Milewood Healthcare Ltd

Willow Tree House

Inspection report

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Haxby
York
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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?	Requires Improvement

Summary of findings

Overall summary

Willow Tree House is a supported living service for people with a learning disability and/or mental health needs. The site at Haxby supports people to live as tenants in self-contained flats comprising of a lounge, which includes a kitchenette unit, a bathroom and a bedroom. There is also a communal lounge where people can sit and socialise, if they choose. The registered provider is not the landlord for these flats, and people have a tenancy agreement with the landlord. The service can also provide support for people in their own homes, who do not live at the address in Haxby. Since our last inspection the service had started providing support to a group of tenants who lived in self-contained flats at a property in Heworth. At the time of our inspection, 13 people were supported at the site in Haxby and five people were supported at the site in Heworth.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good overall, although the key question: Is the service well-led? now requires improvement. This was because there was no registered manager at the service. The service is required to have a registered manager, and as such, the registered provider was not meeting the conditions of their registration. 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. A new manager was in post, but had yet to register with the Commission.

There were systems in place to prevent the risk of harm or abuse. Staff were knowledgeable about what constituted abuse and how to respond if they had any concerns. The registered provider completed a range of risk assessments according to people's individual needs, and these provided guidance to staff on how to minimise the risk of harm to people.

There were systems in place to ensure people received their medicines as prescribed. People were also supported to maintain good health and access healthcare services.

There were sufficient staff to meet people's needs, and staff received training and supervision. Staff had been recruited following appropriate checks, to ensure they were suitable to work in a care setting.

There was a lack of clarity in some mental capacity assessments, which the manager agreed to address. However, care staff we spoke with had an awareness of their responsibilities in relation to the mental capacity act and were able to demonstrate a good understanding of the importance of gaining consent before providing care to someone. People confirmed that their choices and decisions were respected.

People told us they had good relationships with staff and during our inspection we observed positive, caring interactions between staff and people who used the service. People also told us that staff respected their privacy and dignity, and always sought permission before entering their flats.

There were comprehensive care plans in place, which guided staff on how to meet people's individual needs. These were regularly reviewed. The level of support people received was tailored to their needs, and support was provided to enable people to pursue hobbies and interests. Most staff demonstrated a good knowledge of people's individual needs and preferences.

People confirmed they would feel comfortable raising concerns or complaints if they had any, and there was a system in place to respond to complaints. They were also able to raise issues in tenants meetings and individual care reviews.

The registered provider conducted quality assurance audits and satisfaction surveys to measure the quality of the service provided. Some suggestions for improvement from a relative and a visiting professional included activities and communication, but overall most survey respondents were satisfied with the service provided, and all the people we spoke with during our inspection were happy with the care they received.

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.

There were systems in place to protect people from avoidable harm. Staff were knowledgeable about safeguarding vulnerable adults procedures and knew how to respond to any concerns.

The registered provider completed appropriate checks before staff started work, to ensure that people were supported by staff who were considered suitable to work with vulnerable people.

There were systems in place to ensure people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff received an induction and refresher training, although records in relation to these were not always consistently maintained.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care.

People accessed healthcare services and professionals in order to maintain good health. Staff provided support with people's nutritional needs.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and we observed friendly, supportive interactions between staff and people who used the service.

Staff supported people to develop independent living skills and promoted people's independence wherever possible.

People we spoke with told us that staff respected their privacy

and dignity.

Is the service responsive?

Good

The service was responsive.

The registered provider developed detailed care plans to enable staff to provide personalised care. Most staff were able to demonstrate that they knew people's needs and preferences well.

There were systems in place to manage and respond to complaints, and to listen to the views of people who used the service.

Is the service well-led?

Requires Improvement

The service required improvement to become well-led.

The service had a manager, but they were not yet registered with the Commission.

Staff told us the manager was approachable and provided them with the support they needed. We found there was a person centred culture at the home.

The registered provider conducted a range of audits in order to monitor the quality of the service provided.

Willow Tree House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 14 and 16 February 2017 and was announced. The provider was given 24 hours' notice because the service provides support to people in their own flats and we needed to be sure that someone would be in.

The inspection was carried out by two adult social care inspectors and an expert-by-experience on the first day of our inspection, and one adult social care inspector on the second day of our inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service including notifications about any incidents at the service and questionnaire feedback. Prior to the inspection we received some information of concern and we looked at the issues raised as part of our inspection.

We contacted commissioners from the local authority and the manager of a team of healthcare professionals in order to get their views about the service.

As part of this inspection we spoke with eight people who used the service, three support workers, the manager, the deputy manager and an area manager. We looked at three people's care records, medication records, three staff recruitment and training files and a selection of records used to monitor the quality of the service. We spent time in the communal area at Willow Tree House on the first day of the inspection and observed staff interacting with people who used the service at both locations during the inspection.

Good

Is the service safe?

Our findings

People we spoke with all confirmed they felt safe and their comments included, "I'm safe and the general atmosphere is nice," "It's safe. No-one breaks in, there's not too much agro and there's enough staff" and "I definitely feel safe. Both the doors are coded so the public couldn't just walk in. I know the codes. And we have a key for our flat. Staff are always there to help if you need it." We observed that people looked comfortable and at ease when talking with each other and with staff.

The registered provider had policies and procedures in place to guide staff on how to safeguard people from the risk of abuse or harm. Staff confirmed they had received training on how to safeguard people. In discussions, they were clear about what constituted abuse and what they should do if they witnessed poor practice or had concerns. Safeguarding records were retained on the registered provider's computer system, and the manager had recently set up a log book in order to track details of any safeguarding concerns and actions taken in response to these. The service sent information about safeguarding allegations promptly to the CQC, as they were required to do by law. Staff we spoke with were aware of the organisation's whistleblowing procedure. One told us, "I would report if I had any concerns and would use the whistleblowing procedure. [Name of manager] would keep it confidential. And I would go to the area manager if really concerned. They are approachable and would take things seriously."

The registered provider developed risk assessments according to people's individual needs. These included assessments in relation to verbal and physical aggression, road safety, kitchen safety, the risk of financial abuse, choking and specific activities. The risk assessments guided staff in how to respond and minimise risk to people. Most had been regularly reviewed; there were gaps in the frequency with which some risk assessments had been reviewed in the past, but all those we reviewed were up to date at the time of our inspection.

We saw records of accidents or incidents were completed by staff and reviewed by the manager to make sure appropriate action had been taken in response to any incidents. Although Willow Tree House provided support to people in their own tenancies, staff completed checks on the buildings and environment in order to promote people's safety and well-being. This included fire safety checks and fire drills, and a checklist which staff regularly completed with people in relation to the safety and cleanliness of their flats. The registered provider also completed risk assessments in relation to generic service risks such as fire, lone working, electricity and slips, trips and falls, in order to identify any actions required to minimise risk to people and staff.

We found recruitment practices were safe, with employment checks being carried out prior to new staff starting work at the service. These included an application form to explore gaps in employment, two references, an interview and a check made with the disclosure and barring service (DBS). DBS checks highlight any criminal record and whether the potential candidate has been barred from working in care settings. We noted here was an incorrect start date recorded on one staff member's contract and some files were not always consistently organised. However, the manager was able to locate the information we required, in order to demonstrate that appropriate recruitment practices had been followed.

We spoke with staff and people who used the service about whether there were sufficient staff to meet people's needs safely. One person told us, "There are always staff about when I need them. When I first came here the staffing wasn't as good because they were recruiting as it was a new service, but it's better now and I always get my individual hours (of support) now." Other people we spoke with all confirmed to us that they felt there were enough staff.

Staff told us there were enough staff to meet people's needs. We saw from rotas that people had designated individual support hours each week according to their needs, and these hours were used when people wanted them. In addition, there was a 'float' staff member who was available to people should they need any additional assistance at other times. Staff told us they planned on the rota in advance if someone wanted to go on a trip out somewhere, but there was usually sufficient flexibility in the rota to make shorter unplanned trips, such as to the local shops, if people wanted. There had been a number of staff changes in the previous year, but we were advised that there was now a stable team and no current staff vacancies. Staff generally worked either at the Haxby location, or at the Heworth location, but could provide cover at the other location if required.

There were systems in place to ensure people received their medicines as prescribed. Staff received training in medicines management and the registered provider had a medication policy and procedure for staff to follow. Medicines were stored securely in people's flats. The registered provider risk assessed people's ability to manage and administer their own medicines, although the majority of people required assistance from staff with their medicines. People's consent to receiving support with their medicines was recorded. We looked at a selection of medication administration records (MARs). There were some occasional gaps in these records but we found that the majority were appropriately completed, to show that people had received their medicines as prescribed. Any gaps or errors in MARs were explored by the manager in regular medication audits. We noted that the information in people's care plan about the current medicines they were taking was not always up to date or consistent with the MAR. The manager agreed to rectify this straightaway. They confirmed that the MARs were all correct and reflective of people's current medicines, and that staff administered medicines in line with the MARs. We observed staff supporting people appropriately with their medicines.

Nobody raised any concerns with us about the support they received with their medicines, and one person told us, "We all have a cabinet in our flat but staff have a key for it. They always remember to give me my medication. I am very happy with them having a key and helping me, because in the past I've forgotten to take my medication sometimes when I've needed them, so I like the fact that staff have the key and always remind me to take them."

Good

Is the service effective?

Our findings

People who used the service told us that staff had the skills to support them. People's comments included, "The staff are well trained; they know what they are doing" and "I have two keyworkers and they both work really well with me." A healthcare professional told us that although they had some concerns about staff turnover and communication at the service, they found that staff worked very well with people, including a number of people who had particularly complex care needs.

We found staff completed an induction when they started in post, along with training in a range of topics considered essential by the registered provider. This included training in health and safety, moving and handling, medication, safeguarding vulnerable adults, food hygiene and fire safety. Some of the training was delivered face to face and other training was completed via competency workbooks. The registered provider's training matrix reflected the face to face training courses that staff had attended, and staff's completed training workbooks were retained separately. The manager told us that where people had completed training workbooks on topics they would also have the opportunity to attend face to face training in addition, when places became available on the courses. We noted that the number of staff who had completed their induction was incorrectly recorded on the training matrix. The manager addressed this and sent us the updated version after our inspection. Some training certificates were not consistently filed in staff records. Staff confirmed to us the training they had received and one told us, "The induction and training gave me the information I needed. I had some knowledge already (from previous employment) but [Name] was a fantastic trainer. The interactions were really good and based on scenarios, which was really good for discussion." Staff we spoke with were knowledgeable about people's needs and preferences.

We found that staff received regular supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice. We saw examples where supervision was used to address specific concerns regarding practice and to assess staff knowledge on particular topics. Team meetings were also held regularly, which gave staff opportunity to discuss any issues in relation to people or the running of the service.

This showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In community settings applications to deprive someone of their

liberty must be made to the Court of Protection.

We checked whether the registered provider was working within the principles of the MCA. The registered provider had recently introduced new mental capacity assessment paperwork and it was evident from the examples we looked at that the new paperwork was not well understood, because it was incorrectly completed in two cases. In one case, the decision that staff were assessing the person's capacity to make was not clear and in the other case the assessment concluded that the person did not have capacity to consent to their care plan. However, the person had signed all their care plans and discussion with staff suggested they did have the capacity to make some basic decisions about their care. We discussed this with the manager and area manager and they agreed to complete the documentation again, to ensure it was clear and consistent.

Not all staff had completed formal training in relation to the MCA and DoLS, but all of the staff we spoke with were able to demonstrate an awareness of the principles of the Act and understood the importance of gaining consent before providing care to people. One told us that MCA was referenced during other training they had completed, such as medication and MAPA (Management of Actual or Potential Aggression). Another told us they had completed a face to face MCA training course, and an MCA training workbook. Staff were able to give us specific examples of how they knew when people they supported who did not primarily communicate verbally, were consenting to the care they offered. They showed good understanding of how best to present information to particular people in a way that enabled them to understand and retain the information, to help them with decision making. Staff were also able to tell us which people had a Power of Attorney for health and welfare, who should be consulted in decisions about their care. As this was a community based setting, the responsibility for submitting DoLS applications was with the local authority funding the person's care. The manager told us they were currently working with the local authority to ensure that DoLS applications were submitted for three people who used the service.

People were supported to maintain good health and access healthcare services. All the people we spoke with felt their health needs were met, and their comments included, "The staff support me with medical appointments," "I go to the doctors. I make my own appointments at the doctors, hospital, dentist and podiatrist" and "They (staff) would definitely help me see the GP or dentist if I needed to. The GP is only 2 minutes from here; it's walking distance. If staff think there is anything wrong with me, that I haven't already noticed, they will say 'we recommend you see the GP about that'. For example, because of my condition I can't always tell if my feet are cracked or sore, so staff check them for me and will suggest if I need to see the doctor." This person also told us how much they appreciated the fact that staff would be attending a forthcoming hospital appointment with them, because they were anxious about the treatment they would be having and staff had provided them with reassurance that they would be available to support them.

We saw evidence in care files that people had received support from healthcare professionals, such as the community nurse, GPs, psychiatrists, dentists and chiropodists. Pre-arranged appointments were noted on the staff rota, so that staff were available when required. Care files also contained 'hospital passports.' These were communication aids, to be used if people needed to go into hospital. They helped hospital staff understand what people's care needs were and how to communicate effectively with individuals.

People who used the service were supported with their nutritional needs. Details of the support people required with their food and nutrition was contained in their care files. Some people were able to shop for food and prepare most of their meals independently, but others required more support from staff with food preparation and cooking. Staff were aware of the importance of encouraging a healthy, balanced diet but were also respectful of people's choices. They were also aware of people's specific dietary requirements. People confirmed to us that they received support from staff with planning and preparing meals, where this

was required. One person told us, "Staff help me with lunch and tea. I do it myself but they stand beside me to check I'm doing it alright and that it's cooked properly. They try and promote healthy eating. They know I struggle with money and knowing what to buy, so help me with this and take me shopping." Another told us, "I cook with the staff. I'm not the most accomplished chef but I'll have a go. I try to eat healthily." One person mentioned to us that they liked fruit and we noted they had fresh fruit available in their flat.

Good

Is the service caring?

Our findings

We spoke with people about whether staff were kind and caring in their approach. People's responses included, "They (staff) are very kind. I have no problem with them. Every so often they ask me if I'm alright and they do that with everyone. They will come and watch soaps with me and talk to me, ask me how my day was. I know everyone that works here. [Manager] will always introduce us to new staff." Other people told us, "Staff are approachable," "If there's anything wrong I can go to the staff" and "I can talk to the staff, they look after me and care for me."

Throughout our inspection we found that interactions between staff and people who used the service were generally warm and friendly. Staff were respectful, attentive to people's needs and requests, and listened to what people had to say. One staff member told us, "I'm really proud of the relationships people have with staff, and seeing people's faces when they see certain staff."

Although people had their own flats, comments from people suggested that there was a sense of community within the overall properties. For instance, one person at the Heworth property told us, "We all like living together. We all chat together. We come together and play games with staff sometimes. Every so often a staff member may have an idea to cook a big meal for everyone who lives here and for staff and we all eat it together; that's nice. Just every so often though, not all the time, because we usually make our own meals in our flats."

People told us they were involved in decisions about their care and about issues in relation to the service. There were 'speak out' meetings where people could meet collectively to discuss any concerns and ideas for the service. People confirmed to us that they met with their keyworker/s regularly to review their care plans and felt involved in this process. One person told us, "Staff always listen to my views. If I want to arrange a day out, for example, they always help me arrange that. So I know they definitely listen to me."

The number of support hours each person received per week varied according to the needs of the individual. This was based on an assessment by the funding authority, in discussion with the registered provider. Some people were very independent and required minimal support from staff each week, such as with budgeting and aspects of daily living skills. Other people required more support, such as assistance with personal care, accessing the community, shopping and cooking. Staff described to us how they promoted people's independence, and gave us specific examples of how they encouraged people to do as much for themselves as possible. This was confirmed by people who used the service. One told us, "Compared to where I was living before I get a lot more independence and freedom. I can go out on my own or with staff."

People told us that staff respected their privacy and dignity. Comments included, "They (staff) respect my privacy, they always knock" and "Staff support me with everything with personal care. They explain everything to me every time, to remind me what I'm doing. They knock on the door before they come into my room and make sure I'm okay when I'm showering, from my room." Another person told us, "Staff will knock on the door (to my flat) and I answer it. I like to leave my door open so I can interact with people coming past. But staff will knock even when my door is open."

We discussed with staff if anybody who used the service had any particular diverse needs in respect of the protected characteristics of the Equality Act 2010. Most people who used the service could potentially be at risk of discrimination due to their disability. Staff told us how they supported one person with specific nutritional needs in relation to their faith. This was confirmed by the person. Care files contained care plans in relation to people's spiritual and cultural needs and personal relationships, and the registered provider had an equality and diversity policy, which was reviewed regularly.

People confirmed to us that their friends and family could visit them whenever they wanted and several people told us they had very regular contact with their family.

Good

Is the service responsive?

Our findings

The registered provider developed a care plan for each person, which detailed the support required from staff. It was evident that people had been involved in developing and reviewing their care plans. People told us, "I have a care plan and targets; we review them. I've got one (review meeting) coming up" and "I am definitely part of doing the care plan. They (staff) sit down with me every month and ask me how it is going and if there is anything I want changing. If I ask for a copy of anything in my care plan they will give me it."

We found care files contained detailed information about people's needs and preferences. There were care plan sections in relation to the support required from staff in a range of areas, including; communication, personal care, finances, leisure activities and social networks, spiritual and cultural needs, daily living skills, mobility and health. We found care plans contained information about people's personal objectives. Care plans were reviewed regularly and updated where required. This meant that staff had the information they needed to provide personalised care to people.

Our discussions with staff showed that they knew people's needs and preferences well. We saw staff adapted their approach to the needs of individuals. There was however, one incident where a newer staff member mistakenly believed that it was part of one person's care plan that they should not be told in advance which member of care staff was going to be supporting them each day, to avoid potential distress and anxiety should staffing need to change at short notice. The mistake led to the person involved becoming frustrated and angry. We saw that the manager took prompt action to clarify the misunderstanding with the staff member and provide assurances to the person. Staff also responded appropriately and took time to listen to the person and reassure them, until they felt calmer and less distressed. Whilst the incident highlighted that the new staff member had not understood this aspect of the person's care plan and therefore the incident could have been avoided, the response to the situation showed that the team knew how to work with the person to resolve their anxieties and ensure the issue did not occur again. Staff told us they were given time to read people's care plans.

There were a range of monitoring records in place to document the support provided and monitor particular issues, such as behaviour monitoring records, records of activities offered, support provided with personal hygiene and daily handover records. These were generally well completed, but we did note occasional gaps in the personal hygiene records and food charts. We noted a reminder had been given to staff in a recent team meeting about monitoring records and the detail required in handover records.

People told us about the leisure and work related activities they took part in, and the community facilities they accessed. Some people required support from staff with this but others were able to access these activities independently. People and staff confirmed that rotas were arranged so that people had staff at the times they needed them. Prior to our inspection a concern had been raised with us about the lack of variation and encouragement with activities, but nobody we spoke with during our inspection raised any concerns in this area. One person told us about a 'healthy mind, healthy body' course they were doing at the local university, and another told us about the work placement they had and the social activities they took part in. We saw people came and went throughout our inspection, on their way to activities and

appointments, and care files included information about the activities people took part in.

The registered provider had a complaints policy and procedure, and a system in place to respond to complaints. The manager had recently established a new log for recording complaints and minor concerns, including information about action taken in response to these. We saw that some recent concerns had been raised by staff and were still under investigation at the time of our inspection. The registered provider told us that they had also received concerns during the previous year from the family of one person, and they were working with officers at the local authority on an on-going basis to resolve these.

People we spoke with told us they knew how to raise any concerns they may have and would feel comfortable doing so. One person told us, "I could definitely tell staff if I had any problems or complaints. I would probably speak to [Manager] first but if they're not in I'd speak to any of the staff." Others told us, "If I want to make a complaint I go to staff, then to a senior and if I'm still not happy [the Manager]" and "If I've got a complaint I go to staff then [the Manager]." People also told us they had the opportunity to raise any concerns, ideas and suggestions at monthly 'speak out' meetings with other tenants, and at their individual review meetings and in feedback surveys.

This showed us that people's views and opinions were encouraged and that there was a system in place to respond to complaints.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager for the service, which is a condition of the service's registration. A new manager had been in post for approximately five months but they had only recently begun the initial stage of application to become the registered manager for the service. We are therefore unable to rate the question: Is the service well-led? any higher than requires improvement. The registered provider has advised us of their intention to ensure the manager is registered with CQC as soon as possible.

The manager was supported by a deputy manager. They each typically spent half their week at one site, and the rest of their week at the other site, working opposite each other so that there was usually one of them available at each site during the week days. There were also senior support workers, who co-ordinated and supported staff on a day to day basis.

The manager was generally clear about their role and responsibilities. They did not however, demonstrate a confident understanding of all the circumstances which would require them to send a statutory notification to CQC. Notifications are when registered providers are required to send us information about certain changes, events or incidents that occur. They told us they would seek advice from their area manager and would refer to CQC guidance, to make sure they had a good understanding. Notifications had been appropriately submitted to CQC during the previous year.

People and staff we spoke with were positive about the support provided by the manager. All the people we spoke with were aware who the manager was and felt they could talk to them about anything. One told us, "[Manager] is very approachable." Staff told us, "[Manager] is very good, and has changed things a lot. [Manager] and [Deputy manager] know both places very well. Morale is much better now. Staff are well supported. It works well having an assistant manager and a manager." Another told us that the management and leadership of the service was "Really good." Comments from one staff member suggested that there had been some minor animosities between staff in the past, but these had been dealt with. We saw evidence of staff supervision and team meetings, and staff told us they felt able to raise any concerns.

Staff told us that the service aimed to create an environment where people felt safe and could come to staff with any concerns. They also told us they aimed to be an effective service, where people's independence was promoted and daily living skills were gained, in order to empower people. One staff member told us, "I've loved every day so far." This showed us that the service promoted a positive, person-centred culture.

A healthcare professional told us they had experienced some problems with communication and organisation at the service. We also received a separate concern from a member of the public prior to our inspection, regarding a lack of organisation at the service since the last registered manager left. Staff showed us their communication and handover systems and one told us there had been improvements with management and organisation over the last six months. There were communication systems in place and no one raised any concerns with us during the inspection regarding communication and organisation. However, the comments we received prior to the inspection, and a comment we saw in a recent satisfaction

survey completed by a visiting professional, showed that this was an area the registered provider needed to continue to monitor.

The registered provider had a quality assurance system in place. They conducted monthly operations audits and medication audits, as well as six monthly infection control audits. Where audits identified that action was required, there were action plans in place with timescales for the completion of tasks. We found most actions had been completed in a timely manner. For example, the January 2017 operations audit identified that admissions paperwork needed to be completed for one person, and we found that this had been completed because their care plan was in place when we inspected.

As well as audits, the registered provider conducted satisfaction surveys, to seek feedback from people, relatives and professionals. The most recent survey was conducted in January 2017. Of the four responses from relatives, the majority of comments were positive but one respondent felt there was not enough for people to do and there was not always sufficient food in their relative's flat. However, other respondents commented, 'Over the last few months the home has gone uphill. Atmosphere in general seems pleasant and better. I do want to commend the staff for their good effort.' Seven people who used the service had responded to the most recent survey. The majority of responses were positive but one person suggested they had limited communication with some staff. We were told that the registered provider was collating all the responses to the surveys and would respond to the feedback received by making any required improvements.

People we spoke with during our inspection were all happy with the care they received.