered manager was accessible when needed. They had felt supported, the registered manager was accessible and the communication was good. A member of staff told us, "We have now got a good team and we gel."

People's responses were varied when asked if the service was well led, and comments included, "They are very good people trying to do a difficult job, but they could improve a bit," "They went through a bad patch, then got better and now they have slid downhill again," and "They need to improve the system of rostering, I could show them a thing or two." A lot of the feedback we received related to the lack of the receipt of a staff rota and people being unhappy at not knowing which member of staff was providing their care and when. The registered manager acknowledged they were aware this was an area people were concerned about. They told us this had been due to staff changes in the office. However, senior staff where were able to tell us of the plans and work already in place to address this.

Formal systems of quality assurance to monitor the standard of the service provided were in place. For example, the medication administration records (MAR) and financial transaction records were checked for errors. People had been asked to completing quality assurance questionnaires had enabled people to comment on the care provided. The feedback from this had been collated and used to inform the development of the service.

Policies and procedures were in place for staff to follow. Senior staff were able to show us how they had sourced current information and good practice guidance, which had been used to inform the regular updates of the services policies and procedures.

The vision and values for the service was recorded for people to read, and discussed with new care staff in their induction. The aim was, 'To respect our customers' privacy, dignity and lifestyle in the way we work with them. Our care will be provided in the least intrusive way possible. We will treat the service user and

everyone connected with them with courtesy at all times. Our workers are sensitive and responsive to race, culture, religion, disability, gender and sexuality and that of the service users family and representatives. Our ethos is to carry out tasks with the customer rather than for them wherever possible, to help maintain independence and autonomy.' Staff demonstrated an understanding of the vision and values of the service, the importance of people's rights and individuality, and an understood the importance of respecting people's privacy and dignity. All the feedback from people and care staff was that they felt comfortable raising issues and providing comments on the care provided in the service.

The registered manager had regular support from a senior manager, and completed monitoring reports, which was then used to inform the provider and enable them to monitor the care provided. The registered manager also met regularly with other registered managers within the organisation. They told us this was an opportunity for the registered managers to be updated and share information, for example, changes to the provider's policies and procedures. They had then been able to bring this information back and discuss with care staff any changes to be made in their work.

The registered manager and staff worked closely with health professionals such as the local GP's and health specialists when required. Senior staff told us they worked very closely with all professionals they were in contact with, to ensure people received the correct care and treatment required. The registered manager had kept up to date with best practice and updates in health and social care. They were also aware of the CQC's revised Key Lines of Enquiries that were introduced from the 1st November 2017 and used to inform the inspection process. They understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. We discussed this with the registered manager during the inspection, who demonstrated an understanding of their responsibilities.