Leonard Cheshire Disability

Douglas House - Care Home with Nursing Physical Disabilities

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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

Douglas House is registered to provide nursing care and support to 29 people. People living in the home have a range of needs which include complex physical nursing needs and learning disabilities.

The home had a registered manager. 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.

Summary of findings

This inspection took place on 24 November 2015 and was unannounced. There were 27 people living at the service at the time of the inspection. The service was last inspected in February 2014, when it met the regulations we looked at.

The service had a new registered manager. Staff told us "She's done really well" and "(Registered manager's name) knows what goes on". People, a relative, and staff told us the registered manager was approachable. Comments included "It's never an issue to approach her" and "I feel very happy I can talk to her". The registered manager had taken steps to ensure there was an open culture. They told us they had recently faced challenges as they did not have a full permanent staff team. They had identified this had impacted on people through use of agency staff, reduced key working time (a key worker is a staff member who is allocated to a person and supports them in their daily life at the service), and not as many activities as they would have liked. They were trying to recruit and retain the right staff, were keen to provide a good service and committed to making improvements. We found a number of changes to people's needs had not been updated in the care and support plans. This may have placed people at risk of inconsistent care. The registered manager had identified that care and support plans needed updating, before our inspection. They told us they had organised additional support until all plans were reviewed and updated.

People told us they were happy with the care and support they received. Comments included "The staff are very caring" and "I've always found them very helpful, nothing could be better". Staff spoke passionately about people they supported and wanted to achieve the best outcomes for them. People told us if they needed help, staff always came. Comments included "They attend to me quickly" and "I only have to ring my bell and they're here". During our inspection, staff responded to people's needs and requests in good time.

Staff knew people well and respected their wishes. Staff recognised when people were not feeling well and responded to this. Care plans contained some very personalised information. For example, how to meet personal hygiene by preparing washing items in a particular way. 'One page profiles' and personal histories were also available, to help staff know what was important to or about the individuals they supported. For example, what family they had, what their interests were, and what particularly mattered to them regarding any support they received from staff.

We saw people had friendships with others living at the home and were actively involved in making decisions within the service. For example, people had been involved in choices about the re-decoration of the dining room. The service had a day centre on the top floor that people could attend. On the day of our visit some people had gone swimming. Three people felt there were not enough person-centred activities and told us they would like more time with their key worker. Another three people told us they were happy they had enough to do. We saw a notice on the board in the corridor telling people about a planned meeting to discuss activities. People were supported to achieve their goals. For example, one person told us how staff had supported them to arrange a holiday and made sure all the proper arrangements were in place.

People were protected by staff who knew how to recognise signs of possible abuse. Where safeguarding concerns had been raised, the registered manager had worked with the local authority safeguarding team and taken appropriate action. Safe staff recruitment procedures were in place. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable people. Staff told us they were happy with the training they had received and felt skilled to meet the needs of the people in their care. People told us staff knew how to meet their needs effectively. Comments included "They know what they're doing, they really make an effort" and "They're continually training".

Where people lacked mental capacity to take particular decisions, these were made on their behalf, in their best interests and were as least restrictive as possible. Mental capacity assessments were in place. Staff gave examples of best interest decision-making they had been involved with, such as when one person wanted to remain in one place for a long time, causing risks to their health. One person was being deprived of their liberty as they were not able to leave the service on their own. The provider had made the appropriate application which had been authorised and they were meeting the conditions applied to the authorisation. Staff supported the person to access the local community and pursue their interests. People

Summary of findings

were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. Risk had been assessed for each person. For example, risk assessments were in place after a person had a serious accident, to safeguard them yet allow them to continue a lifestyle choice. Premises and equipment were maintained to ensure people were kept safe and there were arrangements in place to deal with foreseeable emergencies.

The service had systems in place to assess, monitor, and improve the quality and safety of care. The local authority's quality team had recently carried out an audit at the service. They had not identified any areas that needed action. People told us they felt able to make a complaint. The provider had a free phone helpline for people to make complaints, suggestions and compliments about the service. Where complaints had been received, the registered manager had investigated and responded to these. There was evidence that learning had taken place as a result of complaints. For example, staff had been spoken with in supervision to make sure an issue did not happen again. The quality team at the service's head office reviewed complaints to ensure they were managed appropriately.

Summary of findings

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.

People were protected from abuse by staff who could recognise signs of potential abuse and knew how to raise safeguarding concerns.

People were protected because recruitment procedures were robust. There were sufficient numbers of staff to keep people safe and meet their needs.

Accidents and incidents were reported and action was taken to reduce the risks of them happening again.

Is the service effective?

Good 

The service was effective.

People were supported by staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked capacity, relatives and health and social care professionals were consulted and involved in decision making about people in their best interest.

People were supported to maintain good health and access healthcare services. Staff recognised any deterioration in people's health and sought medical advice appropriately.

Is the service caring?

Good 

The service was caring.

People were positive about the caring approach of staff.

Staff knew people, spoke passionately about them, and wanted to achieve the best outcomes for them.

The service made sure that staff knew how to manage, respect and follow people's choices and wishes for their end of life care.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People may have been placed at risk of inconsistent care as a number of changes to people's needs had not been updated in the care and support plans. The registered manager had taken action to ensure all care plans were reviewed and updated.

Some people felt there were not enough person-centred activities to promote their wellbeing. The registered manager was aware of the situation and told us once permanent staff were recruited this would be addressed.

Summary of findings

Staff were responsive to people's individual needs and gave them support at the time they needed it.

Is the service well-led?

Good

The service was well-led.

The service had a new registered manager. They were approachable and had taken steps to ensure there was an open culture.

The service had systems in place to assess, monitor, and improve the quality and safety of care. The registered manager was keen to drive improvements in the home. They had identified the areas they needed to work on and had taken action to make improvements.

Douglas House - Care Home with Nursing Physical Disabilities

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 24 November 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This was a form that asked the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority to ask for their feedback about this service.

On the day of our visit, 27 people were using the service. We used a range of different methods to help us understand people's experience. We spoke with eleven people and one relative. We spoke with the registered manager, two nurses, and seven staff. We received feedback from two visiting health professionals. We looked at three care plans, medication records, staff files, audits, policies and records relating to the management of the service.

Good

Is the service safe?

Our findings

People said they felt safe and secure at the home. Comments included "I feel safe, there's no problem that way" and "Nothing to worry about". People were not afraid or reluctant to approach staff, and responded readily when staff engaged with them. There was information about how to raise safeguarding concerns on the walls in the corridors. People were protected by staff who knew how to recognise signs of possible abuse. Staff told us they had received training in how to recognise harm or abuse and knew where to access information if they needed it. Staff knew their responsibilities to report concerns about abuse and possible signs of abuse. This was important when some people couldn't say verbally if they were being abused. They felt the registered manager would listen to their concerns and respond to these. A nurse told us they had been involved in safeguarding investigations, linking safeguarding to Deprivation of Liberty Safeguards and the Mental Capacity Act, and had completed relevant training. Where safeguarding concerns had been raised, the registered manager had worked with the local authority safeguarding team and taken appropriate action.

People benefited from sufficient staff to meet their needs. People told us if they needed help, staff always came. Comments included "They attend to me quickly" and "I only have to ring my bell and they're here". Staff responded to people's needs and requests in good time. Staff did not seem rushed and remained calm and attentive to people's needs. One person told us staff did not have much time to chat. The registered manager told us staff would have more time to spend with people when permanent staff were recruited. The registered manager was on duty with a nurse, a care supervisor, a team leader and ten care staff. The service was using some agency care staff to cover shifts, until new staff were recruited. In addition there was a cook, a kitchen assistant, two housekeepers, laundry staff, and maintenance staff. At handover there was a 15 minute overlap of staff to ensure there was time to discuss people's needs. Staff we spoke with confirmed there were enough staff provided to meet people's needs. Some staff were working extra shifts to avoid people being supported by unfamiliar agency staff. Although some of the agency staff had regularly worked in the service and knew the people who lived there. Staffing levels were flexible so that people were able to go out or attend appointments. When a person with complex nursing needs moved in recently, an additional staff member worked overnight so the service could assess how the person was settling.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable people.

Risk had been assessed for each person. For example, risk assessments were in place which gave information to staff about the risks of pressure damage and malnutrition. These described the action staff needed to take to manage identified risks, such as the use of pressure relieving equipment and dietician involvement. We saw the actions had been taken, and the risk assessments had been reviewed regularly, promoting people's health and safety.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. People had locked storage in their bedrooms for their prescribed medicines. The nurse on duty gave people their medicines. Records of medicines administered confirmed people had received their medicines as they had been prescribed by their doctor to promote good health. The local authority trust carried out a medicines audit on 18 November 2015. They told us they were happy with the management of medicines at the service.

Where accidents and incidents had taken place, the registered manager reviewed these to ensure the risk to people was minimised. For example, risk assessments were in place after a person had a serious accident, to safeguard them yet allow them to continue a lifestyle choice. Staff had also considered how to keep other people safe who may be at risk.

The premises and equipment were maintained to ensure people were kept safe. For example, checks had been carried out in relation to fire, gas, electrical installation, lifts and hoists.

There were arrangements in place to deal with foreseeable emergencies. For example, fire plans were on display throughout the home. Staff were able to describe the action they would take in the event of a fire.

Good

Is the service effective?

Our findings

Staff told us they were happy with the training they had received and felt skilled to meet the needs of the people in their care. The provider employed a training team who visited the service to hold face to face training. Staff received regular training to make sure they knew how to meet people's needs. For example, this included training in fire, first aid, food safety, infection control, and medicines management. Some staff had been trained to deliver moving and handling training to their colleagues.

New staff completed the care certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. New staff worked alongside experienced staff to get to know people and observe how people had their care delivered. The registered manager told us they planned to introduce peer mentors for new staff. Peer mentors would be experienced staff members who would provide support and guidance. People told us staff knew how to meet their needs effectively. Comments included "They know what they're doing, they really make an effort" and "They're continually training".

The agency staff on duty, on the day of our inspection, had worked at the home on a number of occasions. They were familiar with the people who lived in the home. One person told us "There's been a lot of agency but they don't put two together" and "Some have been here quite a lot". Another person told us the agency staff didn't always know what they were doing. One person with communication needs indicated they sometimes felt frustrated. They felt they weren't always given enough time by staff to say what they wanted. We discussed this with the registered manager. Further to this, the person's key worker spoke with them and they indicated they found new agency staff didn't always understand what they needed. This was causing them some frustration. The registered manager told us agency staff always worked with the service's staff, so they worked with someone who knew people well. If an agency worker was struggling to communicate with a person, they were encouraged to seek help from a member of the service's staff. The registered manager added a reminder to the handover sheet for all staff to allow the person time to communicate their wishes.

Nurses accessed training from the NHS and local hospice, and support from specialist nurses. For example, one person was returning from hospital with equipment for promoting wound healing and staff were to be trained by tissue viability specialist nurses on how this was to be maintained. Nurses completed regular updates on first aid, rescue medicines, catheter and bowel care (such as needed to support people with paralysis) and PEG (Percutaneous endoscopic gastrostomy) feeding. This is a feeding tube used for people who are unable to swallow. A nurse told us they had just attended training on the verification of death.

Staff told us the staff handovers were useful. Staff commented "You find out who you will be working with. We each have a handover sheet and staff talk about each person. They are very clear" and "We have a really good handover, everyone's input is listened to and acted upon. If something works well, let's all do it".

Most staff felt supported in their role. They commented "We speak every day" and "I have regular supervision". Staff told us they spoke with their manager about their job role and felt able to discuss any issues. Where it had been identified that staff needed additional support and supervisions, these had taken place. One nurse told us they had received one supervision meeting in the past year, adding "More would be good" in order to discuss any concerns. The registered manager told us more regular supervisions would take place when they were fully staffed.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

The 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. Mental capacity assessments were in place. Staff gave examples of best interest decision making they had been involved with, such as when one person wanted to remain in one place for a long time, causing risks to their health.

Good

Is the service effective?

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). The service had made one DoLS application which had been authorised. The provider was meeting the conditions applied to the authorisation. The person was not able to leave the service on their own. Staff supported the person to access the local community and pursue their interests.

People had regular access to healthcare professionals such as GPs, occupational therapists, chiropodists, opticians, and dentists. One person told us they made their own health appointments and were supported by staff to attend these. Two people told us about their visits to the in-house physiotherapist. They were both happy with their progress. One person said "I go up every morning for 30 minutes. (Physiotherapist's name) is very good. It's tailored to what I can do". The speech and language therapist (SALT) told us they had a good relationship with the registered manager and care supervisor. They said "They ring and talk to me about patients and request regular reviews. When I'm there somebody usually accompanies me to see the patient and so I am able to feedback to them and often talk to the kitchen staff too. I feel they know their clients well". A respiratory specialist nurse said "The team seem very able with some initial support from the specialist team to provide safe and effective care of a high standard to patients with very complex ventilation needs".

People were supported to have enough to eat and drink. People who were able to could help themselves to hot drinks in the dining room. Staff offered other people drinks. Drinks with thickeners were given to the people who had been prescribed them. Staff were available to assist where necessary. At lunchtime people ate in the dining room or their bedroom. If people wanted an alternative, these were always available. The meal on the day of our inspection was gammon, egg and chips. The cook told us alternatives served had included pies, sausages, jacket potato, and a hot pot. Some people enjoyed their lunch independently, whilst staff encouraged others to eat. Where staff assisted people to eat, this was done at the person's pace. Staff chatted with people as they assisted them.

Mealtimes were flexible to meet people's needs. For example, some people chose to get up later than others. Breakfast was available in the dining room until late morning. One person told us "There's eggs, a huge variety of cereals, croissants, fruit and a brunch once a week. You can have as much as you like". Three people had gone swimming and their lunch was kept for their return. People also had fridges in their rooms which they stocked themselves, with staff doing shopping for them if necessary.

The cook had a clear understanding of people's likes and dislikes. Information for staff about people's preferences and special diets was kept in the kitchen. People who required a soft diet had this individually pureed. A range of desserts were available for diabetics and sweeteners were used when baking cakes. Snacks such as fruit, biscuits, crisps, and cheese and biscuits were available between mealtimes.

Good

Is the service caring?

Our findings

People told us they were happy with the care and support they received. Comments included "The staff are very caring" and "I've always found them very helpful, nothing could be better". People told us staff gave them explanations, listened to them, and respected their wishes or choices. A visiting health professional told us "Communication and care always appears to be very good and the patient appears to be at the heart of what they do".

Interactions showed staff were patient and gentle when meeting people's needs. For example, when a staff member went to assist one person to eat their lunch, they found the person was dozing. They used gentle touch and asked the person if they would like their lunch. They spent time sitting next to the person and checked they were ready for more. When a sudden noise was heard outside, the staff member held the person's hand, chatted to them and reassured them.

Staff spoke with compassion about people. Staff told us "The people who live here are just amazing" and "The people here are put first". We saw the staff had already started buying Christmas presents for people who lived in the home. Staff addressed people's requests politely and promptly. People were involved in their daily care. We heard staff explain what they were doing, including if they were about to leave a person, if they were intending to return and why.

People had friendships with others living at the home and were actively involved in making decisions within the service. For example, at the last meeting for people in September 2015, we saw they had discussed the re-decoration of the dining room. A choice of flooring, blinds, and paint had been placed on a mood board in the dining room for people to see. People had made their choices. For example, the lights in the dining room had been replaced with red shades which people had chosen. A meeting was held every few months. An agenda was placed on the wall in the corridor for people to add items for discussion. One person told us they were able to say what they thought.

The provider information return told us the provider employed personalisation and involvement officers. Their role was to support people to have the confidence to speak up themselves or access local advocacy services who would speak up on their behalf. If people needed support, they had access to a customer support team via the telephone. The telephone number was on a poster in the corridor.

People told us their privacy was respected. Some people who lived in the home had chosen to have a sign on their door which told staff and visitors "This is my front door, Please knock and wait for my response". People confirmed that staff did wait before entering their bedroom. People were called by their preferred name. Staff were careful to close doors when carrying out personal care to respect people's privacy. We saw there were curtains across bedroom doors, which could provide privacy if a person wanted their door left open. The people who lived in the home had written a 'residents charter'. This asked staff and visitors to "Please respect our home as you would yours".

People's rooms were personalised to reflect their personality and interests. One person told us how staff had recently helped them to put their new furniture together.

Relatives and friends could visit at any time. One relative told us staff always made them welcome.

People were involved in the planning and management of their end of life care. For example, one person was diagnosed with a terminal illness. The person had a 'bucket list' of things they wanted to do. Staff supported the person to achieve the activities on the list. The person wished to remain in their home so the service worked with visiting hospice staff to make sure this happened. The service had completed 'Last years of life' forms to describe what support people wanted at the end of their life and in the event of certain medical emergencies. These provided detailed information for staff.

Requires improvement

Is the service responsive?

Our findings

Each person had a care plan and a support plan which contained their social and medical needs. These were meant to be updated every six months or when a person's needs changed. We found a number of changes had not been updated in the care and support plans. This included one person's sleeping pattern and how to manage their distress, how to support people during the morning and at lunchtime, and a change to mobility equipment. This meant people may be placed at risk of inconsistent care. The registered manager told us changes were reported to care staff verbally at each handover. They had identified that plans needed updating. They told us they had organised for additional support to review and update all care and support plans. One of the nurses was working on the plans, three days a week, until this was completed.

However staff knew people well, checked their understanding of the person's response and respected their wishes. Staff recognised when people were not feeling well and responded to this. For example, staff told one person they would assist them to the dining room for breakfast and the person replied they wanted to stay in their room. Staff checked they had understood and through making further conversation realised the person wasn't feeling as well as they usually did. They then explored what the person wanted for breakfast, offering alternatives to try to tempt them to eat something. They also said they would tell the nurse about the person's condition, and we later noted the nurse following up how the person felt.

Care plans contained some very personalised information. For example, about how to meet personal hygiene by preparing washing items in a particular way; putting toothpaste on their brush so the person could clean their teeth; using skin wipes on one person's face (rather than using water, which the person disliked), and how to meet dressing needs such as which arm to put into clothing first. In some cases, photographs were used to show staff exactly what care was required, such as for positioning of a limb. 'One page profiles' and personal histories were also available, to help staff know what was important to or about the individuals they supported. For example, what family they had, what their interests were, and what particularly mattered to them regarding any support they received from staff.

People or those acting on their behalf were able to contribute to the assessment and planning of their care. A relative told us staff from the service had carried out an assessment in hospital. They told us they were completely involved in the process. Despite the person being discharged at short notice, the service responded and worked really hard to ensure the person's room was ready and they were comfortable during their first night. They said "It was the right choice".

The service had a day centre on the top floor that people could attend. Activities included art, quizzes, and pottery. Volunteers held a curling session at the weekend. The service had access to four minibuses. On the day of our visit some people had gone swimming. Staff told us some people were always "in and out", and that more outings took place in the summer or better weather – to shops, the bank, Brixham festivals, or just for a ride around. One person told us how they enjoyed helping out in the home's reception area. They greeted visitors, answered the phone, and took messages. Several people told us they had enjoyed the service's fun day event which had been open to the local community.

Three people felt there were not enough activities available. Staff had suggested in a meeting that people would benefit from a 'more diverse in-house activity programme'. Records did not reflect how people were supported to carry out person-centred activities to promote their wellbeing. Several people told us they would like more time with their key worker. A key worker is a staff member who is allocated to a person and supports them in their daily life at the service. Staff had raised concerns in a meeting that there was not enough time for key working. The registered manager was aware of the situation and told us once permanent staff were recruited these issues would be addressed. Three people told us they were happy they had enough to do. We saw a notice on the board in the corridor telling people about a residents' meeting that had been planned to discuss activities.

People were supported to achieve their goals. For example, one person told us how staff had supported them to go swimming, arrange a holiday and made sure all the proper arrangements were in place.

People told us they felt able to make a complaint. Complaints information was in people's care files. There was also information about a free phone helpline for people to make complaints, suggestions and compliments

Requires improvement

Is the service responsive?

about the service. Where complaints had been received, the registered manager had investigated and responded to these. There was evidence that learning had taken place as a result of complaints. For example, staff had been spoken with in supervision to make sure an issue did not happen again. One person told us they had made a complaint to the service's head office because a piece of their equipment was broken for some time. It was then dealt with promptly. They felt able to complain again if necessary. The quality team at the service's head office reviewed complaints to ensure they were managed appropriately.

Good

Is the service well-led?

Our findings

The home had a registered manager. They had registered with the CQC in March 2015. Staff told us "She's done really well" and "(Registered manager's name) knows what goes on". The registered manager was working towards the Level 5 Diploma in Leadership and Management.

The registered manager told us they had recently faced challenges as they did not have a full permanent staff team. They had identified this had impacted on people through use of agency staff, reduced key working time, and not as many activities as they would have liked. They were trying to recruit and retain the right staff, were keen to provide a good service and committed to making improvements.

The provider information return said "We encourage open and honest communication with people who use the service, staff and other stakeholders". People, a relative, and staff told us the registered manager was approachable. Comments included "It's never an issue to approach her" and "I feel very happy I can talk to her". The registered manager had taken steps to ensure there was an open culture. For example, staff had completed a training scenario which encouraged them to think about how they communicated with people on a daily basis.

Staff worked well as a team to make sure people got what they needed. Comments included "The team is really good" and "Staff are really helpful". Staff knew their roles and responsibilities. Staff told us this had been discussed during staff meetings. Minutes of staff meeting showed improvements to the service were discussed. For example, the speech and language therapist had asked for the meat in pies to be cut up smaller. There was an action for the cook to contact the butchers and request this. We spoke with the cook who told us this had been actioned. Staff reported getting some feedback for learning or improvement purposes, such as after the residents' survey when staff were asked to stop taking their breaks in the dining room as people didn't like this.

Nominations had been sent to head office for the annual staff awards. Certificates showed Leonard Cheshire Disability had recognised staff for their excellent care and for working together. Minutes of staff meetings showed us that the management team within the home valued them. Comments included "An enormous thank you to everyone, for all your continued support" and "Staff need to be valued and as a team, we need to support each other and our residents".

The registered provider's vision and values for the service were displayed on a wall in the corridor. Staff knew the vision and values for the service and this was reflected in their practice. Staff told us they felt it was important to enable and empower people, make sure they were happy and comfortable in their home, and treat them as equals. One staff member told us one person wanted their wheelchair sprayed a certain colour so this was arranged, for example. They also told us "You're like one big happy family, without [staff] being unprofessional".

There were systems in place to assess, monitor, and improve the quality and safety of care. For example, we saw audits were carried out on a regular basis to look at the environment, management of medicines, and accidents. The local authority's quality team had recently carried out an audit at the service. They had not identified any areas that needed action.

The service had received a food hygiene visit in January 2015. They had been awarded a rating of five. This was the highest rating and showed the service maintained very good hygiene.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.