Ashmoor Health Care Limited

Moorside Hall

Inspection report

Wyresdale Road
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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

Overall summary

We carried out an unannounced inspection of Moorside Hall on 08 and 09 September 2015.

Moorside Hall is a care home registered to accommodate up to 22 people with dementia, and to provide nursing care. Set in its own grounds, and close to Lancaster City Centre, the home consists of mainly single bedrooms with en-suite facilities with a toilet and a hand-wash basin. There is a large conservatory with a dining room and a lounge adjacent to it. There is also a small lounge on the first floor. The first floor is accessible by a passenger lift.

There was no registered manager at the time of our inspection. We saw evidence that an application had been sent and was being processed by the Care Quality Commission [CQC]. The provider was overseeing the day-to-day management of the home and people and staff told us they were accessible, supportive and visible within the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

We last inspected the service on 24 September 2014. We found a breach of legal requirement relating to records, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

The provider responded by sending CQC an action plan of how they had addressed the breach identified. We found the improvements the provider told us they had made had been maintained during this inspection.

The manager had systems in place to record safeguarding concerns, accidents and incidents and take necessary action as required. Staff had received safeguarding training and understood their responsibilities to report any unsafe care or abusive practices. Staff spoken with told us they were aware of the procedure. They said they wouldn't hesitate to use this if they had any issues or concerns about other staff members care practice or conduct. People who lived at the home told us they felt safe and their rights and dignity were respected. One person who lived at the home told us, "I've never had any problems living here. I feel safe."

We found recruitment procedures were safe. Required checks had been completed prior to any staff commencing work at the service. This was confirmed from discussions with staff. Recruitment records examined contained a Disclosure and Barring Service check (DBS). These checks can include information about any criminal convictions recorded. Staff spoken with and records seen confirmed a structured induction training and development programme was in place. This included mentoring and shadowing experienced staff members.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs. We found staffing levels were sufficient with an appropriate skill mix to meet the needs of people. The deployment of staff was well managed and provided people with support to meet their needs.

People were happy with the variety and choice of meals available to them. Regular snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. The cook had information about people's dietary needs and these were being met.

We found people who lived at the home and were living with dementia were supported to be as independent as possible. At lunch time we observed staff encouraging people to eat their meal independently.

Care plans we looked at confirmed the manager had completed an assessment of people's support needs before they moved into the home. We saw people or a family member had been involved in the assessment and had consented to the support being provided. People we spoke with said they were happy with their care and they liked living at the home.

We observed staff demonstrated an effective understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Discussion with the manager confirmed she understood when an application should be made and in how to submit one. This meant that people would be safeguarded as required. Systems were in place to protect people's human rights and we observed staff followed their recorded preferences and diverse needs.

The environment was well maintained clean and hygienic when we visited. No offensive odours were observed by the inspection team. The people we spoke with said they were happy with the standard of hygiene in place.

We found medicine procedures in place were safe. Staff responsible for the administration of medicines had received training to ensure they had the competency and skills required. Medicines were safely kept and appropriate arrangements for storing were in place. People told us they received their medicines at the times they needed them.

People's health needs were being met and any changes in health managed well. The people we spoke with said they had access to healthcare professionals when they needed them.

People told us they were happy with the activities arranged to keep them entertained. One person said, "It's a nice place, staff do an incredible job and we do singing, baking and play board games."

Summary of findings

The manager used a variety of methods to assess and monitor the quality of the service. These included surveys which were issued to people to encourage feedback about the service they had received. We noted responses to surveys in meeting minutes and changes actioned due to feedback received. The people we spoke with during our inspection visit told us they were satisfied with the service they were receiving.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff had been trained in safeguarding and were knowledgeable about abuse, and the ways to recognise and report it.

Risks to people were managed and staff were aware of the assessments in place to reduce potential harm to people who lived at the home.

There were enough staff available to safely meet people's needs, wants and wishes. Recruitment procedures the service had in place were safe.

Medicines protocols were effective and people received their medicines safely and according to their medicines plan.

Good

Is the service effective?
The service was effective.

The registered manager was aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS) and had knowledge of the process to follow.

Staff had the appropriate training and supervision to meet people's needs.

People were protected against the risks of malnutrition.

Good

Is the service caring?
The service was caring.

People were treated with dignity and respect and were responded to promptly when they required support.

We observed people's privacy and dignity were maintained.

Staff spoke with people with appropriate familiarity in a warm, genuine way. People were looked after by a staff team who were person-centred and kind.

Good

Is the service responsive?
The service was responsive.

Care records were personalised to people's individual requirements. People received personalised care that was responsive to their needs, likes and dislikes.

People were encouraged to participate in a variety of activities that were available daily.

People's concerns and complaints were listened to and responded to accordingly.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The management team had developed aims and objectives to meet the needs of people who lived at the home. The manager had clear lines of responsibility and accountability.

The manager had a visible presence within the service. People and staff felt the management team were supportive and approachable.

The management team had oversight of and acted upon the quality of the service provided. There were a range of quality audits, policies and procedures in place.

Moorside Hall

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 08 and 09 September 2015 and was unannounced.

The inspection was carried out by a team of two adult social care inspectors, a specialist advisor who focussed on medicines management and an expert-by-experience who took part in the 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. The expert by experience who took part in this inspection had experience of dementia care.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events which the provider is required to send us. We spoke with the local authority to gain their feedback about the care that people received. This helped us to gain a balanced overview of what people experienced accessing the service.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore 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 observed how the staff interacted with the people who lived at the home and how people were supported during meal times and during individual tasks and activities.

We spoke with six people who lived at the home and two relatives. During our visit we spoke with the manager, deputy manager and team leader. In addition, we spoke with two members of care staff, the chef, and a member of the domestic team. We spoke with one visiting health professional on the day of the inspection.

We also spent time observing staff interactions with people who lived at the home. We looked at six people's care records to ensure they reflected their needs and were up-to-date. We also reviewed eight staff files including recruitment, supervision and training records. In addition to this we looked at records for the maintenance of facilities and equipment that people used. We also looked at further records relating to the management of the service, including quality audits, in order to ensure that robust quality monitoring systems were in place.

Good

Is the service safe?

Our findings

People we talked with told us they felt safe. We noted the safeguarding policy and procedures were on display on the notice board at the entrance to the service. One person told us, "I've never had any problems here. I feel safe." Another person stated "I have no worries. I feel more content. I wasn't safe at home. I feel safe, that's something I like about here." One relative told us about a family member, "We wanted her to go home but knew it wasn't safe, she needs 24 hour care. All of us agree that she is safe now."

There were procedures in place to enable staff to raise an alert to minimise the potential risk of abuse or unsafe care. Staff demonstrated a good understanding of safeguarding people from abuse, how to raise an alert and to whom. Training records we reviewed showed staff had received related information to underpin their knowledge and understanding. One staff member told us, "I would report any concerns to the nurse in charge, [the management team] or the owner."

Where safeguarding concerns had been raised, we saw that the service had taken appropriate action. They liaised with the local authority to ensure the safety and welfare of people involved. Documentation had been put in place for staff to note any behavioural changes. Work routines had been changed based on information gathered and to protect people.

We noted that people who had a history of falls had sensor mats and/or sensory beams in their bedrooms. This alerted staff when they had got out of bed and minimised the risk of falling.

People had risk assessments in place for identified and potential risks. Plans were drawn up with guidance for staff to follow in order to keep people safe. Updated information was recorded and shared with staff and health care professionals to promote good practice. Individual care plans had been chosen by the clinical lead nurse and discussed with staff. This reinforced their understanding of the plan and ensured staff understood the individual risks to people and how to provide care and support to them.

We checked how accidents and incidents had been recorded and responded to within the home. We found accidents had been documented along with a record of actions taken to reduce the risk of further incidents. This meant that incidents at the home had been monitored to ensure the recurrence of risk to people was minimised.

A recruitment and induction process was in place that ensured staff recruited had the relevant skills to support people who used the service. We found the provider had followed safe practices in relation to the recruitment of new staff. We looked at eight staff files and noted they contained relevant information. This included a Disclosure and Barring Service [DBS] check and appropriate references to minimise the risks to people of the unsafe recruitment of potential employees. The DBS check help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Staffing levels were sufficient to ensure people's requirements were met in a timely manner. On the day of inspection, one agency nurse was working alongside contracted staff. A member of staff had that morning telephoned to say they would not be attending work due to them being sick. The agency staff member regularly worked at the home and had knowledge of the people who lived at the home. We observed the manager provided support during the day. This showed they were knowledgeable of the care requirements of the people within the home.

We saw recent rotas that showed agency staff had been frequently used. However future rotas showed recently recruited staff had replaced agency staff. This would allow continuity of care for people who lived at the home. The owner stated "we only used the same bank staff for familiarity."

There was a business continuity plan to demonstrate how the provider planned to operate in emergency situations. The intention of this document was to ensure people who lived at the home continued to be supported safely under urgent circumstances, such as the outbreak of a fire. Premises and equipment were managed to keep people safe. During the inspection, we undertook a tour of the home, including bedrooms, the laundry room, bathrooms, the kitchen and communal areas of the home. We found these areas were clean, tidy and well-maintained.

People had free access around the home and into the well maintained gardens.

Good

Is the service safe?

On the day of inspection we observed the fire extinguishers were having their annual service. Fire extinguishers require stringent maintenance to ensure they will work when needed, or are more importantly, safe.

The water temperature was checked in seven bedrooms, one bathroom and two toilets, all were thermostatically controlled. This meant the taps maintained water at a safe temperature and minimised the risk of scalding.

Window restrictors were present and operational in the seven bedrooms, one bathroom and two toilets checked. Window restrictors are fitted to limit window openings in order to protect vulnerable people from falling.

During the inspection we observed medicines administration and could determine that this was carried out safely. The medicines trolley was locked when unattended and the nurse administered people's medicines by concentrating on one person at a time.

The medicine trolleys were clean tidy and well presented with a rota being evident for cleaning equipment, bottles and checking inhalers. We checked how staff stored and stock checked controlled drugs and noted this followed relevant best practice guidelines.

There was a clear audit trail of medicines received and administered. This showed that the medicines were managed safely. Related medicine documents were clear, comprehensive, fully completed following national guidance on record keeping.

The home had two medicine trolleys, one for day time medicines and the second for night time medicines. When not in use, the night time trolley was stored in a locked cupboard. The day time trolley remained in a recessed area in the main lounge/dining area when not in use. Whilst the trolley was locked, it was not secured from being moved which posed a risk. This was shared with the management team on the day of inspection.

The management team had recently adopted a new provider for all pharmaceutical needs. The system was very comprehensive and contained people's photographs, descriptions of their individual medication and any known allergies.

We noted an audit with the new pharmaceutical provider was planned for September 2015. This was designed to check the quality and safety of the new medication system.

Good

Is the service effective?

Our findings

From our observations and discussions with health professionals, people who lived at the home and relatives, we were able to confirm people were receiving effective and appropriate care which was meeting their needs. One person commented "It's not like living at home but I like living here. The staff are very very good."

The provider had a clear and structured induction in place which involved shadowing team leaders and nurses who assess the new staff on work based competencies. The team leader had completed a "Train the trainer" course for moving and handling. The team leader told us, "It's more viable for the provider and means I can do moving and handling as part of their induction." Staff were receiving training through an on line training tool which was introduced in June 2015. The manager stated that the modular training is more flexible which encourages staff to access and complete the training. The manager said,"They can do it in bite size chunks." We were told by one member of staff "I get a lot of in house training and I am doing my care certificate and have had outside training for moving and handling." We looked at eight staff files and these indicated that supervisions and appraisals were taking place regularly.

Within the care records, a broad assessment of people's needs was made and recorded. This included mental health, physical health, weight, nutrition, mobility, maintaining a safe environment, sleep, communication, recreation and skin integrity. Records also indicated patient specific interests, likes and dislikes through "this is me" documentation. We noted photographs of the person on the outside of the bedroom door. Inside the bedroom we noted one page profiles, fluid balance sheets, night check paperwork, mattress checks, topical cream plans and hoist instruction. The manager stated this was to encourage the immediate documentation of support delivered.

We noted evidence that care needs were being met with documentation showing involvement from several outside agencies to manage health and behavioural needs in a responsive and timely manner. These included dietician, district nurse, consultant psychiatrist, general practitioner [G.P] and parkinsons nurse and the care home support team. Moorside Hall had several G.P's visit as we were told that it is important for people to have the choice to remain with their family G.P. where possible.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We spoke with six staff members and all showed an understanding of safeguarding DoLS and working in someone's best interest. We saw evidence that documentation was being completed by the manager in line with current legislation that showed the home was working in people's best interests.

On talking about a person who displays challenging behaviours one staff member showed a good understanding of the MCA, DoLS and working in someone's best interest. They mentioned capacity and balancing risk, talked about choices and that people had a right to get up and go to bed when they want.

Breakfast was staggered throughout the morning depending upon the time people chose to rise. We were told by a member of the catering team "We wait to serve, people are never going to go without breakfast." There was fresh fruit offered at 11am, lunch at 12.30pm, biscuits/cake at 3pm and the evening meal at 4.30pm. Kitchen staff were aware of which people were on special diets or required pureed or soft foods. They were aware of people who only wanted small portions. We found the kitchen clean and hygienic. Cleaning schedules were in place to ensure that people were protected against the risks of poor food safety.

On the day of inspection we observed lunchtime. We noted people had the choice of moving to the dining room or remaining where they sat to eat lunch. A choice of foods were offered. The food looked appetising and plentiful and staff explained to each person what was on their plate. People who required support with a meal received this in a relaxed and unhurried manner. They conversed throughout the mealtime seeking feedback on the food. We observed staff enquiring if they had enjoyed their meal. People that required additional support had plate guards and adapted cups to aid with the eating of their meals and drinking of fluids. Care staff had knowledge of who required special

Good

Is the service effective?

diets and who needed support. We observed staff at the end of the meal, document food and fluid intake in care files. Drinks were offered throughout the day, teas, coffees and juice drinks were available with meals and in between times. We observed staff encouraging people to drink fluids during the day.

When talking with one family member, they told us about the food "From what I have seen and tasted of the food [I have had meals here] it has been very good." Another stated "I've been here two years and only had one meal I can complain about. The braising steak was tough."

People's healthcare needs were carefully monitored and discussed with the person as part of the care planning process. Care records seen confirmed visits to and from general practitioners and other healthcare professionals had been recorded. The records were informative and had documented the reason for the visit and what the outcome had been. This confirmed good communication protocols were in place for people to receive continuity with their healthcare needs.

For example on the day of inspection a qualified nurse from the care home support service visited. This was for the purpose of demonstrating the technique for changing a particular wound dressing. The intention being that Moorside Hall staff would subsequently carry out the procedure themselves. This showed partnership with other agencies and a timely approach to delivering high quality care.

DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms were satisfactorily completed, correctly dated and were easy to locate at the front of the care record. One person's records showed that a conversation about DNACPR had taken place and they had chosen not to have one.

Good

Is the service caring?

Our findings

People who lived at the home, relatives and visiting health professionals told us staff were caring, kind and respectful. One person told us "I like the staff." Another person stated "Yes I'm happy here and they [staff] are lovely." A family member stated "I think the staff are incredible. They try to do the best for the patient."

Care records were personalised around the individual's requirements, holding detail of valuable person centred information. There were guidelines to ensure that when supporting people who lived at the home with their personal care needs that they are covered up and their dignity is preserved. We were told that staff are to offer choices on how people who lived at the home were supported with their personal care and to maintain independence where possible. Management complete "walk arounds" to observe staff and monitor standards.

We observed one person being transferred from a chair to wheelchair using a hoist. The two staff members talked through what was happening, went at a sedate pace and gave the person lots of eye contact.

We observed that staff were respectful towards people. We noted people's dignity and privacy were maintained throughout our inspection. We observed staff members demonstrate compassion towards the people in their care and treated them with respect. Staff were able to describe how they maintained people's privacy and dignity by knocking on doors and waiting to be invited in before entering. We noted that people had dignity support plans. These directed staff on how to maintain a person's modesty when supporting them with personal care.

Staff walked with people at their pace and when communicating with them, they got down to their level and used eye contact. They spent time actively listening to people and responding to their questions.

Relationships between people who lived at the home and staff appeared open and friendly. Staff were knowledgeable on people's past histories and present likes and dislikes. There appeared to be a genuine fondness shown for the people they cared for. There was a rapport and banter which people appeared to enjoy and showed familiarity. People who lived at the home and staff were relaxed in each other's company. We observed staff instigate social conversations and reminisce with people about their past experiences. We observed one member of agency staff who had experience of working at the home had a good bond with some of the people they were supporting. One person was clearly delighted to see this member of agency staff and gave him her hand to hold.

We observed one person who lived at the home become agitated and verbally aggressive when in the dining room. Staff were very clear about the language used and in a discreet but respectful manner they dealt with the situation. Another staff member later interacted with this person getting down to their eye level and diffusing the situation. We were told by one person who observed the situation "Staff are kind when people are kicking off, they don't use force, they use gentle persuasion."

The management team showed kindness and compassion to the people who lived at the home. For example, a member of staff told us that they requested a sewing machine be provided so that they could do repairs to people's clothing as necessary. One was purchased within 2 days of the request being made.

We spoke with the manager about access to advocacy services should people require their guidance and support. The manager had information details that could be provided to people and their families if this was required. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.

Three out of the six care records we looked at included people's end of life wishes. These included preferred priorities of care and advance care plans, which had been discussed with the person and their family.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Within each person's care record, there was a document entitled, "This is me" which provided a pen picture of the person. There was information about people's social history, cultural preferences and spiritual beliefs. Care plans provided staff with detail about people's preferred name, their G.P. details, past and present medical history, mobility, dietary and communication needs. There was information on how to reassure someone if they become anxious, falling risk assessments and preferences for personal care. All files we looked at had a hospital passport which allowed relevant information to be portable and could be taken with the person should they be admitted to hospital.

We observed that all bedrooms viewed had personal items and photographs on view and were individually styled. People had been able to bring their own furniture and the rooms were clean, fresh, light and airy. One person had a pet budgerigar plus a sign for the door which stated don't open the door the budgie is out of the cage. In another bedroom there was a photoboard on the wall with family members' names to facilitate positive interaction. We saw several relatives visit during our two day Inspection and there did not appear any restriction on visiting times.

One family member told us "We are more content now that mum's here. Someone visits everyday."

There was an activities co-ordinator employed at Moorside Hall. An activities co-ordinator is responsible for organising a wide range of activities for people. On the day of inspection we observed a party organised by the care staff to celebrate Queen Elizabeth becoming our longest serving monarch. This involved decorations, a singalong, significant events during the Queen's reign being discussed. People appeared to enjoy the ice cream sodas, cakes and the staff dressing up for the event. The member of staff who had taken the lead role in organising the activity spent a lot of time telling people what to expect; giving the information on a number of occasions. There were activities displayed on the wall including photos of film stars. There were maps with stickers on the wall, to show people's names and who had an association with that part of the country/world. We noted that a musician visited monthly but the home also had its own instruments so could arrange music making sessions independently. Pamper sessions and trips out were advertised on the notice board.

On activities, one person told us "Staff have made a special effort to get things for people that they enjoy; [X] likes colouring so they bought him colouring books. They have also bought a special book with pictures of Morcambe and Heysham in the past. I've looked at that." Another person told us "It's a nice place, staff do an incredible job and we do singing, baking and play board games." On the day of inspection we observed a reminiscence board game being used.

One relative told us "There are always various activities going on in the afternoon and the patients always seem so cheerful."

A well maintained enclosed garden was available to people, access was direct from the lounge. On the day of inspection we noted people enjoying the garden. An up-to-date complaints policy was visible on the notice board. Staff were able to describe how they would deal with a complaint, including referring the matter to the manager. One person who lived at the home stated "If I was unhappy I would check on what I'd signed for. I would complain to the manager." A relative told us "If I had any complaints we would have no problems and would complain to everyone."

Good

Is the service well-led?

Our findings

The manager had a visible presence within the service. People and staff felt the management team were supportive and approachable. One staff member stated "[the owner] looks after his staff," whilst another stated that they felt confident in [the owner]. Another staff member stated that if they needed support they called for the manager and they would work alongside them.

We were aware prior to inspection that Moorside Hall had undergone significant changes in management and personnel. On the day of inspection a member of staff had phoned in sick. The atmosphere within home remained relaxed with the manager working alongside the staff. The atmosphere within the home remained calm which promoted good personalised care.

Regarding the home, people felt the changes were positive; we were told by one staff member "It's changed a lot, it needed to…..we are getting up there." Another staff member stated that "It's going in the right direction."

The service demonstrated good management and leadership and there was a clear line of management responsibility, from the provider through to the management team and staff. The management team had oversight of and acted upon the quality of the service provided. Staff we spoke to stated that the changes had been positive and improved the care delivered.

The manager understood their responsibilities and was proactive in introducing changes within the workplace. This included informing CQC of specific events the provider is required to notify us about by law and working with other agencies to keep people safe. We saw evidence that the manager had attended provider forum meetings and used these links to source additional training for staff. Provider forum meetings are organised by the local authority.

All the staff we spoke with said the management team was approachable. Staff told us there were regular staff meetings and supervisions took place regularly.

We saw evidence of resident's meetings [minutes displayed on the communal notice board]. Satisfaction surveys had taken place with relatives. We saw eight replies, one negative comment regarding "unhappy at too many staff changes." This was an issue remarked upon in a relatives meeting. We saw evidence that the provider had written to relatives in response to the meeting stating that staffing numbers were now satisfactory. People were assisted to comment about their experiences of care and support. This was done through resident's and relatives' meetings which were advertised on the notice boards. One family member stated "We know about relatives' meetings but I have not been able to attend any."

There were night staff meetings, day staff meetings and kitchen staff meetings. Topics discussed were falls risks and what procedures needed to be put in place, how to improve work output and safeguarding.

There was evidence of a variety of quality audits taking place, for example. These included hand hygiene, safeguarding, medicines audits including competency assessments. We also saw mattress audits, accident and incident audits, care plan review audits, equipment checklists, cleaning audits, kitchen audits and laundry cleaning. There was evidence these audits took place and were reviewed. Night staff's role included audits on people's health issues, falls audits and complaints audits. Policies and procedures were in place and available .