Deaconstar Ltd

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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

The inspection took place on 5 and 6 January 2016 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

We last inspected Deaconstar on 9 April 2014, at which time it was meeting all our regulatory standards.

Deaconstar is a small domiciliary care provider based in Bishop Auckland providing personal care to people in the Durham area. It provides support to people with learning disabilities. It is registered with the Care Quality Commission to provide personal care. During our inspection we found the service provided personal care to 21 people.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC 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 registered manager had extensive experience of working with people with learning disabilities.

We found the service had in place a range of risk assessments to ensure people were protected against a range of risks as soon as they started using the service.

People who used the service, relatives and external healthcare professionals expressed confidence in the ability of staff to ensure people were safe. No concerns were raised from relatives, external healthcare professionals or local authority commissioning professionals.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service and that staff rotas corresponded to the levels of support required by people.

There were effective pre-employment checks of staff in place and effective supervision and appraisal processes, with all staff we spoke with confirming they were well supported.

We found staff were trained in core areas such as safeguarding, as well as training specific to the individual needs of people using the service, for example diabetes and abdominal massage. We found staff had a good knowledge of people's likes, dislikes, preferences and communicative needs.

In this regard the service used recognised specialist tools and detailed care plans to ensure staff were best able to communicate with people who were unable to verbally communicate. The service provided some documentation, such as questionnaires, with pictoral prompts intended to help people with learning disabilities, although the service user guide had not been adopted into an easy-read format.

People with specialised diets were supported through detailed and thoughtful meal planning through liaison with specialist nurses and a dietitian.

We found care plans to be person-centred and in sufficient detail so as to give members of staff a range of relevant information when providing care to people who used the service. These care plans were reviewed regularly and with the involvement of people who used the service, relatives, healthcare professionals and, where applicable, advocates.

The registered manager displayed a good understanding of capacity and the need for consent throughout care practices. We saw people had been supported to receive the support of an advocate.

People's changing needs were identified and met through close liaison with a range of external health and social care professionals.

The service had in place strong community links with the police and other organisations and we saw the registered manager and other staff took a pro-active approach to continuous service improvement. Staff, people who used the service, relatives and other professionals praised the openness and responsiveness of the management of the service.

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.

Risk assessments were detailed, individualised and regularly reviewed to manage and mitigate risks people faced.

All people who used the service, relatives and professionals we spoke with expressed confidence in the ability of the service to keep people safe.

Pre-employment checks of staff ensured the service reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Good

The service was effective.

People received a range of positive outcomes to their health through the ongoing involvement of a range of healthcare professionals.

People with specialised diets were supported through detailed menu planning alongside dietitian and Speech and Language Therapy (SALT) input.

Staff received a range of mandatory training as well as training specific to the needs of people who used the service.

Is the service caring?

Good

The service was caring.

People, relatives and professionals spoke consistently of the patient and thoughtful interactions by staff, as well as the positive and trusting relationships people made with staff.

People's rights, beliefs and independence were respected and supported.

People were involved in the interviewing of prospective staff, asking questions where they were comfortable and able to do so and playing a part in the recruitment of suitable staff.

Is the service responsive?

Good

The service was responsive.

Weekly meetings with people ensured staff took account and acted upon preferences and activities as well as any changes in people's needs.

Where people's needs changed the service liaised promptly and effectively with external care professionals to ensure people's needs were met.

People were able to pursue hobbies and interests meaningful to them through staff support.

Is the service well-led?

Good

The service was well-led.

The registered manager had built and maintained strong community links with police and local colleges.

All people, relatives and spoke positively of the responsiveness and openness of the management team.

Where changes to care practices were implemented, staff were consulted and their feedback acted on in order to ensure the service was able to continuously improve.

Deaconstar Limited

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.

We visited the service on 5 and 6 January 2016 and our inspection was announced. The members of the inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who had personal experience of using or caring for someone who used this type of care service. The expert in this case had experience in caring for people with learning disabilities.

On the day we visited we spoke with the registered manager, the nominated individual, deputy manager and two office administrators. Following the inspection we contacted six people who used the service and their relatives. We also telephoned four further members of staff, two healthcare professionals and one social care professional.

During the inspection visit we looked at five people's care plans, risk assessments, staff training and recruitment files, a selection of the service's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the Care Quality Commission. We contacted the local authority commissioning team, who raised no concerns about the standard of care provided.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

Good

Is the service safe?

Our findings

One social worker we spoke with told us, "They have good security measures in place." We saw individual risks were considered before a person started using the service and managed through tailored risk assessments and care plans. Relevant historical information from other agencies regarding risks were incorporated into current care planning. This included details about what factors had previously been successful or unsuccessful in terms of managing risks to individuals. For example, one person was identified as being at risk of tripping. We saw specific plans in place identifying and minimising environmental hazards as well as clear details about how to support the person during specific tasks, such as tying their shoelaces. The risk assessments also gave clear instructions to carers regarding how best to communicate these mitigating actions to people who used the service.

People who used the service and their relatives were similarly confident in the safety of the service. One relative told us, "[Relative] is safe and is properly looked after." Another relative said, "[Relative] has had no accidents whilst with them – they plan and check everything." Another said, "They are very safe and at ease with the staff." Health and social care professionals we spoke with were similarly confident and, during our inspection, we saw there was a clear focus on safety throughout policies and procedures. For example, we saw minutes of staff meetings where safety was discussed as an ongoing issue, with reminders of safeguarding protocols discussed and outcomes agreed such as updating people's Personalised Emergency Evacuation Plans (PEEPs) to make them more detailed.

In addition to PEEPs, which people kept in their homes in case of emergency, the service had put in place individualised 'grab sheets' for people, which contained important information such as contact details, communication and medical needs. These sheets provided a snapshot of the person's needs and personal information, which could travel with the person if they needed urgent help.

We saw the safeguarding policy and procedure was shared with staff as part of their induction pack and we found the policy to be current and clear in terms of individual staff members' responsibilities with regard to safeguarding. We found the procedures were supported by easy-to-follow flow charts, template forms should staff require them and relevant contact information. We also saw information regarding the Reporting of Diseases and Dangerous Occurrences' Regulations (RIDDOR) and medicines management were provided to staff as part of the induction pack. We reviewed documentation recording accidents and injuries to people who used the service and found there to have been none meeting the RIDDOR criteria. We saw that any accidents and incidents were recorded and reviewed by the registered manager and other office staff before archiving to ensure necessary action could be taken. For example, one person who used the service had slipped and fallen, although not injured themselves. We saw the registered manager promptly ensured an Occupational Therapist visited the person's home to review the environment with a view to providing additional support that would reduce the risk of recurrence.

All staff we spoke with were aware of how to raise concerns should they need to and were aware of safeguarding and whistleblowing policies. Whistleblowing is when staff raise concerns about practices in the service they work for. Staff were also able to tell us about the types of indicators of abuse they were

mindful of, and what to do should they suspect abuse. Relatives of people who used the service also confirmed they were aware of how to identify and raise concerns and confirmed relevant safeguarding information was accessible to people in their homes. This meant the service ensured people, their relatives and staff understood what to do if they had concerns about people's wellbeing.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including enhanced Disclosure and Barring Service checks. The Disclosure and Barring Service restrict people from working with vulnerable groups where they are considered to present a risk and also provide employers with criminal history information. We also saw that the registered manager asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. This meant that the service had in place a robust approach to vetting prospective members of staff and had reduced the risk of an unsuitable person being employed to work with vulnerable people.

All staff we spoke to felt staffing levels were appropriate. All relatives of people using the service we spoke to agreed there was ample staffing. We looked at staffing rotas and saw, where people required support from two care staff, this was in place. This meant that people using the service were not put at risk due to understaffing.

The service had adequate medicines policies and procedures in place. We reviewed the medicines policy and found it to be informed by guidance from the Royal Pharmaceutical Society (RPS), the National Institute of Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE). The policy had been recently reviewed and provided clear instruction on the provider's administration of medicines. We saw that annual supervision of staff was in place to assure their competency with medicines administration. We also saw that all staff had recently completed relevant training regarding the safe handling of medicines. When we spoke with a range of staff they were able to discuss the medicines procedures they adhered to in line with the medication policy and people's assessed needs. We sampled Medication Administration Records (MARs) and found there to be no errors. This meant that people were protected against the risk of the unsafe administration of medicines.

With regard to infection control, one person said, "They keep the house nice," and, in questionnaires returned to CQC, people confirmed staff used personal protective equipment (PPE) such as gloves and aprons where appropriate.

The registered manager confirmed there had been no recent disciplinary actions or investigations. When we spoke with people who used the service and their relatives, they confirmed they had not had concerns regarding staff conduct or the provision of care. We saw that the disciplinary policy in place was current and clear. We saw the policy was outlined in the employee handbook, which staff confirmed they received on joining the service.

Good

Is the service effective?

Our findings

Family members and external healthcare professionals alike told us they were impressed with the level of skills and knowledge of staff supporting people, stating for example, "They understand people and their needs."

We saw staff training covered areas the service considered mandatory, such as safeguarding, person-centred planning, first aid, infection control and food safety, mental capacity, privacy and care, dementia awareness health. The service's mandatory training for staff had been revised since the implementation of the Care Certificate to ensure that, in time, all staff and not just new staff, would have a comparable set of skills through training. The Care Certificate is a qualification based on a set of standards that health and social care workers adhere to in their daily working life. This meant the service had regard to these standards when delivering staff training that incorporated best practice.

We saw staff were provided with additional training where people's needs required. For example, we saw that care staff supporting a person with specific needs were trained in massage that supported the person's needs. The outcome for the person who used the service was that they received care from staff trained in a specialised technique that had previously been delivered by nursing staff. This aspect of care, along with a range of other aspects of care planning, meant the person was able to manage their condition with the support of suitably trained staff with whom they had already built a rapport. Likewise, we saw staff who supported people with diabetes had been trained in diabetes awareness. When we spoke with them, they were able to describe the person's needs in detail, and how they supported those needs. We also saw evidence of detailed and ongoing liaison with external healthcare professionals to ensure people with diabetes had their needs met.

We saw that staff appraisals happened annually and staff supervisions happened between every four and six weeks. Staff supervision meetings took place between a member of staff and their manager to review progress, address any concerns and look at future training needs. We spoke to staff who confirmed that they felt fully supported. Staff told us, "We get fantastic support and training is always updated," and, "We can approach them with anything." Likewise we saw a range of responses in recent staff surveys indicating that all respondents felt supported by their line manager. Comments included, "If I have concerns management are very willing to listen and act." This meant that staff received a combination of formal appraisal, supervision and other support as and when required to fulfil their roles.

We saw staff signed to confirm receipt of the employee handbook, which contained outlines of key policies and procedures, such as staff conduct, disciplinary processes and appraisal procedures. We found staff appraisals and supervision meetings were carried out and recorded in line with these documents.

Members of staff who had joined the service recently spoke positively about the induction process and confirmed they received the induction pack. They also confirmed they shadowed experienced members of staff and sat with them to review relevant care plans before providing care to people.

Where people required support with specialised diets we saw there were clear instructions in place. For example, one person required a pureed diet and had to limit their intake of calories. We saw the 'meal' section of their care plan contained descriptions of the types of food they could choose, along with pictures of the required consistency of food before serving and clear guidance on the recommended portion amounts for each foodstuff for each meal. This information had been produced in conjunction with the Speech and Language Therapy (SALT) team and a dietitian. This meant people's health benefitted from regular involvement from healthcare professionals, the advice of which the provider incorporated into care planning.

We saw evidence of prompt and effective communication with other healthcare professionals to ensure people's healthcare needs were met, such as GPs, chiropody practitioners, specialists, dentists and opticians.

Where aspects of people's care could be provided effectively by care staff rather than visiting healthcare professionals, this was facilitated. For example, care staff had been trained to take blood pressure measurements and to apply eye drops following consultation with the district nurse, meaning people could receive this care at the same time as other aspects care. This meant people were able to receive efficient and effective care due to staff receiving additional training.

We saw that members of staff had been trained on the subject of Mental Capacity recently and were comfortable talking about the subject. We saw one person who used the service had experienced a loss in their ability to make informed decisions over a period of time. Staff had identified this and ensured other agencies were involved to provide advocacy support for this person, who was no longer able to make some decisions regarding aspects of their care. The registered manager demonstrated a good understanding of mental capacity considerations, the need to assume capacity and the need to ensure people were given support to make decisions where they were unable. We saw the actions taken were in line with the advocacy policy in place. We noted that people who used the service were given a Service User Guide but that this did not contain information regarding advocacy. The registered manager acknowledged and agreed to rectify this.

We saw the service anticipated training needs and had recently delivered End of Life care training to staff. Whilst the service was not currently supporting any people at the end of their lives, staff told us they valued this training as a means of better preparing them for supporting people who may require end of life care in the future.

Good

Is the service caring?

Our findings

People who used the service and their relatives were consistent in their praise of the attitudes of staff, stating, "The carers are lovely," and another, "They are absolutely brilliant." Health and social care professionals we spoke with similarly spoke highly of staff, stating, "There is a caring atmosphere," and, "Their support is not just about physical support but about mental health and wellbeing needs."

When we spoke with staff they were passionate about the care they provided to people and had in a number of instances had formed strong bonds of trust and rapport with the people they supported. Relatives confirmed they had observed strong bonds and positive, trusting relationships develop between care staff and people who used the service.

Aspects of the service were tailored to meet the communication needs of people who used the service and to ensure they had a say in how their care was delivered. For example, weekly one-to-one meetings, called 'Dreams and Wishes', with people who used the service, included a section of pictoral indicators of people's mood. Where people were unable to contribute verbally to the weekly assessment of their mood and their progress against agreed goals, we saw a mark had been put against relevant icons. We saw this feedback had been acted on with additional goals and actions noted.

These weekly, "Mini reviews," as one member of staff described them also showed that people were involved in the provision of their care and had regular opportunities to question practice or raise any concerns. People and relatives we spoke with confirmed they felt involved in their care and support and that their independence was respected and supported.

We saw the registered manager involved people who used the service in the interview process, where they were interested. People who used the service were able to compose questions in advance, to ask questions of prospective staff, or to just observe. People who used the service and relatives confirmed their participation in interviews and staff agreed this was a positive means of ensuring people were satisfied with the carers who would be supporting them. It also meant the service could establish how prospective members of staff interacted with the people they would potentially be caring for in the future.

The registered manager and other staff had successfully ensured people were partners in their care planning. Another example of this collaborative approach was the recent oral hygiene training sessions staff had received, whereby people who used the service also attended the session in order that they could better understand aspects of care they would receive.

The registered manager acknowledged that, whilst all people who used the service were given a Service User Guide, not all could read it. The registered manager agreed to review the Service User Guide and to produce an associated document in line with other easy-read or pictoral documentation the service provided people with.

More generally, the identification of specific communication needs and subsequent actions in order to help

people receive quality care was a feature of the service. For example, staff used the Disability Distress Assessment Tool (DISDAT) to help identify when a person who was unable to verbally communicate was experiencing distress. The DISDAT tool helps identify distress in people who have limited communication abilities. We found this tool had been completed in detail and when we asked respective members of staff about the content of the tool and how people they supported who express discomfort, they displayed a good knowledge.

People's rights were respected and upheld. For example, one person who used the service expressed a wish to be Christened. We saw staff had contacted a local church to begin making arrangements for this to happen and had also begun plans for a party to celebrate the Christening. This meant people's religious beliefs, which are one of people's protected characteristics as set out in the Equality Act 2010, were respected, supported and celebrated.

Relatives of people who used the service consistently observed improvements in the emotional wellbeing of people, with a number of relatives describing the eagerness of people to return, "Home" to a supported living environment after visiting relatives. Relatives told us people who used the service were, "Happy," and that the caring attitudes of staff at all levels contributed to this. One relative said, "They are such a wonderful family at Deaconstar." This meant the service had helped enabled people to feel settled through supporting their independence. The service also ensured people were able to maintain relationships with, for example, members of their family they had previously lived with.

Staff took an interest in the pursuits of people they supported and people who used the service and relatives confirmed they were treated with dignity and respect.

Good

Is the service responsive?

Our findings

People's preferred hobbies, activities and interests were sought through a range of means, primarily through the completion of an 'About Me' file when they started using the service but also through weekly 'Dreams and Wishes' meetings, where these interests could be updated. We found care planning documents to be person-centred, as were other important documents such as emergency 'grab sheets' and the hospital passport. A hospital passport documents essential information that can be used by other healthcare professionals if a person is admitted to hospital.

Each person who used the service had a key worker and when we spoke with staff they displayed a good knowledge of people's needs, likes and dislikes.

We saw staff had a good knowledge of people's interests and were able to facilitate these, setting goals in conjunction with people that could then be achieved with support. For example, we saw one person had expressed an interest in gardening and was supported to pursue this hobby. Likewise, one person had expressed an interest in computers and wanted to learn more IT skills. We saw the service support this person to attend a day service with an IT suite.

The service routinely involved people using the service in activity planning by holding weekly one-to-one meetings with people to establish their views and preferences. We saw people kept activities logs so they could keep a record of their progress against their targets and we saw reviews of care involved family members and people important to people who used the service. One relative told us, "My sister and I attend the annual reviews and they give me all the papers and details of things like medication. I produce the agenda for the reviews." Another said, "They have good communications and always let us know if there are any issues."

We saw evidence that the registered manager liaised promptly and proactively with healthcare professionals to ensure people using the service received positive outcomes from treatment. For example, one person had a history of negative behaviours prior to using the service. The registered manager ensured the person was referred to an external healthcare specialist to ensure the person's medication was appropriate. They also incorporated guidance from the person's social worker and other healthcare professionals to ensure that staff were aware of the problem and best able to support the person. We found care plans to be comprehensive and easy to follow, incorporating explanations to help staff and the person meet their goals. We saw the outcome for the person was that their mental wellbeing had improved without the need for further medication. Their relative also told us, "They are 100% better. They got a specialist nurse to support them." This meant there was further evidence of the service ensuring people's changing healthcare needs were met through liaison with external healthcare professionals.

We also saw that the registered manager proactively sought and responded to the opinions of healthcare professionals. For example, people's houses were reviewed by an occupational therapist where the registered manager and other staff identified potential risks or barriers to independence. We spoke to an occupational therapist, who told us, "It's not a 'one size fits all' service. They are flexible about the

individual." They went on to explain how the service had recently supported a person recovering from a hip injury and had given positive encouragement to enable the person to recover and regain independence.

We reviewed five people's care plans and saw evidence of people, their relatives and advocates involved in regular reviews of their care plan, as well as being consulted when needs arose. The service assessed a range of input to ensure people's care plans were accurate and responsive to the changing needs of people. For example, we saw advice had been sought from Occupational Therapy, Podiatry and Social Services.

Daily notes we saw were detailed and broken down into a range of subjects, such as health, diet and nutrition, medication, emotions and daily activities undertaken. We found these accounts of people's day-to-day experience to be in line with what people told us about the support they received.

The service protected people against the risk of social isolation through a range of means. For example, people were supported to access day services where that was their preference. Other people were supported to attend a social night at a local pub to pursue their hobby of playing pool. We also saw people who used the service had been supported to attend discos, karaoke events and parties. One relative said, "They have a better social life than I have!"

In questionnaires returned to CQC by relatives, all respondents confirmed they felt people were involved in their care and were regularly involved in the reviewing of it.

We saw the registered manager had a clear complaints policy in place and people we spoke with were clear about how they could complain should they need to. We found the service user guide to lack information relating to how to make a complaint and the registered manager agreed to review this aspect of the service's literature.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC 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 registered manager had extensive experience of working with people with learning disabilities.

Praise for the management and leadership of the service was consistent from all people we spoke with, including people who used the service, relatives and external professionals. One relative said, "It's a well-run management and their communications are good." One healthcare professional told us, "They flag things up very pro-actively, they are approachable, willing to take opinions and actually seek them."

Staff were consistent in their praise for the levels of support they received from management. One member of staff said, "Support is good – you can go and talk to them about anything, anytime." Another said, "They're always making sure we're up to date with training and other things – we get fantastic support."

We found the management and office staff benefitted from a range of skills and experiences. For example, the registered manager, nominated individual and deputy manager were all registered nurses, two with a specialism in caring for people with learning disabilities. We also saw that staff were able to utilise information technology skills and systems to maintain and update staff records. This meant the service and external agencies were more easily able to interrogate and analyse information the service held. The registered manager had therefore ensured the service was accountable for internal audit purposes and for external agencies.

All people who used the service, relatives and staff we spoke with were consistent in their description of a service that, in line with its priorities as set out in company literature such as the Statement of Purpose, respected and upheld the choices of people who used the service. People were also consistent in their description of staff who were uniformly positive, warm and supportive. The registered manager and other staff had successfully established and delivered a person-centred culture within the service.

We also found a consistency between the policies and procedures the service maintained and the practices in place. For example, we saw the content of the key worker policy to have been put into practice throughout the detailed care plans we reviewed.

We saw the registered manager ensured the service kept abreast of best practice and changes in legislation through partnership working. For example, they were a member of the Tyne and Wear Care Alliance. This is an independent organisation that aims to improve care through linking local authorities and independent care companies to ensure they are aware of training opportunities and best practice. We saw the registered manager had organised a range of additional training through this source.

We also saw that the registered manager had signed up to the Learning Disabilities Health Charter, a charity-

led (Voluntary Organisations Disability Group) approach designed to "Support social care providers to improve the health and well-being of people with learning disabilities, thus improving people's quality of life generally." The registered manager also told us they were looking into how to sign up to the Social Care Commitment.

The registered manager had also built strong working relationships with local police. The registered manager allowed police to use the service's facilities for training purposes. The registered manager had used this as an opportunity to educate new police officers about the potential challenges and vulnerabilities faced by people with learning disabilities. This meant the service had successfully promoted relevant social care issues to external stakeholders who played a part in keeping vulnerable adults safe in the local community.

We saw there were also strong links with local colleges, who contacted the service during our inspection to enquire if more students could attend the service on a vocational placement. One member of the management team had initially begun their career in social work through a placement with the service.

The registered manager had a sound knowledge of the day-to-day workings of the service and took an active role in reviewing the provision of care. For example, we saw they had ensured daily notes were completed comprehensively by including a 'Practice Guidance' document in each person's care file, in front of the daily report sheet. This document emphasised the importance of these daily notes being detailed and made it clear the standards expected. The registered manager had also recently implemented a new method of recording daily notes and sought staff feedback. We saw that staff comments had been taken on board to develop a more efficient version of the daily notes records. Staff we spoke with confirmed their views had been sought and their opinions listened to. This meant the registered manager sought ways to improve the service through involving staff.

With regard to oversight of the service, the registered manager arranged regular team meetings and performed a range of audits on aspects of the service. We saw, for example, audits of daily records had led to the implementation of the 'Practice Guidance' document. Audits were carried out on all aspects of care file documentation before they were archived but these audits were not always clearly documented. The registered manager acknowledged aspects of their auditing processes required improvements and endeavoured to review this aspect of the service.