We Care Together Southampton

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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

This comprehensive inspection took place on 3, 4, 5 September 2018 and was announced. This was the first inspection of We Care Together Southampton since it opened in 2017. At the time of our inspection 21 people were receiving a service from We Care Together Southampton.

We visited the provider's offices on 3 September and made telephone calls to staff, people using the service and their relatives on 4 and 5 September.

This service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older people, younger adults, people living with dementia, people who have mental health conditions and people who have disabilities.

There were two registered managers 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.

Staff had a clear understanding how to keep people safe when they were delivering care and to support them to remain safe at other times. Risks assessments concerning people and their homes were completed and regularly updated. Staff could access these at the providers office or in care files retained in people's homes.

Sufficient staff were deployed to meet people's needs without needing to rush care delivery. Travelling time had been built into staff schedules and ensured that booked times were usually met.

The service had expanded since being set up however it had grown slowly as the registered managers recruited new staff prior to taking new clients to ensure they were always able to meet commitments.

Recruitment practices were safe however there were problems at times in obtaining references from other similar providers. The registered manager evidenced attempts to obtain work references and had sought character references when work references were not possible.

Staff received training and equipment in order to safely complete their work and had annual updates in training to ensure they remained aware of current best practice.

Safety checks were in place so that the on-call manager was informed when staff were safely home after an evening shift to safeguard their well-being.

An in-depth assessment was completed before people's care packages commenced and people or their relatives were involved in care planning as fully as they were able.

Staff participated in supervision and appraisals and were supported to complete diploma level training to develop their careers. Regular spot checks were carried out by senior staff to ensure that care staff were providing appropriate care to people.

Food and nutrition were central to people's care provision and whenever possible staff would prepare and cook fresh meals for people rather than reheating readymade meals.

Staff were trained to prepare meals for people who had safe swallow plans and when necessary received training from nutrition nurses so they could support people with PEG feeds.

The service was very caring, people told us they were very happy with the care they received.

Care plans were person centred and reflected the person's preferences as to how to receive their care.

Once care tasks were completed, staff supported people with household tasks or sat with them for a chat. Staff did not need to rush off to the next call and enjoyed spending time with people.

Staff communicated with people in the most appropriate way for each person. Information on people communication needs was seen in care plans. Written information was presented to people in their requested format and staff would read peoples care bookings out to them.

The provider responded to emergencies well and had sent staff to additional calls when asked.

There was a complaints procedure however very few complaints had been received by the service.

The service supported people with palliative and end of life care and were committed to providing these types of care at a very high standard to ensure that people could have a good death.

The service was recently restructured and a new deputy manager now supported the two registered managers.

Quality assurance and training are focus areas for the service with each registered manager training in and developing these areas.

Staff morale was good and staff retention levels were high. Staff felt valued by the provider.

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 were familiar with safeguarding and could identify signs and symptoms of suspected abuse.

Risks concerning the environment and care tasks were assessed and reviewed regularly.

People were encouraged to be independent with medicines and staff were trained and assessed as competent prior to administering medicines.

Is the service effective?

Good

The service was effective.

Staff completed mandatory training courses which were regularly updated in line with current good practice.

Regular supervisions and appraisals annually provided support to staff and enabled development within their roles.

Good nutrition was promoted and the provider offered support with shopping and advice about healthy and appealing diets.

Is the service caring?

Good

The service was very caring.

Staff were committed to providing person centred care and promoting people's independence.

Staff communicated effectively with people and care plans reflected people's communication needs.

Staff sought consent before providing care and consents and agreements to care plans were held in peoples care files.

Is the service responsive?

Good

The service was responsive.

Quality assurance questionnaire responses showed that people and staff were happy working with and receiving care from the provider.

The provider was committed to supporting people receiving end of life care to have a good death.

A complaints policy and procedure was followed when complaints were received.

Is the service well-led?

Good

The service was well-led.

Two registered managers would support people in their homes regularly so they were aware of issues faced by staff members.

Staff morale was very good and staff were encouraged to develop through training and progress to more senior roles within the service.

The provider was committed to providing quality care and making continual improvements to the services they provided.

We Care Together Southampton

Detailed findings

Background to this inspection

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 took place on 3, 4 and 5 September 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

Before this inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. We also checked other information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we visited the providers offices and looked at information they held there including four staff files to see how recruitment was managed and five peoples care files to check that records and assessments were current. We also checked policies and procedures, audits of the service and reviewed records including training records and staff supervision and checks.

We spoke with five people who received a service from the provider and two of their relatives by telephone. We also spoke with five staff members and two registered managers.

We sought feedback from health and social care professionals to inform our inspection however did not

receive any feedback on this occasion.

Good

Is the service safe?

Our findings

People told us they felt safe receiving care from the service. One person said, "Yes, I feel safe, I would recommend them to friends and family".

The provider had a safeguarding policy and staff completed safeguarding training when they commenced working with the provider. We spoke with staff and they were aware of different types of abuse and the signs and symptoms that may indicate that someone was being abused. Staff told us they would tell the registered managers of any concerns they had about people and would record their concerns carefully.

The registered managers had a clear process of referring to the relevant safeguarding authority to alert them of possible cases of abuse and would also complete a notification to CQC. The registered managers had seen only one case that had caused them concerns since they had started their service and spoke about it with emotion and genuine distress. The actions they had taken went over and above their contracted role in this case which had been necessary due to the lack of a support network for the person. The registered managers had learned from the experience of caring for this person and had shared aspects of this with their team. The experience had made the provider more determined to provide safe, quality support to people.

We looked at people's care files and saw there were individual risk assessments for people. The registered managers would visit people and assess not only their care needs but would assess risks of using any equipment needed for care tasks, the environment such as slip or trip hazards, whether there were areas of clutter and access to the property. Risk assessments mitigated as far as possible the risk of harm to the person and to staff supporting them. The registered managers were mindful when assessing risks that at times, for example during bad weather, some people may be hard to reach and made sure there were contingencies in place to meet their needs.

Staff ensured that people were safe when they left them after completing their care calls. Staff would check that doors and windows were secured and ensure that any hazardous items were out of reach and appliances such as cookers were switched off. Items the person may need before they next had a care call were left in reach of them as were their emergency call alert pendants. Staff told us they would let people know they were leaving then wait outside until the person had locked the door.

Staff and the registered managers told us there were sufficient staff available to complete the care calls booked both at the right time and for the full duration of the call. When we inspected, a staff member called in unwell for their shift just 20 minutes before their first call. The senior carer was able to cover these calls with another staff member, the person expecting the first call was informed there was a short delay and the second call taken by another team member with capacity. This meant that apart from one short delay, the rest of the calls were completed as planned that day.

The registered managers had taken a measured approach when taking on new clients and had not expanded their service fast but in line with the staffing they had. A relative of someone that had received a service since just after the provider set up the service told us, "They [registered managers] were very careful

in developing and at one point said they were not able to take us yet as they didn't have enough staff. They don't stretch themselves or push the service too far".

The provider had a clear recruitment procedure and application forms and interview notes were held on staff files. Every staff member was required to supply a full employment history, two employment references and a character reference as well as having a check completed with the Disclosure and Barring Service (DBS). The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people. This ensures that people employed at the service are suitable to work there. All staff files had the above checks however there were clear problems in obtaining references. The registered manager told us they had increasing problems in getting references from some similar providers, they did not acknowledge reference requests or even confirm that people had been employed by them. Providers do not have to give references for employees and after discussing this with the registered manager they agreed to provide evidence of correspondence with the referees in people's files and seek references from other employers or character references.

Staff were trained in administering medicines and were shadowed by senior staff and assessed as competent before being able to give medicines to people. The provider did not routinely order medicines for people but assisted in administering medicines in the form of prompts or checks or taking full responsibility for giving them. Whenever possible, people were supported to be independent with medicines however if, after a period of assessment by staff, people did not appear to be managing their medicines safely, staff would alert the registered manager who would arrange for the service to increase their support of medicines. The service did not support people with medicines other than those prescribed.

Staff were provided with personal protective equipment (PPE) by the provider and signed out stock as and when they needed it. Aprons, gloves and hand gels were provided and staff were trained in infection prevention control so were aware when they should use PPE. Care plans stated that areas should be cleaned after care was given and people told us that staff often offered to support with additional cleaning tasks if they finished their care tasks early. The registered managers told us that in one instance they had purchased cleaning items for a person who had been referred to them as there were none on the premises which were not safe for the person to be in.

When finishing shifts, staff were required to text the 'on-call' staff member to let them know they had returned home safely. If the text was not received, the on-call staff would phone to check the person was safe. Whenever possible, calls with two staff supporting had been arranged as the last call of the evening. This had been possible initially however, as the numbers of people receiving a service had increased, this was less feasible. The provider did not employ any staff who walked or rode pushbikes to care calls as these were less safe means of transport and the geographical area they covered was not suited to these modes of transport.

Good

Is the service effective?

Our findings

An in-depth assessment was completed before people received a service. The registered managers visited people to assess and discuss their care needs and expectations of the service. The assessment considered what support people needed to attend to their care needs and was person-centred. Care plans devised following this assessment were sufficiently detailed to ensure that people were not only supported but also their current abilities were maintained or improved. Initial assessments, risk assessments and care plans were reviewed formally after four weeks or before if necessary. After the initial review of care, subsequent reviews were held at approximately three-monthly intervals if someone was receiving palliative care and six-monthly intervals for all other people.

When starting work with the provider, staff completed 17 training courses. These courses covered safeguarding, infection prevention and control, moving and assisting and health and safety. The registered manager told us they believed all of these courses to be important for providing a quality service to people. Staff updated their training annually. Staff told us they could complete training that led to qualifications such as diplomas. Most staff members had completed the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working in health and social care positions. In addition, staff were completing level 2, level 3 and level 5 health and social care diplomas.

Staff participated in regular supervision or one to one sessions with the registered managers. When they commence in post, following a period of shadowing experienced staff members, staff meet with the registered manager every four weeks. This is maintained for the duration of their three-month probation. Supervision then takes place every six months and staff participate in an annual appraisal in addition to the supervisions. Staff told us that supervisions were beneficial, "We always discuss something useful". Another staff member told us, "I have supervision with [registered manager], I can also have a weekly chat if I want".

In between supervisions, at least monthly, registered managers and senior carers completed spot checks on staff members when they were delivering care. These spot checks included observing how care was delivered, the appearance and practice of staff, medicines administration and how staff left the person. In addition, the staff member completing the spot check spoke to the person and discussed their care plan, staff attendance and timekeeping and any concerns they may have. Information from these checks was fed into the supervision meetings or addressed immediately if of concern.

The provider focussed on providing quality nutrition to people. Lunchtime visits were usually at least 45 minutes long so that staff could prepare a meal from scratch for people rather than reheating 'ready meals' in a microwave. A registered manager told us, "We promote fresh cooked meals and the time to do this instead of it being rushed visits. Nutrition is a key part of our daily needs, we eat with our eyes, it's all about sensory with nutrition. It's important we make this appetising, but it is also about time spent with someone when they haven't seen anyone else all day". They also discussed how they were aware that nutrition would benefit peoples skin, health, weight and well-being generally and how they focused a great deal on providing quality meals. They also told us they were proud of how they supported people with their diet and

nutrition. They advised people on how to eat healthily, supported other people in shopping and menu planning and ensured staff members could cook and provide safe and nutritious meals for people.

Some people had specific dietary needs such as having safe swallow diets recommended by speech and language therapists (SALT). Staff were trained in preparing food and fluids to specific consistencies and were also trained to feed people by PEG. PEG or percutaneous endoscopic gastrostomy, is a tube inserted into a person's stomach directly so they can receive nutrition. This is usually used when the person has significant difficulties with swallowing. Staff received training specific to each individual who was fed in this manner.

People's food preferences were recorded in their care files. If staff were aware that someone had enjoyed cooking or baking, they would engage them in baking some cakes or biscuits if time allowed; this was encouraged particularly when caring for someone living with dementia.

Staff did not weigh people regularly however if concerned they would do so and, with the person's consent, would speak with their GP or district nurse to ask for advice. They were aware of available nutritional supplements and supported people with these if prescribed. Staff would also contact healthcare professionals if they were concerned about medical conditions such as urine or chest infections.

One of the registered managers had experience of supporting people who had pressure ulcers. They told us that no-one receiving care currently had any pressure areas that were causing concern and they hoped to maintain that standard as they were proactive in managing peoples skin.

Care files were retained in people's homes and with their permission were shared with other professionals. The provider told us that the local ambulance service, when attending calls in people's homes, had been complimentary about the quality of their care files. The paramedics had been able to access information about the person's health condition and their current medicines in the care file which had enabled them to make more accurate clinical decisions regarding the person's care.

If a person was moving from their home into a care home, the registered manager told us they would, with the permission of the person or their family, share information with the home. The registered managers were committed to offering a person-centred care service and saw no reason not to share learning they had about a person with others significant to their care and well-being, assuming that permissions had been sought.

We spoke with staff about how they supported people to make decisions and found they were aware of the principles of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. Staff told us they would support people with day-to-day decisions such as what to wear or what meal to have for lunch, and if they were not able to make those decision, staff told us they would be aware of the persons preferences from their care files. For more significant decisions staff told us they would speak to the registered managers who would in turn either contact people who made decisions on the persons behalf or they would facilitate a best interest decision.

People's care files held capacity assessments and if lacking in capacity, or if they had a progressive condition such as dementia which would ultimately affect their capacity there would be copies of Power of Attorney documentation. A Lasting Power of Attorney gives named people authority to make decisions on a person's behalf if they become unable to make those decisions themselves. Lasting Powers of Attorney will

give permission to make decisions about finance or health and welfare and the correct documents must be seen before decisions are made on a person's behalf. The provider had copies of all relevant paperwork and the names of people acting on behalf of clients was clearly recorded in care files.

Good

Is the service caring?

Our findings

The service was caring. People and their relatives were complimentary of staff and the services they provided. One relative said, "I honestly and truly can't fault them. With We Care [Together Southampton], we are all so pleased. They are considerate, patient, trustworthy, they check with me, they check with [person] to see we are ok and happy. They aren't perfect but if there are issues, they are put right." Another person told us, "The carers are lovely, really nice. I had them for six weeks and found them to be lovely, they really care and the girls were really entertaining and gave me such a laugh". One person receiving care told us, "They [care staff] are kind and polite, I couldn't fault one of them". Another person said, "They are polite and very kind. I have the same carer most of the time and she is very good".

The registered managers of the service were focussed on providing excellent care and told us, "The reason myself and [registered manager] decided to start We Care Together Southampton is because we wanted the clients to have the very best in care, we believe the exception should be the norm across the board". Their commitment to providing quality care was reflected in staff when we spoke with them. One staff member told us, "We provide personalised care. We only have 22 clients and we know them all. We do their care, get them sorted and make sure they are comfortable and then see if their husband or wife needs anything…. We feel like a part of their family and can give them some down time as they know there is someone there to support the person, they can get some relief from caring".

Care plans were holistic and person centred. Plans were divided into the different calls the care staff made and were written including the persons preferences as to how they wanted to be cared for. Staff, people and their relatives told us that care calls were not rushed. The registered manager confirmed that between every call there were15 minutes travelling time so staff were not pressured to rush a call so they could get to the next call on time. Staff were also aware that if someone needed additional time they should inform the office and remain until care was completed rather than rush them. In cases such as this, the next call would either be covered by other staff or the person would be advised that the carer would be late and given a new arrival time. If a person's call ran over several times then the package of care would be reviewed and additional staff allocated or the call time extended to cover the persons changing needs.

The staff and people we spoke with confirmed that staff members stayed for the duration of the call and did not appear to want to leave early. Staff only left early if the people they had cared for asked them to; staff would usually use the time remaining to support with some laundry or other tasks or sit and spend some time chatting with the person.

The registered manager told us they, whenever it was appropriate, would include the person they cared for in their reviews. If necessary they would speak to them alone in advance of the review to ensure they said what they wanted to say and not what they thought their relatives would like to hear. Staff communicated with people in the most effective way for them and the provider used communication books in people's homes as they found that sometimes people preferred to write requests rather than have to ask for things. How best to communicate with people was evident in care plans and staff were aware if they needed to focus on a particular side due to hearing loss or if someone was visually impaired and may struggle to see

written information. One staff member told us they would ensure that the TV volume was low, that there was sufficient light and they were facing someone if they had to pass on important information. They also told us that some people they supported used speech cards where they pointed to words or electronic speech aids.

People were respectful of the people they cared for and their families. One relative told us, "They really respect the family, we are so grateful and so pleased. They knock the door and they really help, they are really respectful". Staff told us they would always knock doors and would ensure that when delivering personal care, they closed the curtains, ensured they had a towel to cover the person so they were not fully exposed and would speak to them throughout to tell them what was happening.

People had signed to consent to their care or their consents had been signed by someone with the legal authority to do so on the persons behalf. Care files were stored in the providers office in locked cabinets. Care files were also retained in people's homes and were accessed by other professionals such as district nurses and paramedics. These were accessed with the consent of the person or their nominated person. Additional information that needed to be given to staff that was of a confidential nature was passed during phone calls, text messages were not used as they may risk people's confidentiality.

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive. One person told us, "I have contacted the office as sometimes I need to get to the toilet. An emergency call to them and they have so far always managed to send someone as I'm only ten minutes away".

Care plans reflected people's needs and wishes and were developed as far as possible with the person or their family members. The registered managers reviewed care plans after four weeks to ensure that people had the correct amount of support and that they were being cared for in their preferred way. A relative commented to us about how well care staff knew their relative, "They understand their [health condition] and they [staff] know to brush their teeth in the morning and they can then manage to eat for the day. This is really personal care, they [staff] listen to them, encourage them and if then they really don't want to do it then they [staff] step back". The relative was impressed that staff would try very hard to engage the person in tasks that would benefit them while continuing to respect their wishes.

We were present at a Monday 'Huddle' meeting and saw how the weekends developments were shared and cascaded to relevant staff members. Items such as reading through the log book of calls to the 'on-call' telephone, new medicine records needed and a discussion about a person who currently had support from one staff member maybe needing to increase their package to two staff members took place. Where possible, solutions were put in place at this huddle and actions such as telephoning people, relatives and health and social care professionals were allocated to staff.

The provider had a complaints policy and procedure details of which were given to people in their information pack when they commenced their care package. There had only been one complaint recorded since the service started and this had been noted, investigated and resolved at an early stage of the procedure. One of the registered managers told us, "We would apologise immediately, if we are in the wrong then we will own it and if we are not at fault we would still apologise as someone has felt strongly enough to complain." A relative told us, "The office deal with issues quickly and usually call me back within 30 minutes". Another relative said, "It's best to resolve issues here rather than call them back later if they have left [person] uncomfortable. They will always return before our next due call to address problems".

The provider also issued quality assurance surveys to people, relatives and staff. There had not been many returned from people and relatives however no concerns had been seen on those that had been completed. Staff had also completed surveys about their work and how they feel the service performs. We looked at the last survey responses and found all were positive. Staff felt strongly that they could care for people in a safe way, were suitably trained and supported by registered managers who showed strong leadership.

The provider had supported many people with palliative and end of life care. The palliative care training was a course that the registered manager considered to be one of their core mandatory training courses due to the number of people they cared for in this area. Staff were committed to providing care at a very high standard, particularly at the end of a person's life. We asked how they felt about end of life care, one staff member told us, "Yes, I love it. Lots of people struggle but if you have done your best and they are

comfortable they come to terms with it and are OK". Another staff member told us, "It is an emotional thing but as long as they are comfortable and you couldn't do more it is OK. You should treat people as you would like to be treated in that situation".

Care plans were adapted to people's needs at the end of life. One of the registered managers told us, "It is how they want things to be, some people don't want to talk about it and some families don't want it in the care plans, we respect that". After the death of a person, they would remain with the family until they were no longer needed and support them with any necessary actions such as arranging for the removal of the person. This would be as per the wishes of families they support. Staff will visit the family and stay in contact while they need support. Staff are telephoned and informed about the loss of a person, the registered manager would not inform people by text message, they prefer to speak to staff. Staff are also supported through the situation and enabled to attend funerals if possible.

Good

Is the service well-led?

Our findings

The provider had recently restructured the management of the service. Two registered managers were now supported by a trainee deputy manager and a trainee care coordinator. In addition, there were senior carers in post and a lead administrator will be recruited to. The new structure was developed to release the registered managers to focus on the services development.

Both registered managers have enrolled on training to support the development of the service. One will be completing a diploma which will aid the service in developing quality assurance. The other registered manager is completing a teaching and educational qualification so they can deliver in-house training. Following the generic teaching course, they will complete additional training in areas such as first aid and health and safety so they have the skills to provide high quality training to staff.

This was the provider's first inspection and as such they were not yet rated. Their website displayed a CQC registered logo link leading to their details on the CQC website. The registered managers had submitted a Provider Information Return (PIR) for the service evidencing practice for the last 12 months and telling us what they will focus on for the next 12 months. The provider also submitted notifications of significant events that they are required to tell us about by law, as and when they needed to.

The provider remained current with their knowledge and skills about care through training. One of the registered managers was being used by a training provider as a case study as they had successfully achieved their level 5 diploma in Health and Social Care in less than one year while developing a new care company and providing direct care to people. The provider used online training for staff which was updated as best practice or guidance changed. In addition, the provider retained a company to produce health and safety and human resources policies and procedures and practical support and guidance for dealing with HR matters.

Regular staff meetings were held however the provider recognised that staff would not all be able to attend each meeting. In addition, the provider had a private social media account where information could be shared that staff could access. If information needed to be communicated to staff members urgently the service was still small enough to contact each staff member by telephone and advise them. The Monday 'Huddle' meeting also facilitated sharing of information from the weekend to ensure that staff were up to date with any changes to care plans.

There was a strong commitment to the providers values. Staff were committed to providing high quality empathetic care to people. People were encouraged to make choices and decisions for themselves and staff forged relationships with people and their relatives so they could understand their situations more clearly. All staff members we talked with described how they would ensure someone received dignified care and maintained their respect throughout.

Both registered managers had provided hands on care during the development of the service and had taken a step back from the provision to focus on development. They had committed to attending each new

person's assessment and were also willing to step in and cover a care call if a staff member was delayed. Their involvement in the care delivery was respected by staff members who told us, "We love them [managers], I wouldn't leave as the bosses know what the girls can go through when on calls, that is the beauty of still being quite a small company".

The registered managers were proud of the staff retention levels they had achieved. They had lost only two staff members and staff indicated to us that they enjoyed working with the provider. Staff told us they were appreciated by the registered managers. If staff had worked particularly hard or had been able to supply cover for several shifts they would be thanked and the registered manager sent frequent flowers and other small gifts to staff members. They also gave gifts to staff at Christmas. Staff reported that morale in the teams was good. One staff member told us, "The job can be difficult, the hours are long but we help each other out. I have just completed my second 'on-call' shift and everyone was really supportive. I managed to cover some shifts in just 30 minutes".

Staff were encouraged to develop their career within the company. The provider funded some training courses to ensure that staff could develop their knowledge and skills. The registered manager told us they were keen to ensure that if staff wanted to take on more responsibility or training they could.

The provider had started to audit some systems and concerns such as accidents and incidents. At this stage in the services development, due to having a relatively small number of clients, audits were still in development. These would be developed as the service increased in size and as the registered manager completed their quality assurance qualification training.