Lancashire County Council

Woodhill House Home for Older People

Inspection report

60 Woodhill Lane
Morecambe
Lancashire
LA4 4NN

Tel: 01524423588
Website: www.lancashire.gov.uk

Date of inspection visit:
29 February 2016

Date of publication:
15 April 2016

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

The inspection visit at Woodhill House Home for Older People was undertaken on the 29 February 2016 and was unannounced.

Woodhill House Home for Older People is a two story building located in a quiet residential area of Morecambe. At the time of our inspection visit there were 42 people who lived at the home. People who live at Woodhill House Home for Older People are older people who may be living with dementia. It is a local authority residential home and is currently divided into three areas or suites. One of the suites is residential, providing care for people who have no mental health needs. The other two suites support people that require personal care and mental health support.

The service had a registered manager in place. 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.

At the last inspection on 24 October 2013, we found the provider was meeting the requirements of the regulations that were inspected.

During this inspection, staff had received abuse training and understood their responsibilities to report any unsafe care or abusive practices related to the safeguarding of vulnerable adults. Staff we spoke with told us they were aware of the safeguarding procedure.

The provider had recruitment and selection procedures in place to minimise the risk of inappropriate employees working with vulnerable people. Checks had been completed prior to any staff commencing work at the service. This was confirmed from discussions with staff.

We found staffing levels were suitable with an appropriate skill mix to meet the needs of people who used the service.

Staff responsible for assisting people with their medicines were trained to ensure they were competent and had the skills required. Medicines were safely kept and appropriate arrangements for storing medicines were in place.

Staff received training related to their role and were knowledgeable about their responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

People and their representatives told us they were involved in their care and had discussed and consented to their care. We found staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Comments we received demonstrated people were satisfied with their care . The registered manager and staff were clear about their roles and responsibilities. They were committed to providing a good standard of care and support to people who lived at the home.

A complaints procedure was available and people we spoke with said they knew how to complain. Staff spoken with felt the registered manager was accessible, supportive and approachable and would listen and act on concerns raised.

The registered manager had sought feedback from people who lived at the home and staff. They had formally consulted with people they supported and their relatives for input on how the service could continually improve. The registered manager had regularly completed a range of audits to maintain people's safety and welfare.

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.

Staff had been trained in safeguarding and were knowledgeable about abuse and the ways to recognise and report it.

Risks to people were managed by staff, who were aware of the assessments in place to reduce potential harm to people.

There were enough staff available to safely meet people's needs, wants and wishes. Recruitment procedures the service had in place were safe.

Medicines were managed in a safe manner.

Is the service effective?

Good

The service was effective.

Staff had the appropriate training to meet people's needs.

There was regular meetings between individual staff and the management team to review their role and responsibilities.

The registered manager was aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS). They had knowledge of the process to follow.

People were protected against the risks of dehydration and malnutrition.

Is the service caring?

Good

The service was caring.

People who lived at the home told us they were treated with kindness and compassion in their day to day care.

Staff had developed positive caring relationships and spoke about those they cared for in a warm, compassionate manner.

People were involved in making decisions about their care and the support they received.

End of life care was valued as part of a person's care plan.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs, likes and dislikes.

The provider was committed to providing a flexible service which responded to people's changing needs, lifestyle choices and appointments.

The provider delivered activities to stimulate and maintain people's social health.

People told us they knew how to make a complaint and felt confident any issues they raised would be dealt with.

Is the service well-led?

Good

The service was well-led.

The registered manager had in place clear lines of responsibility and accountability.

The registered manager had a visible presence throughout the service. People and staff felt the registered manager was supportive and approachable.

The management team had oversight of and acted to maintain the quality of the service provided.

The provider had sought feedback from people receiving support, relatives and staff.

Woodhill House Home for Older People

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.

The inspection was carried out by an adult social care inspector, a specialist advisor who focused on medicines management and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who took part in this inspection had experience of dementia care.

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. The registered manager stated they planned to arrange an open day to promote the service. Other planned actions included all staff, new and long-term would undergo care certificate for health and social care professionals training.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events which the provider is required to send us. We spoke with the local authority to gain their feedback about the care people received. This helped us to gain a balanced overview of what people experienced accessing the service. At the time of our inspection there were no safeguarding concerns being investigated by the local authority.

Not everyone was able to verbally share with us their experiences of life at the home. We therefore 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 observed how staff interacted with people who

lived at the home. We observed how people were supported during meal times and during individual tasks and activities.

We spoke with a range of people about this service. They included two members of the management team, five staff, seven people who lived at the home and two relatives. We checked documents in relation to seven people who lived at Woodhill House and six staff files. We reviewed records about staff training and support, as well as those related to the management and safety of the home.

Good

Is the service safe?

Our findings

People we spoke with told us they felt comfortable and safe when supported with their care. Observations made during the inspection visit showed they were comfortable in the company of staff supporting them. One person who lived in the home told us, "I feel quite safe." Individuals visiting the service told us they had no concerns about their relative's safety. We were told by one relative, "They are totally safe."

During the inspection, we undertook a tour of the home. We found the home to be clean, tidy and well-maintained. We observed staff made appropriate use of personal protective equipment, for example, wearing gloves when necessary.

The water temperature was checked from taps in six bedrooms, two bathrooms and four toilets and we found all were thermostatically controlled. This meant the taps delivered water at a safe temperature and minimised the risk of scalding. Window restrictors were present and operational in the six bedrooms, two lounges, two bathrooms and four toilets checked. Window restrictors are fitted to limit window openings in order to protect people who can be vulnerable from falling.

We spoke with the registered manager on how they managed accidents and incidents. They showed us their falls protocol which included a 24 hour to 48 hour observation log. We saw documentary evidence that investigations had taken place regarding accidents. For example one person had tests to see if there were underlying medical problems for their falls. Sensor mats had been introduced to minimise risk by alerting staff that the person may need support. Documents we looked at showed audits of accidents and incidents on a monthly and six monthly basis. This showed us the registered manager had systems in place to manage and review accidents and incidents.

There was an up to date fire plan and weekly testing of smoke alarms. This showed the provider had systems in place to minimise risk and protect people in the event of an emergency.

We found call bells were positioned in bedrooms close to hand allowing for people to summon help when they needed to. Throughout our inspection we tested and observed the system and found staff responded to the call bells in a timely manner.

The registered manager had procedures in place to minimise the potential risk of abuse or unsafe care. Records seen confirmed the registered manager and staff had received safeguarding of vulnerable adults training. There were procedures in place to enable staff to raise an alert. Staff demonstrated a good understanding of safeguarding people from abuse, how to raise an alert and to whom. Care staff told us they would raise an alert if they had any concerns about inappropriate practice or conduct. Training records we reviewed showed staff had received related information to underpin their knowledge and understanding.

A recruitment and induction process was in place that ensured staff had the relevant skills to support people. We found the provider had followed safe practices in relation to the recruitment of new staff. We looked at six staff files and noted they contained relevant information. This included a Disclosure and

Barring Service (DBS) check and appropriate references to minimise the risks to people from unsafe recruitment of potential employees. The DBS check helped employers make safer recruitment decisions and prevent unsuitable staff from working with vulnerable people. The registered manager checked any gaps in employment during the interview process.

We looked at staffing levels, observed care practices and spoke with people being supported with their care. We found staffing levels were suitable with an appropriate skill mix to meet the needs of people who lived at the home. We saw the deployment of staff throughout the day was organised. Staff were deployed to a specific area or suite within the home and worked regularly within the allocated area. This showed the provider had systems in place to allow people to get to know staff and for staff to get to know people's skills and abilities. For example we observed one person who had a history of falls being supported into the dining room. They used a walking frame and had a staff escort. This showed the provider supported positive risk taking and balanced a person's right to independence alongside keeping people safe.

We looked at how medicines were dispensed and administered. Medicines were stored securely in a locked trolley which when not in use was stored in a locked cupboard. Each person had their picture on the front of their medicine administration recording form (MAR). The MAR contained people's photographs, descriptions of their individual medicine and any known allergies. We observed staff administering medicines at Woodhill House. This was done as the MAR instructions directed. Staff who administered the medicines received training and annual competency checks by a member of the management team. Documentation looked at indicated competency checks had taken place. The annual checks consisted of questions about the medicines and a medicine administration observation. One person who lived at the home told us, "They bring all the medicines to me – they tell me what they are and what they are for."

We observed consent was gained from each person before having their medicine administered. The MAR was then signed. Eye drops were correctly stored on the trolley and not in the fridge. This ensured the drops were administered at room temperature and were not painful to the person. Medicine audit forms were seen and checked as correct. Controlled Drugs were stored correctly in line with The National Institute for Health and Care Excellence (NICE) national guidance. The controlled drugs book was kept in the office, it had no missed signatures and the drug totals were correct. This showed the provider had systems in place to protect people from the unsafe storage and administration of medicines.

On the day of our inspection there was an occurrence of a gastric infection throughout the home. The provider had put in place strategies to control and manage the infection seeking to prevent further contamination. For example travel between suites for people was minimised. There were signs on the doors informing people entering the building of the infection. We saw a spreadsheet documenting people with the infection and what medical support had taken place.

Good

Is the service effective?

Our findings

People we spoke with were complimentary about the care within the home. One person said, "The staff are good, they know what they are doing." A second person told us, "I am exceptionally well looked after. They're marvellous. I haven't got a worry." A third person told us, "At home, everything was a bother. I love it here. They really care for me." A relative told us, "[Member of the management team] is a lovely woman who knows her job."

To ensure they delivered effective care the management team assessed each person's needs before they came to live at Woodhill House. This ensured the placement would meet their needs and reduce the risk of a failed placement.

There was a structured induction process in place. New staff had a period of shadowing more experienced staff until they were competent in their role. One care staff member told us, "It was good to be told what to do. I didn't fall into bad practices. I got shown how to do things the right way." Another staff member told us, "I was paired with a member of staff, shadowing. I was not left on my own." They further commented, "They [the management team] give you a competency checklist you have to complete when you are new. Then you can work on your own."

We spoke with staff members, looked at individual training records and the service's training matrix. We saw the registered manager had identified what training was required for staff. They had identified mandatory and refresher training and had forecast dates for the forthcoming year. Staff we spoke with told us the training they received was provided at a good level. One staff member said, "I've done loads of training since being here." A second staff member told us, "There is always a different training course to attend. I enjoy it." This showed us new and experienced staff were trained to be effective in their role.

The registered manager told us about their 'me and my mum campaign.' Care staff and people being cared for swapped roles. Care staff wore goggles which impaired their vision or headphones that impaired their hearing. We were told it gave staff an insight into what it was like to be supported. The Management team ensured there was a mix of staff skills and experience on each shift with staff working on specific suites within the home. This allowed staff to get to know people they were supporting and people got to know staff. People received effective care because they were supported by trained staff who had a good understanding of their needs.

Staff we spoke to told us they had regular supervision meetings with their manager. One staff member told us, "We have supervision all the time. It is an opportunity for me to voice any concerns. Usually I have no concerns." Supervision was a one-to-one support meeting between staff and a senior staff member to review training needs, role and responsibilities. Staff meetings looked at changing working practices within the home.

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. The application 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.

The registered manager demonstrated an understanding of the legislation as laid down by the MCA and the associated DoLS. The manager was aware of the changes in DoLS practices and had policies and procedures regarding the MCA 2005 and DoLS. The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive someone of their liberty. Discussion with the registered manager confirmed she understood when and how to submit a DoLS application.

The registered manager told us all but one person who lived at Woodhill House had a DoLS in place to deprive them of their liberty in order to safeguard them. Care records had mental capacity assessments and best interest decisions. There was a signed consent to care and treatment form in all the care records we looked at during our inspection. Staff demonstrated an awareness about the MCA and DoLS and how it effected their work practices. For example one staff member said, "People have got to have choice. We have to put people's beliefs thoughts and wishes first." A second staff member told us, "Every day we always give choice, we show options. We show options to simplify the choice making for people." A third staff member commented, "People have got to have choices, we can't just take over someone's decision."

On the day of inspection we observed lunchtime. A choice of foods was offered. The food was appetising and plentiful and staff explained to each person what was on their plate. People came in and left in their own time and chose where they sat. One person ate their soup and then asked if they could move to sit with their friend at a different table. They were told, "of course". Staff were aware of individual likes and dislikes of people who lived at the home. For example they knew one person would not like soup and they were offered sandwiches, crisps and salad. Furthermore, went and got plain crisps as they knew this was what they preferred.

We discussed the quality and quantity of meals with people who lived at the home. One person told us, "I get nice food and I can have as much as I want." Another person stated, "The food is quite nice really. I have to have my cake." Drinks were offered throughout the day. Teas, coffees and juice drinks were available with meals and in between times. We observed staff encouraged people to drink fluids during the day. One staff member told us, "The drinks are constant. We don't have set times, people can help themselves or get us." This showed people were protected against the risks of dehydration and malnutrition.

When we visited the kitchen we were asked to wear a white kitchen coat for our protection and to comply with infection prevention. We found the kitchen clean and hygienic. Cleaning schedules were in place that ensured people were protected against the risks of poor food safety. The chef had knowledge of special diets, who required fortified drinks and preferences of people who lived at the home. The provider and chef had knowledge of the food standards agency regulations on food labelling. This showed the provider had kept up to date on legislation on how to make safer choices when purchasing food for people with allergies. The provider had achieved a food hygiene rating of five. This was advertised in the porch at the front of the building. Services are given their hygiene rating when it is inspected by a food safety officer. The top rating of five meant the home was found to have very good hygiene standards.

People's healthcare needs were carefully monitored and discussed with the person as part of the care planning process. Care records seen confirmed visits to and from general practitioners and other healthcare professionals had been recorded. During our inspection two health care professionals visited the home to manage ongoing treatments. We noted one person was supported to an health appointment during our inspection. We were told the physiotherapist and chiropodist visited people regularly and visits to or from dentists and opticians were arranged. Records we looked at were informative and had documented the reason for the visit and the outcome. One staff member told us, "As soon as you notice a mark the doctor is called. Concerns are taken up quickly." A second staff member said, "We know people as an individual, we know when things are not right. The doctor comes and then we write it in the care plan." This confirmed good communication protocols were in place with health professionals for people to receive continuity with their healthcare needs.

Good

Is the service caring?

Our findings

As part of our observation process [SOFI], we witnessed good interactions and communication between staff and people who lived at the home. Relationships between people and staff were open and friendly. Staff were knowledgeable on people's past histories and present likes and dislikes. One person told us about staff, "They're very nice here." One relative told us, "I cannot praise them enough. They do special things they don't have to. They get excited about doing special things." Another relative stated, "I think the staff are wonderful. That was the reason we chose the place originally and we haven't been disappointed."

When we looked in people's bedrooms we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy which demonstrated staff respected people's belongings. A small clear reminiscence box was on the wall outside each bedroom. Within the box were items relevant and personal to the person. For example we saw knitting needles, old photographs and family photographs. This showed the provider had knowledge of peoples' histories and likes and used the information to enhance their environment.

Whilst walking around the home we observed staff members undertaking their duties. We noted they knocked on people's doors and waited for a response before entering. We spoke with people who were in their rooms and asked if staff respected their privacy. People we spoke with felt staff were very good at knocking on doors and waiting to enter. There was a phrase on display at Woodhill House 'Our residents do not live in our workplace. We work in their home.' This showed the registered manager had promoted a positive culture of respect for a person's home and their belongings.

We noted when in conversation with people who lived at the home staff listened and responded appropriately. For example staff bent down or crouched next to the person so both people could make eye contact. There was positive interaction between the person and the staff member.This showed us they were engaged by the person and it was not an automatic response.

The garden at Woodhill House had a memorial section. Once a year the provider had a memorial day for people to remember friends and family who had passed away. The local minister attended as did families of people who had passed away. The registered manager had held a dignity day and shared people's views on what dignity meant to them. For example, for one person dignity to them was 'having my jewellery on'. For a second person it was 'being listened to' and for a third person it was 'having space'. The provider had also gathered people's memories and had an 'our memories' board at the home. For example one person's childhood memory was 'getting a new coat for Christmas'. There was a 'My Wedding Day' display which featured photos from people on their wedding days as well as those of staff. The photos and information were presented as 'us' rather than 'us and them'. The provider had spent time with people and encouraged them to be individuals. Their personalities and past lives were acknowledged respected and reminiscence encouraged.

Relatives we spoke with told us they were made to feel welcome when they visited. One person told us, "My visitors can come when they like and they give them a drink." A relative commented, "They know us as a

family. They enabled us to have a family do." They further explained on their relative's birthday there were 21 family members of different generations who wanted to visit together. The staff arranged for them to use the large lounge and provided food. This showed the provider valued and promoted positive relationships for people who lived at Woodhill House.

We spoke with the registered manager about access to advocacy services should people require their guidance and support. The manager showed good knowledge and we saw leaflets on advocacy services. The leaflets highlighted what an advocate was and the different types of advocates available. There was information specifically about independent mental capacity advocates (IMCA). The role of the IMCA is to work with and support people who lack capacity. They represent their views throughout best interests processes. Having access to an IMCA meant the rights and independence of the person were respected and promoted. At the time of our inspection no-one required the support of an advocate.

We saw evidence staff had received training on end of life care. People had do not attempt cardiopulmonary resuscitation [DNACPR] forms within care plans. These were signed and ensured end of life wishes were valid and current. A DNACPR decision is about cardiopulmonary resuscitation only and does not affect other treatment. Regarding end of life support one staff member told us, "We will sit with the person and work closely with the nurses. We are mindful of families, we offer tea and someone to talk to."

Good

Is the service responsive?

Our findings

People were supported by staff who were experienced, trained and responded to the changing needs in their care. Staff had a good understanding of people's individual needs. People received personalised care that was responsive to their needs. For example one person who lived in the home told us, "I wash and dress myself. I can have help if I want it." A second person commented, "They help me a lot. I seem to have lost my memory – I get things muddled up and they really help me. I wash and dress myself but they do bath me ."

The registered manager had introduced one page profiles for both people who lived at the home and for staff. The profiles included activities, what was important to them and what staff liked and admired about the person. The registered manager told us they tried to match up people with staff who had similar backgrounds or interests. This showed the provider had sought to provide care that responded to a person's culture and interests.

The registered manager and staff encouraged people and their families to be fully involved in their care. This was confirmed by talking with people who lived at the home and visiting relatives. A relative told us they were kept informed about their family member's care requirements. They commented, about their relative's care, "They [the management team] get in touch. They'll ask. I don't feel at all distanced from [my relative]. Whatever we want that's fine."

Staff had been on training for activities, one staff member told us, "I went on training, simple things can be an activity. Helping with tasks or making a bed can be an activity." A second staff member said, "It is amazing what you learn about someone when you dust together." The registered manager also told us about handbag therapy. Handbags contained old English money such as pounds, shillings and pennies. People then used the money to pay for drinks. The registered manager told us, "It gives people the feel good factor."

On activities, one person who lived at the home told us, "I do go into the garden and I have been on trips." Another person who lived at the home stated, "I go on trips. I'll do anything." A relative told us, "Staff take [my relative] shopping so she can choose her own clothes. They do more than they let on with trips and crafts."

We noted there was a current weekly timetable of events which included arts and crafts, a music quiz and baking. There was a future events list advertised, for example a musical entertainer was due to visit. In the previous 12 months there had been 35 trips and outside activities for people to take part in. These included a trip to Blackpool and a fish and chip supper in a pub. They also participated in Morecambe carnival with a decorated bus and dressing up. People were supported to follow their interests and maintain relationships. This showed the provider recognised activities were essential and provided a varied timetable to stimulate and maintain people's social health.

We looked at care records of three people to see if their needs had been assessed and consistently met. We found each person had a care plan which detailed the support they required.

The plans showed evidence of capacity assessments and moving and handling guidelines. The care plans were informative, current and enabled us to identify how staff supported people with their daily routines and personal care needs. The plan included sections on 'how I can best be supported', 'what is important to me', 'mobility', 'night time support', 'nutrition and hydration' and 'social and cultural needs'. For example, we were told communion was held regularly within the home.

Plans had one page profiles and a document called 'This is my life' information. These identified unique characteristics such as preferred name, type of personality, personal care requirements and preferred lifestyle choices. For example we noted 'Doesn't eat main meal, has a large sweet; but does enjoy breakfast.' We also noted, 'Staff to spend time with [named person] if crossword is in small print.' This showed us the management team saw people as unique and respected their individuality. The plans we looked at were updated by staff, which showed us people's needs were regularly assessed.

An up-to-date complaints policy was visible on the notice board. Staff were able to describe how they would deal with a complaint. People we spoke with told us they were happy and had no complaints about the service. One person who lived at the home told us, "There's nothing I'd like to change. It's alright as it is. If I wasn't happy I'd speak to the manager." Another person stated, "I'd complain to anyone who's around." They further commented about complaints, "It's never entered my head."

Good

Is the service well-led?

Our findings

The service demonstrated good management and leadership. There was a clear line of management responsibility from the area manager through to the management team and staff. People and staff felt the management team were supportive and approachable. One staff member told us about the registered manager, "They get involved and care about the people."

People we spoke with who lived at the home recognised and knew the roles of each member of the management team. One staff member told us, "Management do walk rounds all the time." A second staff member confirmed, "I think the office are strict with spot checks which is good." This showed the management team had a visible presence within the home.

One staff member told us they had personal development meetings with the registered manager. They told us it had enabled them to get a senior carer role. This staff member said, "They [the registered manager] pointed me in the right direction." We spoke with the registered manager about developing staff, and they commented, "It is lovely to see people develop and gain skills. It is what it's all about." This showed the registered manager valued and motivated staff.

Throughout our inspection we observed the office door was not closed and families and friends called in. We observed people who lived at the home and families both approach the management team throughout the inspection. One staff member told us, "[The registered manager] has got a very open door policy, you can go and talk, she listens, she always tries to find a solution." A second staff member said, "[The registered manager] is easy to talk to." This showed the registered manager operated an open and inclusive culture.

We were told monthly staff meetings took place in each specific area or suite in the home and there were team meetings for the full staff team. We saw minutes of meetings which included agenda items on teamwork and laundry. Minutes also included information sharing on safeguarding. One set of team meeting minutes looked at infection prevention. We spoke to the registered manager who told us they used an ultra violet light within the meeting to scan staff hands. This highlighted the germs everybody carried and emphasised the need to wash hands. They told us they did this to show how important it was for staff to wash their hands properly. The meetings enabled the registered manager to support and develop staff. It also gave a forum for staff to discuss any issues or concerns.

Surveys were sent by the local authority to families and staff. The results were displayed on notice boards for people to see under the heading, 'You said, we did'. We saw laundry had been raised as an issue in feedback received from families. We read minutes of discussions regarding laundry in team meetings. We spoke with the registered manager who told us they had introduced a new tag system in response to feedback. This showed the registered manager had positively changed working practices based on feedback received to improve service quality.

We saw evidence there was a structured schedule in place for audits. There was a full audit of the service every six months. The schedule identified who was responsible for taking the lead with these tasks. Quality

checks included management and administration, personal care, staffing, mental capacity, mattress audits, nutrition, falls and medication. The registered manager also completed care documents, care plan reviews and safeguarding information. We saw training matrix reviews, maintenance safety certificate checks and fire alarm drills had taken place. These ensured the service provided remained consistent and people were safe.

The services liability insurance was valid and in date. There was a business continuity plan in place. A business continuity plan is a response planning document. It showed how the management team would return to 'business as normal' should an incident or accident take place.

The registered manager understood their responsibilities and was proactive in introducing changes within the workplace. This included informing CQC of specific events the provider is required to notify us about and working with other agencies to maintain people's welfare.