Dorrington House

Dorrington House (Wells)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 20 and 22 September 2016 and was unannounced. Dorrington House (Wells) is a care home providing personal care for up to 38 people, some who live with dementia. At the time of our visit 37 people were living at the service.

The home has had the current registered manager in post since January 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were aware of safeguarding people from the risk of abuse and they knew how to report concerns to the relevant agencies. Individual risks to people were assessed by staff and reduced or removed. There was adequate servicing and maintenance checks to fire equipment and systems in the home to ensure people's safety.

People felt safe living at the home and staff supported them in a way that they preferred. There were usually enough staff available to meet people's needs although people sometime had to wait when there were sudden shortages. Recruitment checks for new staff members were obtained before new staff members started work.

Although medicines were securely stored, temperature checks of storage areas showed high temperatures, which put the effectiveness of medicines at risk. Medicines were safely administered, and staff members who administered medicines had been trained to do so. Staff members received other training, which provided them with the skills and knowledge to carry out their roles. Staff received adequate support from the registered manager and senior staff, which they found helpful.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was meeting the requirements of DoLS. The registered manager had acted on the requirements of the safeguards to ensure that people were protected. Staff members understood the MCA and presumed people had the capacity to make decisions first. Where someone lacked capacity, best interest decisions had been made.

Most people enjoyed their meals and were able to choose what they ate and drank. Guidance for staff about how much people should drink each day was not always available and records showed that some people did not drink enough. Staff members worked together with health professionals in the community to ensure suitable health provision was in place for people.

Staff were caring, kind, respectful and courteous. Staff members knew people well, what they liked and how they wanted to be treated. Staff responded well to people's needs and support was nearly always available.

Care plans contained enough information to support people with their needs.

A complaints procedure was available and people were happy that they did not need to make a complaint. The manager was supportive and approachable, and people or other staff members could speak with him at any time.

The provider monitored care and other records to assess the risks to people and ensure that these were reduced as much as possible and to improve the quality of the care provided.

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 not always safe.

There were usually enough staff although sudden shortage of staff at some times meant people were sometimes kept waiting. Checks for new staff members were obtained before they started work.

Risks had been assessed and acted on to protect people from harm, people felt safe and staff knew what actions to take if they had concerns.

Medicines were safely administered to people when they needed them.

Is the service effective?

Good

The service was not always effective.

Staff members received enough training to provide people with the care they required.

The registered manager had acted on recent updated guidance of the Deprivation of Liberty Safeguards and staff had access to mental capacity assessments or best interests decisions for people who could not make decisions for themselves.

Staff worked with health care professionals to ensure people's health care needs were met.

People were given a choice about what they ate and drinks were readily available to prevent people becoming dehydrated. Staff did not always monitor people's food and drink intake well enough.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people living at the home, which ensured people received the care they wanted in the way they preferred.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People had their individual care needs planned for and staff responded quickly when people's needs changed.

Activities and entertainment was arranged but some people became bored between these events.

People were given information if they wished to complain and there were procedures to investigate and respond to these.

Is the service well-led?

Good

The service was well led.

Audits to monitor the quality of the service provided were completed and identified the areas that required improvement. Actions had been taken that addressed any issues raised from the completion of the audits.

Staff members and the registered manager worked with each other, people's relatives and people living at the home to ensure it was run in the way people wanted.

Dorrington House (Wells)

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 20 and 22 September 2016 and was unannounced. This inspection was undertaken by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return. 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 reviewed this and other information available to us about the home, such as the notifications they had sent us. A notification is information about important events, which the provider is required to send us by law.

We spoke with nine people using the service and with four people's relatives. We also spoke with the registered manager, nine staff members and a health care professional visiting at the time of our inspection.

We spent time observing the interaction between staff and people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records for six people, and we also looked at the medicine management process and records maintained by the home about staff training and monitoring the safety and quality of the service.

Good

Is the service safe?

Our findings

People told us that staff were quick to respond to call bells and that these were answered usually within five minutes. One person said, "The bells get answered quickly usually. If it rings more than five minutes before they come that is unusual." A visitor also said that they would have a longer wait at weekends for a staff member to answer the front door as there was no-one in the office.

We observed that call bells rang throughout our visits to the home and staff answered these quickly most of the time. On the first day of our inspection, an agency staff member who had been engaged by an external healthcare team to provide one to one care for a person failed to arrive for their shift. This resulted in a disrupted mealtime for other people in this part of the home as existing staff members had to spend time with the person. Staff members told us that the poor attendance by the agency staff member occurred regularly each week, but that it did not always result in such a disrupted routine. We saw that on the second day of our visit the person was more settled. We spoke with the registered manager who confirmed that when the agency staff member did not arrive they contacted the external healthcare team. However, alternative staff were not usually available and staff in this unit had to manage the person's care, and at times this had an impact on other people's care.

Staff members told us that they thought there were usually enough staff available and that they were able to meet people's care needs. The registered manager told us that usual staffing numbers were eight care staff during the day and four staff at night. There were dedicated kitchen and housekeeping staff throughout the day, as well as additional support staff for meal times. We examined staffing rotas for a four week period prior to our visit and found that except for one morning shift, staffing numbers were at the level described by the registered manager.

We saw that people's dependency levels were assessed and this information was collated to provide overall numbers in each category of low, medium, high and total dependency. The provider had developed a staffing tool that considered this information. This showed that there was an additional 50 hours of staff time per week, compared with the assessed care hours. We concluded that there were enough staff available to keep people safe, although there were times when they were not able to meet everyone's needs immediately.

We found that temperatures in medicine storage rooms and the medicine fridge were recorded each day. However, storage room temperatures were recorded frequently at temperatures over manufacturers' guidelines, which may reduce the effectiveness of the medicines kept there. We spoke with the registered manager about this and they said that they would discuss effective methods to ensure storage room temperatures were kept within medicine manufacturers' recommendations. Medicines were stored safely and securely in locked rooms and trolleys for the safety of the people who lived in the home.

Information was available in care records to tell staff whether people received their medicines covertly, although there was no detail about how best to do this. We spoke with staff members who were able to tell us how this was completed for two people and that they had discussed this with the local pharmacist. They

included the safe preparation of medicines given in a different way, such as when they were crushed. The assistant manager confirmed that only staff members trained to administer medicines and who knew these two people were responsible for giving their medicines in this way.

People told us that they received the medicines as they had been prescribed, one person saying that, "I always get my medicines on time." The records kept regarding the administration of medicines were in good order. They provided an account of medicines used and demonstrated that people were given their medicines as intended by the person who had prescribed them. We found that where medicines had not been given, there were codes to show the reason for this.

People told us that they felt safe living at the home and that they could talk to someone if they had any concerns. One person told us, "There's always someone about to call on even at night and that makes me feel secure" and another person said, "Carers here know what they are doing so that gives me confidence to know I am safe."

The registered manager had taken appropriate steps to reduce the risk of people experiencing harm. The staff members we spoke with understood what abuse was and how they should report any concerns that they had. There was a clear reporting structure with the registered manager responsible for safeguarding referrals. Staff members knew who to report to, both within the organisation and to external agencies, and how to do this. These contact details were available in the office for everyone at the home to see. Staff members had received training in safeguarding people and records we examined confirmed this. This meant we were confident that staff recognised and reported any safeguarding concerns correctly.

Risks to people's safety had been assessed and recorded. These were individual to each person and covered areas such as moving and handling, people's risk of developing pressure ulcers or from falling. Each assessment had clear guidance for staff to follow to reduce the risk so that people remained as safe as possible. Our conversations with staff showed that they were aware of these assessments and they were able to explain how they followed the guidance.

Servicing and maintenance checks for equipment and systems around the home were carried out. The registered manager confirmed that systems, such as for fire safety, were regularly checked and we saw records to confirm these were completed. We saw that fire safety equipment had received a maintenance check in the six months prior to our visit. Personal emergency evacuation plans (PEEPs) were available to guide staff or emergency services in the event of an emergency. We concluded that individual and environmental risks had been appropriately assessed and reduced as much as possible, although not all of these were recorded.

We checked three staff files and found that all of the recruitment checks and information, such as Disclosure and Barring Service (DBS) checks, was available. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. These had been obtained before the staff members had started work. This meant that the provider took the necessary steps to make sure prospective staff members were as safe to work with people as possible.

Good

Is the service effective?

Our findings

Six people we spoke with told us that they liked the meals they were provided with. One person told us, "I am a bad eater and I don't like most vegetables and ask for salads. The cook tries to make my food interesting and adapts the menu. I also get fruit offered daily." Another person, who liked the meals they received, told us how they had to wait for up to an hour to have breakfast if they woke early in the morning. They told us that they found this difficult, especially when they were hungry. Of the eight people who we spoke with about food, half said that the meat they were served was tough. We spoke with the registered manager about this, who said they would address this with the staff member responsible to identify the best solution for improvement.

We saw that the lunch meal was not a social affair, as few people used the dining areas, with many people continuing to sit in the armchairs they were already sitting in. When the dining area was used, there was limited conversation and interaction between people and staff members. In one part of the home, an intercom was situated in the dining area. This was quite loud and went off several times, and we saw that this confused one person and distracted them from their meal.

We saw that people were offered a variety of drinks throughout the day, although staff did not always return to encourage people to consume them. We saw that staff did not remind one person to do so and that records showed the person drank as little as half a litre a day on some days.
This person's care plan did not provide enough guidance for staff about how much the person should drink or what to do if they did not. Because staff did not have this guidance and on some days records showed they had very little to drink, they were at risk of not drinking enough.

Records showed that people's weight was recorded and this enabled staff to take the necessary action if there were any concerns about unintended weight loss. We found that staff completed people's nutritional assessments accurately, which meant that they monitored the risk of people not eating enough. Staff took appropriate actions, such as providing soft or puree meals, fortified meals and referral to an appropriate health care professional. However, staff did not write food records in enough detail to fully describe the food eaten. This lack of detailed recording and guidance puts people at risk if they do not eat or drink enough.

We saw that people were offered a choice of meal and people who had difficulty understanding this were shown the meals available. When one person told the staff member that they did not want either option, they were able to request an alternative of their own choice. Where people needed help to eat, and except for a disrupted mealtime in one area of the home, staff were available to provide this. We saw that staff members sat with people, explained what food they were giving people and encouraged them to eat as much as they could.

Staff members received enough training to provide them with the knowledge and skills to meet people's care needs. People told us that they thought staff were able to meet their care needs. One person commented, "The staff here know what they are doing when they do anything for us. They seem well trained." Another person told us that new staff were always shown how to do something by experienced

staff before completing a task themselves.

Staff members told us that they received enough training to meet the needs of the people who lived at the service. They said that they had completed a mixture of practical hands on and theory training from the assistant manager and external trainers. They received annual updates to training that they had already received and they were able to complete national qualifications. One staff member told us that some staff had received training from district nurses in diabetes management and administration of insulin. This provided hands on training, theoretical information that staff members kept available and on-going support from the district nursing team.

We checked staff members' training records and saw that they had received training in a variety of different subjects including food hygiene, eating and drinking, and safeguarding adults. The assistant manager described the training they had received in order to provide training to staff. We observed them guiding a new staff member who was completing their induction training.

Staff members told us that they had regular supervision meetings with the registered manager and felt well supported to carry out their job. They told us that the support came in different forms, such as formal meetings, where their performance was discussed, and team meetings, in which they could raise any issues they had. Records were kept of these discussions and the staff members were able to see these whenever they wanted.

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 so that they can 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found that this was happening in practice and all related records had been completed. Staff members were clear about what the MCA meant and their role in ensuring people were able to continue making their own decisions as much as possible. We saw that staff members had received training in this area. We observed that staff applied these principles during our visit. For example, staff supported people to make decisions about the care they received, activities they took part in and what they did during each day.

Staff completed mental capacity assessments for people whose records showed they received medicines covertly. This meant that staff undertook a formal process to determine whether these people were able to make their own decisions about taking their medicines.

People told us that staff asked their consent before carrying out care tasks and respected their decisions. One person commented that, "They [staff] always ask permission before they do anything for me." A visitor to the home echoed this person's view, saying, "They [staff] ask permission before they do anything for my husband. They might say, '[Name] are you ready for your bath?'." We saw that staff asked for people's consent before delivering care. They understood the importance of supporting people to make their own decisions, for example, by offering people choices if making decisions was difficult for them.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to lawfully deprive a person of

their liberty. The registered manager submitted applications to the local authority for people living at the home who would not be able to leave or who required constant supervision. They were aware of DoLS and the actions they needed to take if they had to deprive someone of their liberty in their best interests.

People told us that they had access to health care professionals. One person said, "They [staff] are very careful about the health side and get in touch with a doctor if you ask for one." There was information within people's care records about their individual health needs and the actions staff needed to do to support people to maintain good health. We found evidence that people saw specialist healthcare professionals when they needed to. For example, staff referred people to a speech and language therapist and a dietician when they had been concerned about their weight loss. Advice from the specialist had then been implemented to reduce the risk of further reduction in the person's health or welfare. Other people's records showed that they had their care needs reviewed by a range of health care professionals, including the local GP, dentist, and optician.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that staff were kind and caring. One person told us, "All carers are very good. I think they must be trained to be kind as they are like that without exception." Another person said that, "The staff are so friendly and polite. When I thank them they always reply, 'You're welcome.' One pops into my bedroom at night to check I am okay. I don't see how they could be better at their jobs." People told us that they were able to develop relationships with staff members, they could joke and chat with the staff and that this meant they were comfortable and happy.

Visitors to the home echoed people's views of staff members and that they were gentle and comforting. One visitor commented that, "The relationship the carers have with [relative] is lovely to see. They show real affection for her and that makes me feel really good."

During our visit we found that staff were kind and considerate towards people, and developed caring relationships with them. We heard and observed laughter when people joked and talked with each other and with staff members. They were relaxed with the staff who were supporting them and the interactions we saw were positive. Staff engaged in meaningful conversations with people and we saw that they were treated as individuals. We observed a staff member have a lengthy discussion with one person about their family photographs, while arranging flowers that had been delivered. The staff member knew the significance of each photograph displayed and spoke to the person kindly and with warmth throughout the conversation.

Staff involved people in their care and listened to their responses. People told us that staff listened to them and asked how they wanted their care to be given. One visitor told us, "I've not been involved in the care plan so far. I missed the first review, but there is another next month." We saw that care records contained details of who had been involved in planning and reviews of the person's care.

We saw that staff asked people what they would like to do and offered them options to help them decide. For example, we saw that staff members asked people whether they wanted to come to the lounge or to sit in another area of the home. Once in the lounge we saw staff members discuss with people where they wanted to sit. People were given choices about what to eat, drink and where to spend their time within the home. We saw that people were able to complete personal care tasks when they wanted to throughout the day and this was not limited to a particular time. From our observations it was clear that staff consulted people about their care.

Care records provided staff members with guidance about how able people were and we saw that people were encouraged to continue as much as possible for themselves. There was information in relation to the person's individual life history, likes, dislikes and preferences written within the person's care records. Staff members told us that this helped them to strike up conversations with people.

We asked people if staff respected their right to privacy. One person told us that, "I ask for ladies to do my hygiene and the home respects that." Another person said, "They [staff] are always respectful- never

anything else." Visitors also agreed that staff members respected people's privacy. One visitor said, "The level of respect is impressive..."

We saw that staff were polite and respectful when they talked to people. They made eye contact with people and we observed staff communicating with people well. One person told us, "They [staff] really do see me as a person with feelings and opinions." Staff members were patient with people who found it difficult to verbally communicate and consequently understood their requests.

We saw that staff respected people's dignity and privacy. They were seen quietly asking people whether they were comfortable, needed a drink or required personal care. Throughout the day we saw that staff members knocked on people's doors before entering their room, they spoke with people in a respectful way and called people by their name. However, three people living at the home and visitors told us that staff sometimes spoke with each other in their own language. One person confirmed that this was not when they were with people but they had overheard staff doing this nevertheless. Another person told us that it made them uncomfortable to hear this as they did not know what the staff members were talking about. We spoke with the registered manager, who said they would address the issue with overseas staff immediately.

People were able to have visitors at any time and we saw this during our visit. They commented that their visitors could spend as much time with them as people wanted and that they were able to do this inside or outside the home. This meant that people were able to keep in touch with friends and relatives in a way that did not place restrictions on how or where they did this.

Good

Is the service responsive?

Our findings

People told us that they received the care they needed in the way they wanted. They said that staff members helped them when they wanted help. One person said, "I can go to bed and get up when I want." While another person told us, "I never get told to go to bed - it's my choice."

We observed that staff were responsive to people's needs most of the time. They encouraged people to drink when they indicated that they were thirsty, to eat when they were hungry and to attend to personal care if this was required. However, we saw that staff were not able to assist people in one area of the home in the way they needed when their attention was diverted to another person. This person displayed behaviour that may upset or challenge others and received individual support from an agency staff member each day. On one day of our visit the agency staff member had not arrived, which meant that other people living in the unit received their meals in a disrupted way while staff members spent time with the person.

The care and support plans that we checked showed that staff had conducted an assessment of people's individual needs before they moved into the home. This was to determine whether or not staff could provide them with the support that they required. Care plans were in place to give staff guidance on how to support people with their identified needs such as personal care, communication, nutrition and with mobility needs. We saw that although there was a variable level of detail, there was enough information for staff. Staff members told us that care plans were a resource in terms of giving information to help provide care and that all staff members helped to record details about people's daily lives.

Staff members had reviewed care plans regularly and updated them when people's needs changed. They had also completed records that showed when care had been given, such as repositioning charts and daily notes. These provided an ongoing summary of the care that people received and meant that records were up to date.

People told us that there were activities organised, although they were able to choose whether to participate or not, as they wished. They told us that they enjoyed the activities that were arranged. One person told us, "I read a lot, have lots of visitors and that keeps me content, so I don't get bored. The carers ask me if I want to take part in activities but I don't really bother, though I like it when we get visitors in, perhaps singers and so on." However, two visitors to the home said they felt there was little stimulation for people living with dementia and two people that we spoke with also told us that there were times when they were bored. One person summed up their feelings by saying, "Yes I am bored but it's difficult for me to explain. I walk about the place and try and keep busy. There aren't activities every day. I enjoy the music and entertainment when that's on."

Staff members organised for outside entertainers to visit the home and we saw that many people attended one of these events on one day of our visit. This had a positive effect on people, with many singing and joining in with the entertainer. We also saw that staff in one area engaged people in an activity, which meant that a staff member spent some time individually with each person during the course of the morning.

Care records were written in a way that promoted people's wishes and preferences. They included details about people's preferences, such as particular food likes and dislikes, and hobbies and interests people had. However, some people were less able to take part independently in activities and we saw that staff members spent little time over the two days of our visit with them. The registered manager told us that the home employed a staff member for four hours every two weeks to spend time with people individually.

Two people told us that they were able to go out with friends or relatives and another person told us that a member of care staff was taking them out later in the week. However, two people said they would like to get out more but were not able to as there were not enough staff.

People told us that they were happy with the care they received, one person told us that they would speak with the registered manager if they were not happy about anything. Another person told us, "I don't have things to complain about." A visitor also told us that they had commented about the loudness of the call alarm and that action was taken to reduce the volume.

We saw that the provider's complaint procedure was widely available on noticeboards throughout the home, although this did not contain contact details of other agencies people could go to with their complaint. Five complaints had been made to the home in 2016 and we found that these had been investigated and responded to within a few days.

Good

Is the service well-led?

Our findings

People we spoke with liked living at the home and enjoyed spending time with the staff who worked there. One person said "…all I can say is that everything's fine. Come here if you want to be looked after well". Another comment we received was, "It's a good home because they treat us as real people who matter."

Staff members spoke highly of the support provided by the whole staff and provider team. They told us that staff worked well together and that they all got on and covered for each other if additional staff were required. They told us the registered manager was very approachable and that they could rely on them for support or advice. Two staff members said that they had needed to contact the registered manager out of normal working hours and that they were able to do this easily. We observed this during our inspection, when staff were able to discuss their concerns and any aspects of their work with the registered manager. They were aware of the management structure within the organisation and who they could contact if they needed to discuss any issues. A whistle blowing policy was also available and information about this was posted on a notice board in the home.

Staff said that they were kept informed about matters that affected the service through supervisions, meetings and talking to the registered manager regularly. Staff knew what was expected of them and felt supported.

The home has had the current registered manager in post since January 2016. The registered manager confirmed that he had support by the provider's management team, who was available at any time if the need arose.

Some people told us that they knew who the registered manager was, while other people were not sure. One person told us that the registered manager was "…very good" and that they always listened to the person. All of the visitors that we spoke with said they knew who the registered manager was. They told us that the registered manager was approachable and available at any time. They told us that they were friendly and easy to talk to. One visitor told us, "The manager is visible, speaks to us, is very approachable and deals with things. [Registered manager is not defensive - he listens."

We found that incidents had been reported to us and to the local authority as required. All of the information about how the service was monitored and people's views of the home showed that there were effective processes in place to assess and monitor risks to people and to develop and improve the service.

People told us about meetings where they could share their views of the home. One person said, "We have a residents' meeting once a month and relatives can come. Views are aired and I think, listened to. At the last meeting I told them the bulb in my room wasn't working properly and when the meeting finished, the manager went straight to my room and changed the bulb. I appreciated that." Another person told us that they had recently completed a survey about their views and experience of living in the home. They also said that the results would be published shortly.

The registered manager completed audits, such as for the domestic environment, care plans and medicines management, every one to two months. We found that audits identified issues and contained clear information to show the actions that had been taken to address them. For example, we found that the medicines audit identified where people had refused or declined to take medicines. Action had then been taken to address this. However, monitoring of the home had not identified that some records were not completed in enough detail or that people did not always receive enough stimulation. We spoke with the registered manager who confirmed that they would address these issues with staff members and with the provider's management team.

Analysis of accident and incident records had been carried out and looked in detail at the type of accident or incident occurred, the time and day, and where it occurred. This was an ongoing part of the electronic care records and subsequently fed into ongoing analysis. The analysis identified trends and themes, such as whether there were more falls on any one particular day or time of day. This also provided an ongoing graph to show how many of these had occurred over a period of time. Information was available in the analysis to show actions that had been taken to address each incident and to reduce the risk of it occurring again.

The registered manager had identified the start of a theme in their complaints analysis in regard to laundry. They addressed this with staff members and we saw that a comment in a recent compliment showed that there had been an improvement in this area. We concluded that the auditing and monitoring systems used were effective in identifying and reducing risk to people and that this improved the quality of the service provided.