St Anne's Community Services

St Anne's Community Services - Calderdale Supported Living

Inspection report

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Date of inspection visit:
05 January 2016

Date of publication:
19 February 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of Calderdale Supported Living took place on 5 January 2016 and was announced. This was to ensure there would be someone at the property to greet us as people attended community activities on a regular basis. At the previous inspection in February 2015 the service was found to be non-compliant in relation to the safety the premises, consent to care and treatment, records and supporting staff. We checked whether any improvements had been made in these areas.

The service provides personal care and support for people with learning disabilities who may also be on the autism spectrum. There were seven people living in adjoining houses, four were in one and three in the other. People lived in tenancies agreed with the housing provider. The personal care support is separate from the provision of accommodation. The accommodation is split into two houses that connect through the office.

There was a registered manager in post on the day of inspection. 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.

People were safe as staff had a sound understanding of safeguarding and how to protect people whilst not unduly restricting them. There were detailed protection plans in place for people who needed them and staff demonstrated they knew what was in them by their actions and responses throughout the day.

We found risk assessments to be person-centred and focused on individual needs. They contained specific information about each person's risk factors and what actions were in place to minimise these. The risk assessments were written in a positive-based risk approach, assessing the merits of a person taking such a risk as well the consequences of such actions. This helped to promote people's independence and encourage choice.

Staffing levels were appropriate to the needs of the service on the day of inspection and medicines were stored, administered and recorded in line with requirements.

People were supported by staff who had received regular supervision and training relevant to their role which was evidenced through their interactions with people throughout the day. The service was adhering to the requirements of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards as requests had been made to the Court of Protection to ensure people were not being unlawfully restricted.

Nutritional support and health and social care support were available for each person according to their needs.

Staff clearly knew people well and acted with professionalism in their conversations, ensuring people were

happy and contented during the day. We saw staff respond to people's anxiety in a calm and reassuring manner and sought people's agreement before any assistance was offered or delivered.

People had the option to spend time in their rooms or in the communal areas as they wished and staff showed that they appreciated this was people's home.

Support was provided in line with each person's support plan as agreed with their social worker and staff responded to people's wishes during the day. People were encouraged to go out and join in activities. Complaints were handled in a professional manner, and any concerns noted and responded to promptly.

Calderdale Supported Living had a relaxed and pleasant atmosphere where people were encouraged to do as much for themselves as possible and where staff were supported by a dedicated registered manager, who was supported by an area manager who visited the service regularly.

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 safe as staff demonstrated through their actions and knowledge that they understood what may constitute a safeguarding concern.

Risks assessments were written for the specific individual and contained information as to how to deal with each potential situation.

Staffing levels met the needs of people in the service and medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff were supported with supervision and an appraisal which identified their strengths and also their training needs. We found staff had an in-depth knowledge of the people they supported.

The service was compliant with the requirements of the Mental Capacity Act and staff understood the implications of the associated Deprivation of Liberty Safeguards.

People using the service had access to support for nutrition and healthcare when needed.

Is the service caring?

Good

The service was caring.

Staff showed very considerate, respectful and patient responses to people throughout the time of our inspection.

People's consent was obtained as far as possible when decisions were made, and every attempt was made to gain this.

Staff ensured they protected the right for someone to have privacy and to maintain their dignity.

Is the service responsive?

Good

The service was responsive.

People had a varied weekly programme centred on their agreed support package which was adapted according to the person's wishes. Records reflected people's daily activities and emphasised their abilities.

Complaints were handled in a timely and professional manner leading to amendments to support where needed.

Is the service well-led?

Good

The service was well led.

The service was structured around the needs of the people using it and was able to adapt to their changing needs. People were happy and settled, and encouraged to do as much for themselves as possible.

Staff felt supported by the registered manager, who in turn, was supported by the area manager.

The management team ensured a robust auditing procedure was in place which identified any areas of concerns and arranged prompt remedial action.

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Detailed findings

Background to this inspection

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

This inspection took place on 5 January 2016 and was announced. The provider was given 24 hours' notice because the location provides a supported living service for adults who are often out during the day and we needed to be sure that someone would be in.

The inspection was carried out by an adult social care inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information from the local authority and feedback from other health professionals.

Most people had limited verbal communication skills but did communicate with sign language, which staff interpreted on occasion and we observed interactions throughout the day. We were able to have limited conversations with two people. We also spoke with three members of staff including two carers and the registered manager.

We looked at two care records, three staff personnel records and audits including health and safety, complaints, medicines and care plans.

Good

Is the service safe?

Our findings

We spoke with staff to find out their understanding of safeguarding. One staff member told us "we call the registered manager if we have a concern and record it in the file. We would also alert other staff depending on what it is." Another staff member explained the different aspects to a safeguarding concern such as "financial, sexual, physical abuse or a person not being treated with dignity."

We found that staff actively displayed an awareness of how to manage potential safeguarding situations through their observations and conduct. Staff were very alert and conscious of the relationship between two people using the service and ensured that they were monitored at all times due to previous safeguarding concerns. One person had been fitted with a thumbprint entry access pad to their room to minimise risk of others entering their room. Another person had an alarm used only at night which was triggered if they left their room. There was detailed evidence in the care records of the best interest decisions around these measures.

Safeguarding incidents were logged appropriately and action taken with all relevant parties including notifications to the Care Quality Commission as required. All incidents were reviewed on a monthly basis and any ongoing issues identified and solutions sought. People had access to an Independent Mental Capacity Advocate (IMCA) to support them through the safeguarding process.

The service had detailed and person-focused risk assessments based on individual need. These were evident for the situation mentioned above where each time there had been a safeguarding concern the risk assessment was reviewed to see if anything else could be provided to minimise the risk happening again. In one situation, we saw a series of risk management meetings had been held with external health professionals and a mental capacity assessment had taken place with regards to consenting personal relationships. This had all been in conjunction with the person living in the service who had been supported by an advocate.

Each risk assessment looked at the mitigating factors which were already in place to minimise the risk of harm. These were all person-specific and contained actions to reduce risk which had all been actioned. The risk assessments showed the service considered all aspects of the risk including the benefits to people of taking the risk. In one scenario we saw the matter had been referred to the Court of Protection to evaluate whether the person had got capacity to make a specific decision around their relationships, and to consider whether the safeguards in place were in their best interests and proportionate.

Staff explained to us the fire evacuation procedure and we saw evidence the alarm was tested weekly. One member of staff told us "We are constantly assessing health and safety, in conjunction with the people living here and around the houses." This was observed by us only a few minutes later as someone went too close to the pressure cooker which was cooking the evening meal. Staff intervened swiftly as the individual was unable to assess the risk to themselves. This showed the service took a positive risk approach as people were able to access the kitchen as long as staff members were around. People were able to open all cupboards and get themselves a drink but some required support with this task to ensure their safety.

Staffing levels were appropriate to the needs of the people living in the service on the day of inspection. Staff were distributed across the two houses and there were always four staff per shift in addition to the registered manager. One member of staff said "We feel short staffed as one person needs constant monitoring and this then limits what else we can do." During the morning one worker took one person out to the shops which left one house with one staff member for two service users. We did not see this caused any issues. Some staff also did sleep ins with agency staff doing the waking nights as this had been funded by the local authority following a safeguarding issue.

Some staff told us they felt under pressure due to the number of shifts and longer hours they had had to cover as the service had had vacancies, but also said that bank staff were used as well. However, we noted that a new worker had recently started at the service to offer support to the regular staff. We saw that staffing rotas were planned in advance and any cover required arranged through bank staff. The rotas reflected the 'service shape' that each person living in the supported living accommodation had. The 'service shape' was designed by each person's social worker to reflect how their specific needs should be met in terms of activities and preferences. This showed the service was provided to ensure all people living in Calderdale Supported Living had their needs met as had been agreed in conjunction with themselves and their social workers.

We observed people receiving their medicines. All medicines were stored in people's own rooms in a locked cupboard accessible only by regular staff. These all had thermometers in to ensure that the storage temperature was within the required guidelines. We saw that staff checked the Medicine Administration Record (MAR) prior to administration to ensure stock levels corresponded with the records and that the time of administration was correct. Staff completed the medicines round in pairs to minimise the risk of errors and provide assistance for the person living in the supported accommodation. People were supported appropriately in taking their medicine and the MAR sheet updated after the person had taken it.

Staff had received training from the pharmacist as the service used the Biodose system where tablets were in a blister pack. This had a picture of the medicine, the dosage required and the time. We found evidence in staff files of staff being observed in administering medication by the registered manager and the staff we spoke with also told us they had been observed. In one file it was recorded that an error had been identified as someone had received a double dose of PRN (as required) medication. It had been identified by the second member of staff but unfortunately the person had swallowed the medication before any remedial action could be taken. There were no adverse effects. This had been dealt by seeking medical advice and appropriate managerial intervention logging the error and the consequences of this for both staff members. This meant that staff were more diligent in checking records prior to administration and utilised their colleague more in checking. We observed this in practice.

There were also medicine competency checks in place where staff were asked questions about each person's specific medication, how medicines were ordered and the side effects of some medication for that individual. They had to demonstrate their knowledge by explaining the difference in liquid medication between the quantity of fluid and the strength of the drug.

If creams and oils were prescribed, these were applied when the support worker was assisting the person with their personal care. PRN (as required) medicines had protocols in place detailing why and when the medicine should be given based on that individual's key signs and behaviours.

Good

Is the service effective?

Our findings

One staff member told us "I completed a two week induction which focused on person-centred care. I had to complete a training booklet and have undertaken different training since this. I have regular performance development reviews." A different staff member said "I also shadowed before picking up any shifts." The most recent member of staff had completed a comprehensive induction which covered communication, mental health and learning disability awareness, and equality and diversity amongst other topics. We saw that a record booklet had been dated and signed by the staff member and the registered manager.

We looked at staff files and found that staff had received supervision and an appraisal over the past year. Supervision meetings reviewed staff performance reflecting on what they had done well and where further training may be needed. In one record we saw "[Name] is the keyworker for [name]. They always put their best interests first. They had dealt with recent safeguarding concerns very professionally and contributed to meetings." This shows that the registered manager had a good knowledge of each worker's performance and acknowledged key aspects of their role which had promoted the benefit of the individuals within the service.

Each appraisal was focused on the member of staff's individual strengths and identified where further development needed to happen. We saw in one record the positive comments "[Name] works well under a certain amount of pressure and always steps forward to help." The appraisal also reviewed where staff had been challenged and recorded how they had overcome these. Each staff member had been set some objectives which linked to key competency areas. Every record we saw had been signed and dated by the staff member and the registered manager.

Staff were recognised when they had taken on additional tasks over and above their usual role. It was evident from the discussions recorded that the process was two-way and that where staff had raised areas of concern, these had been followed up by the registered manager or taken forward to a staff meeting so that all staff could learn. We also saw where staff had been encouraged to develop in their role and how this support had been provided.

We noted from the training matrix that most staff had completed all the core requirements such as first aid, safeguarding, fire, medicines and food hygiene. The registered manager was aware of who needed to update but due to long term sickness this had not yet been possible. It was also evidenced that staff had completed a detailed induction and covered topics including autism, epilepsy and bespoke positive behaviour support therapy.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and found that they had made all the appropriate authorisations to the Court of Protection but were still awaiting the outcomes. All staff had received training in the Deprivation of Liberty Safeguards (DoLS) as required under the Mental Capacity Act 2005 and were able to explain the implications of a DoLS being authorised. One staff member told us "The Mental Capacity Act exists to support vulnerable people who struggle to process and retain information. They may have a lasting power of attorney or need the Court of Protection. It's there so they get a voice. If it is agreed they lack capacity for a specific decision, then a best interest meeting is held involving all relevant parties. A DoLS is there to allow us to keep them safe as they may harm themselves such as when crossing the road."

People were supported with eating and drinking throughout the day, and we saw staff actively encouraged people to do as much as possible for themselves. In each kitchen a pictorial menu was displayed which showed the week's main meals as chosen by each person during their weekly tenants' meeting. We saw from the daily notes that people had breakfast when they chose, one person preferred a cooked breakfast and the others had toast and cereal. At lunchtime we observed two people eating a cooked meal. After their main course the support worker offered them a yoghurt each by showing them a choice of two, and encouraging them to pick.

The meal provision was also evaluated by the area manager when they conducted their audit. They had stressed that 'staff need to try and encourage people to choose healthy options.' We saw that there was a mixture of dishes selected for the week including chicken casserole with vegetables. People tended to have their evening meal together, depending on the activities they were undertaking as this had been their experience in their previous residence where most had lived together. The registered manager told us that when staff had tried to alter this routine people showed their unease.

The service worked in close collaboration with all health and social care agencies as required. We saw that people had been supported to attend GP and other health appointments when needed and that the service shared key information when appropriate.

The environment had recently been redecorated to a high standard and people's rooms were personalised and painted in colours of their own choosing. The communal lounges had comfortable sofas and a TV, positioned so that everyone could share in activities. There was also a mood light in one room to aid with keeping people relaxed. The registered manager advised us the shower rooms were rarely used by people using the service as most preferred to have a bath. Again, these were clean and there was access to soap and towels. In the warmer months people had access to a flagged patio area with seating which was enclosed promoting privacy for people living there.

Good

Is the service caring?

Our findings

We observed staff to be extremely caring and focused on meeting the needs of the people living in Calderdale Supported Living. Staff took time to ensure they understood what someone was saying and checked they had this correct before undertaking any care task. This was especially important as most people using the service had limited verbal communication skills. Staff responded every time a person approached them and never ignored them, always acknowledging them and dealing with their need.

The service had assigned keyworkers for each person which meant that each worker had specific knowledge of an individual and was able to share this with other staff when needed. We saw this happened late in the afternoon with the newest staff member. While all the people in one house were sitting in the kitchen having a drink with the support workers, the longer serving staff member had been quietly reminding the new worker about one individual's tendency to pick up discarded cups and throw them. Without warning this individual promptly threw a cup left on the worktop which immediately smashed. The new staff member responded promptly and calmly, moving the person out of the way and alerting others to the broken china on the floor.

People spent their day between the communal lounges in each house, the kitchen and their rooms. They had the freedom to move around and between the houses for much of the day. One person went outside to smoke at regular intervals and alerted staff when they had finished by banging on the door. As we spent time in the office people tended to come and visit. One of the staff supported a person to leave by asking them if they would like a drink to encourage them to leave. This was done sensitively and gently.

A little later the same person came into the office, obviously curious as to our presence, and the support workers were trying to sort out the money for the day's activities. Again, both workers responded kindly to the person but were not patronising. One support worker explained what they were doing and that they would support the person in a moment. Their tone and body language was reassuring and very patient. They observed that this person's trousers were slipping down, so very discreetly said 'Let's sort these trousers out' before assisting the person to adjust them. We saw it had been noted in this staff member's file that they 'implemented dignity at all times' and we saw this was this staff member's approach throughout the day.

We found that all people had received support with personal care, although for some this was minimal, and that people were smartly dressed. One person was wearing a jumper, shirt and tie. They asked the area manager if they could have help tying their shoelaces and this was promptly offered. The area manager in their monthly site visits observed staff interaction. In their report from August 2015 it was noted 'there was a good staff attitude'.

We asked staff how they ensured people were given choice each day. One staff member told us "We ask them if they would like a wash, bath or shower. We tend to know what they will choose but always ask anyway. Even with tasks such as shaving we encourage the person to put on their own foam and then just support them with the shave. People always choose their own clothes." We saw during the morning that one

person was changing their own bedlinen with the minimum assistance but staff intervened when necessary.

We also saw in the weekly tenant meetings that people were encouraged to make decisions via the use of pictorial images. Areas discussed included the accommodation, key events for people living in the service, any visitors and the menus.

Most people in the service had an advocate who supported them with more complex decisions. All staff were aware of the need to make decisions in the person's best interests in line with legislation and this was reflected in the interaction we saw.

The registered manager said that most staff who worked in the service were dignity champions, having undertaken specific training for this aspect. We saw in one file the notes were also reflective of supporting someone with dignity; 'As I suffer from epilepsy I must not be left unattended in the bath. Though to give me privacy staff will wait outside the bathroom with the door slightly ajar so that I have my dignity.' This shows the service was keen to ensure people were kept safe and yet had opportunity for time on their own.

Good

Is the service responsive?

Our findings

We saw throughout the day that people took part in different activities. One person was making their bed with a duvet set chosen by themselves to match their decorated room when we first arrived. In another person's room we saw some balloons, dinosaurs and balls. They told us "I chose these." Later in the day we found them playing catch with a ball with a support worker and a remote control fire engine which they enjoyed driving into the wall. All people living in the service were encouraged to keep their rooms clean and share in the domestic tasks where appropriate such as the hoovering.

Staff told us about their keyworker role. This involved checking the person had all necessary clothing and toiletries and supporting them to go shopping for more when needed. They were also responsible for ensuring all appointments were attended and that the care records reflected their needs. One staff member told us one person liked playing their guitar and they had researched information about a local percussion class for them to join in. The same staff member said they were keen to encourage the person to do as much for themselves as possible as they could make a sandwich but as the person aged they had become more reluctant to do so.

In one of the area manager reports there was discussion around encouraging wider participation in the community for people in the service. In an analysis over a two week period in August 2015 people had participated in a craft group, gone for walks, visited the library, attended a '40s weekend celebration in a nearby town, gone shopping, had lunch and tea out and been to the cinema. All this was in addition to in-house activities such as playing football, swingball and tennis, and listening to music and watching DVDs. During this period people had also been offered a trip out but they had declined this.

It had been noted by the area manager that people using the service had little awareness of the days of the week unless they were to visit their family. Two people visited family members every week and looked forward to this. One person nodded when we asked if they liked visiting their relative. We saw evidence in care records that some people chose to attend the local church on a Sunday. The registered manager was keen to entice people out more but they preferred to keep to the same routine. Staff were aware in advance via the staff rota of when someone was due to go out whether for leisure or to attend a health appointment and staffing was adapted around this.

Care records were written in a person-centred style. They contained a personal information sheet with a photograph and key details including emergency contact numbers. Each file had a personal evacuation plan in the event of a fire or other building issue. Every individual's service shape was divided into assistance with daily living tasks, regular planned activities and flexible and leisure activities. A timetable had been constructed to support the service in ensuring these needs were met and we saw evidence in people's files that the service was adhering to these outlines.

Each support plan covered key areas such as communication identifying if the person used Makaton or other sign language, photographs of important people in their lives, their ability levels in regards to personal care and domestic tasks, visitors to the supported living, education and spiritual needs. Important details

were recorded focusing on that specific individual's needs and behaviours. They contained comments such as 'I need staff to help me pay for my bus ticket though I like to have the ticket myself' and 'I will help to polish my room and clean my windows. I require staff to spray the polish for me as I tend to put too much on which could damage my belongings.' Each of the support needs had a related risk assessment linking to all other aspects of that person's care plan including one for positive behaviour support. This included the details of the situation, how a person may behave, action to be taken in such a situation and any resources needed to deal with this.

We found that care records were reviewed regularly and again reflected a person's own experiences. Each person had their own objectives set and these were assessed as to whether they were still applicable or had been met. In one review we saw it recorded that one person's objective was to be supported attending a football session which required two support workers. This had taken place but the person had not settled and so an alternative was offered. This meant the person was still able to undertake this activity and other options such as swimming were also explored using staff's local knowledge. We also saw in this person's record they had had a short break to the coast and attended the theatre and cinema on a regular basis.

We saw the service had comprehensive daily notes about each individual's experience. They referred to tasks people had shared in such as washing and laundry and also mentioned their mood. One record stated "[Name] was singing and laughing a lot today and in good spirits." Later in the same week it was noted that the person had been suffering with indigestion and so their PRN medicine had been prescribed and 'they were much better now'. Details of support with personal care were also recorded including information about applying moisturising creams as someone's skin was sore. This shows the service was responding to people's needs as they presented themselves and supported them to have a good quality of life.

We looked at the complaints file and saw the service had a compliments and complaints leaflet. We found two complaints in the file which had been dealt with in a thorough manner. This included an apology and visit by the registered manager to the complainant and action taken to minimise the incidents happening again. There were also compliments in the file, one from a visiting podiatrist who said "staff and clients work well together." Another from a local authority worker said "I've worked with the management team. They demonstrated commitment and understanding in ensuring the individual achieved the best possible outcomes." One comment from the local education supplier said "I've always found support staff fully helpful and effective. They enable clients to achieve learning goals, along with developing a range of skills and awareness."

Good

Is the service well-led?

Our findings

We saw noted in one of the satisfaction surveys the registered provider had sent out there was a comment by a relative which said "Their care and devotion is second to none. They keep me informed of any changes." The service had a positive atmosphere throughout the day of our inspection and people looked happy and responded well to staff. Staff behaved with the utmost professionalism in every interaction we observed, being very clear this was the person's home and they were there to assist, not to lead or direct.

A staff member said "I enjoy working here. I feel able to raise any concerns with the manager." They had been in post over seven years. We asked another staff member if they felt supported and they told us "The manager is very supportive and will always try and accommodate shift changes if at all possible."

We asked staff how they knew they were doing a good job. One staff member said "When the people living here are happy, then so am I. This means I must be doing something right." Another staff member said "We know when people are happy. They are included in everything and we ask their families if they are happy with everything." This view was endorsed by the registered manager who said "We know we are providing a quality service when the people using the service have their welfare looked after and they are settled in their own state of mind."

The registered manager held monthly team meetings, which in conjunction with supervision and training ensured staff were kept informed and motivated to perform well. These meetings gave staff the opportunity to reflect on events in the service, in particular for the person they were keyworker for and to focus on where they may need further support themselves. The meeting also gave staff the opportunity to have current information and to ensure they had read all relevant documentation pertaining to people in the service. Clear direction was given to staff as to how to conduct themselves in certain tasks such as not to use personal mobiles while out supporting someone in the community.

We asked the registered manager what they felt the values of the service were. They told us "To try and lead the team to promote people's independence and dignity. We are very aware of trying to avoid institutionalised care as most of the people in the service came from a hospital setting and we try and offer as much choice and encouragement as we can." They were aware of the daily struggle based on people's previous life experiences and their cognitive abilities to entice people to consider different activities and experiences. We observed the service was very focused on the people in it and very conscious of supporting people to make as many choices as they could for themselves.

We also asked the registered manager what they felt the challenges were and they said the main issue had been staff shortages, again showing their awareness of the impact this had had on staff morale. They recognised that 'staff are tired'. However, they were hopeful that things would soon improve as they had recently had a new member of staff. The service had also been allocated some hours for a deputy to work alongside the registered manager which would assist with the supervision schedule. The registered manager was keen to stress they also worked some shifts and we saw evidence of this in meeting minutes where issues had been picked up.

They told us they felt one of their big achievements had been in supporting two people to attend a safeguarding meeting, allowing them 'to have a voice' and ensuring all in attendance at the meetings remembered why they were there. Additional achievements had been in securing the deputy post, supporting a member of staff through their diploma and overseeing all the redecoration of the premises which had helped to provide such as pleasant living environment.

In feedback from a health professional we saw "The service has a collaborative approach – they are open, honest and prepared to share, listen and change when needed."

There were monthly audits completed by the area manager in conjunction with the registered manager. Each month had a different set of themes and over the course of the year had been adapted to fit in with the Care Quality Commission's inspection framework of the five key areas. This enabled the service to ensure they were looking at all aspects of the service and meeting the needs as required. In addition to assessing different parts of the service regular audits of the people's money and infection control also took place. They focused on key changes to the service such as someone moving in and how the service had adapted to accommodate them.

The audits had identified that supervision and training had fallen behind due to changes in the registered manager but this had been rectified by the time of our inspection showing that the service responded well to any deficits noted. The service also completed a monthly health and safety analysis which was completed in conjunction with people living there. This included water and fridge temperatures. Again, any issues were flagged and dealt with promptly.