The Orders Of St. John Care Trust

Ashwood Care Centre

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

The inspection took place 24 and 25 April 2018 and was unannounced.

Ashwood Care Centre is a purpose built care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashwood Care Centre provides accommodation and personal care for up to 82 people. At the time of our visit, 76 people were using the service.

The home was last inspected on 24 April 2017 and was previously rated as Requires Improvement. Action had been taken to address the breaches in regulation identified at the previous inspection. At this inspection we found the service to be rated as Good in all domains and Good overall.

There was a registered manager in post. 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.

There was an activities team and eleven volunteers working with the service to ensure social inclusion. We saw a broad range of activities were in place, including clubs based on hobbies and interests such as photography. Staff also had time in their day to ensure that people received quality social interactions either in groups, or on a one to one basis.

Medicines were managed safely. Staff were knowledgeable and received training around the management and administration of medicines. There were good relations with local healthcare services and the service utilised the contacts for advice. For example, phoning the district nurses to discuss changes in people's needs and to ensure they received timely advice to address these concerns.

People told us they felt safe. We saw that there were pro-active measures in place to monitor people's safety, such as observation charts and analysis of falls data to identify and address risks. There were risk assessments in place where needs had been identified, for example when a person was at risk of falling.

People were supported to attend healthcare appointments. The service also had visiting healthcare professionals that they could make referrals to, for eyesight, hearing and dental checks.

Care plans were written using person centred details, care staff referred to these for guidance and updated them regularly in the event of a person's needs or preferences changing. Records were well documented and there was clear involvement with health professionals in a timely manner when assessed and required.

People spoke positively about the care they received, they praised the care staff for being kind and caring.

Each interaction we observed was positive, with care staff taking time to ensure people were listened to and supported at their own pace.

Choices were offered visually, or using 'flash cards' for people who benefitted from visual aids to support them in the decision making process.

At meal times people had a visual menu. People were also offered visual choices of the plated meals. If a person did not want an option from the menu, they could choose an alternative of their preference. There was a range of snacks and drinks available and offered throughout the day.

Care staff understood their responsibilities with identifying abuse and reporting safeguarding concerns.

Complaints were responded to thoroughly and efficiently by the registered manager. We saw that complaints were investigated and the registered manager was quick to liaise with people and their relatives following any concerns they raised.

The home was clean and free from odours throughout. Maintenance checks were completed on the building and equipment, with any areas for repair addressed promptly.

There were thorough quality monitoring processes in place. The registered manager had an overview of audits from the whole service and completed detailed checks around any issues raised, to ensure these were addressed in fine detail.

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.

Staff understood how to identify abuse and the procedure for reporting safeguarding concerns.

People's medicines were managed and administered safely.

Detailed risk assessments were in place where needs had been identified.

Is the service effective?

Good

The service was effective.

The service followed the principles of the Mental Capacity Act 2005. Assessments and best interest decisions were in place. Deprivation of Liberty Safeguard applications were made and reviewed regularly.

Staff were well trained. There was a broad range of training available and additional specialist training was sourced in response to changes in people's needs.

There were tools in place to monitor people's food and fluid intake. People's preferences and choices around food, drinks and their dining routines were well known and supported by the staff.

Is the service caring?

Good

The service was caring.

People were supported in a kind and caring way, by staff that respected people's privacy and dignity.

People chose how and where they spent their time.

Staff had time to spend interacting socially with people.

Is the service responsive?

Good

The service was responsive.

Complaints were investigated and followed up efficiently.

There was a varied activities programme in place.

Behavioural care plans detailed support strategies and techniques that staff understood and used to support people's emotional well-being.

Is the service well-led?

Good

The service was well-led.

People, their relatives, and the staff team spoke positively about the way the registered manager led the service.

The registered manager had robust quality monitoring processes in place. Action plans were acted upon and there was evidence that improvements were sustained.

The registered manager maintained an up to date knowledge of the care services sector and attended networking events to share ideas and learn from health and social care professionals.

Ashwood Care Centre

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.

The inspection took place on 24 and 25 April 2018 and was unannounced. The inspection was conducted by two inspectors and one 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 took place we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

During our inspection we spoke with 26 people living at the home, seven relatives, three volunteers, one social care professional, and eight staff members including care staff, housekeeping and kitchen staff. We also spoke with the head of care, the deputy manager, regional operations manager, and registered manager. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for 10 people, medicine administration records in each unit of the home. We looked at five staff recruitment files, and records relating to the management of the service, such as audits and complaints.

We observed care and support in the communal lounges and dining area, and spoke with people in their bedrooms. We spent time observing people's experience at lunch time and observed the medicine administration on one unit.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One relative said, "I am 100% happy. The staff are very helpful. I feel mum is very safe here." Another relative told us, "I have every confidence in the staff here. I feel that my mother is very safe and well looked after."

Staff understood the different types of abuse and their responsibility to report any safeguarding concerns. They told us they had received safeguarding training and felt confident in raising concerns with a senior member of staff. Staff also knew who that they can contact the local authority safeguarding team, as well as the Care Quality Commission.

Risk assessments were in place to protect people from the risks of potential harm or abuse. We saw that where there was a risk of a person falling, falls risk assessments and care plans were completed. Records for one person showed that they could be reluctant and anxious to receive support with their personal care. The care plan documented positive support that care staff could provide to reduce the persons anxieties, such as distraction techniques. There was also a risk assessment to guide staff in reducing the risks for the person.

There were sufficient numbers of skilled staff available to meet people's needs. The registered manager told us that they were fully staffed, however they always have an advertisement for staff because there can be a high turnover due to the home being in a military town.

Safe recruitment and selection processes were in place. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We checked the recruitment records for five members of staff. The records demonstrated that recruitment procedures were being followed.

Medicines were managed and administered safely. The Medicine Administration Records (MAR) for fifteen people were checked and we found no errors or gaps in recordings. One member of staff told us checks were completed daily on the MAR to identify if any gaps are present. We observed that people's consent was sought when medicines were administered. People who were prescribed medicines on an 'as and when required' (PRN) basis had protocols in place. The PRN protocols were cross-referenced to the relevant care plans to provide additional information to support the person and ensure that medicines were only offered once less restrictive support options had been followed. The directions for administering topical medicines, such as creams and lotions, were detailed and well documented. The recordings for topical medicines were consistent and evidenced that the administration guidance was being followed.

There were no medicine care plans in place for people. This meant that people's decisions around managing their medicines and how their medicines were administered were not recorded. However, for those people who wished to administer their own medicines, there were appropriate risk assessments in place. Some people were assessed as lacking the mental capacity to consent to receive medicines. There

were appropriate best interest decisions in place, including consultation with the pharmacy and the person's doctor.

People received their medicines from staff who were well trained to administer these. Staff had their competencies in medicine administration checked every two years, or sooner if there were any errors or concerns. Staff told us they were encouraged to raise any queries or concerns about the administration of medicines with senior staff and they were knowledgeable about the medicines policy.

Staff supported people to move around the home safely. We observed staff offering to walk with people. Staff asked people, "shall we walk together?" and "would you like me to come with you?" when people were walking and appeared unsteady or in need of assistance. Staff prompted people to use their mobility aids and quickly brought the aid to them if required. This promoted people's independence and reduced the risks of people falling.

Systems were in place for staff to report accidents and incidents. The deputy manager and head of care completed electronic records of accidents and incidents that the registered manager then reviewed and maintained an overview. The registered manager analysed the records of accidents and incidents on a monthly basis, to identify any trends or patterns; the analysis findings were then discussed at senior staff meetings. Staff had taken part in reflective team meetings following some incidents. This meant that staff could reflect on what had happened and review how they could respond differently in the future. Learning from serious incidents was also documented in the staff team newsletter as examples from which staff could learn and reduce the risk of an incident re-occurring.

The home was clean and free from odours throughout. We saw that floors were being steam cleaned, and the décor and furnishings were well maintained. There were regular equipment and building checks carried out by the maintenance member of staff and any maintenance issues were resolved in a timely manner.

Good

Is the service effective?

Our findings

People told us their choices were respected. One person said, "I have lots of choice. Staff help wash me as I don't like a shower because I don't like having water on my head. I know they would help me to have a bath if I wanted." We saw that people had added their own furniture to their bedrooms and personalised the rooms with photographs and ornaments.

We observed staff seeking consent from people and giving them time to respond. People were supported to make as many day to day decisions as possible. For example, people chose where they wanted to spend their time and we saw people choosing to have their meals in different dining rooms throughout the service. People went out with their families and had regular visitors. At meal times, people were offered visual choices and could request alternatives that were not on the menu if they chose to. One person told us, they would sometimes request egg on toast, or some soup, if they did not like what was on the menu.

Staff shift patterns supported people's needs. The care team worked twelve hour days, 4 days per week. This had a positive impact for people, because staff were no longer handing over to a late shift team and staff spent the whole day with people instead. For example, one person requested to have support with a bath later in the day. Their request was made in the morning, and the staff member planned the request into their day to ensure they went back to the person at their preferred time.

We observed staff working well together as a team. Staff communicated well with one another and ensured they were deployed appropriately to meet people's needs. During the meal times, people were supported by staff who sat at the dining table with them. Staff offered encouragement to people who required prompts to ensure they ate and drank enough during their meal. People who required assistance with their meal were supported at their pace to eat as much as they wanted to.

There were mixed views from people regarding the food offered at meal times. The positive feedback included, "The food is marvellous, there's lots of choice." Also, "The food here is good." Some people felt that the food could be improved and their comments included, "It could be better." Also, "My food was not hot enough. But when I told them this, it did improve." People told us food and drinks are always available. There were snack bowls of crisps, chocolates and fruit in the kitchenette's and jugs of drinks in the bedrooms and lounges. We saw people being offered drinks throughout the day and those who were able to would make their own drinks when they chose. People were offered second helpings of their lunch and staff offered snacks after the main meal and pudding, which some people took with them to enjoy later in the afternoon.

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.

We saw that the service had consulted with relatives and healthcare professionals as part of the decision making process. This ensured that people's previous wishes and healthcare needs were taken into account when making decisions in the person's best interests. Some people had appointed family members as their Power of Attorney (PoA), which empowered them to act on their behalf. Each care plan documented whether the person had an appointed PoA. The care plans stated if the PoA was for health and welfare, or for property and finances. Staff understood who should be consulted in relation to specific decisions. This ensured people's legal and human rights were upheld when best interest decisions were made.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS authorisations as required and the service was compliant with the conditions of the DoLS for each application.

People were supported by well-trained and enthusiastic staff. Staff told us they received regular training. One staff member said, "I am always on training, every day there is something different to learn, I love it." Another staff member said, "It is the best place I have worked, the training is great, and it is all useful stuff." The service had a training matrix in place and this showed that staff were up to date with their mandatory training, including health and safety, dementia awareness, MCA and DoLS, and safeguarding. The registered manager explained that the staff had received bespoke training from newly qualified dentists from a local university, who supported the staff in completing oral hygiene assessments for people and in learning more about oral health. The service worked with and made referrals to visiting healthcare professionals for people's eyesight, hearing and oral health.

The service consulted with health professionals in a timely manner. Changes in people's behaviours or conditions were well documented and the service was quick to make referrals. For example, one person had been experiencing episodes of low mood, this was documented and monitored, before the GP was contacted. The GP then reviewed the person's medicines and made changes, the service then monitored the person's well-being to ensure they received the appropriate care and treatment. We saw that there were referrals to the Speech and Language Therapists (SALT) for people who experienced difficulties with swallowing. The guidance from the SALT referrals was then documented in the care plans and the kitchen staff were made aware.

People were supported to attend health care appointments outside of the home. We spoke with one member of staff who was heading out with one person in their wheelchair to the town to visit the doctor. Due to the location of the service, the local community is within walking distance. If people were admitted to hospital there was a transfer document in place which was completed at the time of the admission, including up to date details of all medicines, as well as the Treatment Escalation Plan which documented people's assessments or wishes regarding resuscitation. This meant that healthcare professionals were provided with relevant details around the person's current healthcare needs and preferences.

People had specialist equipment in place to support their needs. We observed people using large handled cutlery and lipped plates during their meals. This meant that the service adapted to suit the needs of the individual in the least restrictive way and people maintained their independence at meal times for as long as possible.

The environment of the service was designed to meet people's needs. There were dementia friendly furnishings and accessories throughout the ground floor of the service. This included, tactile wall art,

rummage drawers in corridor dressing tables, hat and jewellery stands and displays. There were large kitchenette and dining areas, these were well used as social spaces with people gathering throughout the day to sit and chat with staff and one another, while having a drink together. There was a coffee shop on the ground floor, we saw this space being used for families to meet with their relatives.

Good

Is the service caring?

Our findings

The service continued to be caring. People received care and support from staff who spoke to them with kindness and consideration. People told us, "The carers are very kind." Also, "Staff are very respectful, they are kind and helpful."

Relatives said the staff made them feel welcome, one relative said, "It has a family atmosphere here, we like to come and they also give us tea and cake." Another relative told us, "I like the staff, I feel very welcome, embraced as part of the service."

Each interaction we observed was positive and it was clear that staff knew the people they were supporting well. Staff knew people's likes, dislikes and their usual preferences. For example, one member of staff knocked a person's door and waited for the person to come to their door. The staff member greeted the person kindly and asked if they wanted anything for their evening meal. The person said, "Egg and just a few chips please." The staff member said, "I know what you mean by a few chips, so four or five chips will be ok?" The person was offered a piece of cake and together the person and staff member said, "Just a small slice." They laughed together and shared a hug. The interaction was person centred and the staff member knew the person well. We spoke with a member of the kitchen staff who had a list with them of each person's specific preferences for snacks when stocking up the supplies in the kitchenettes; as well as their dietary requirements and any allergies. This meant that even the staff who did not work so closely with people, were aware of people's preferences.

Staff worked well as a team to ensure people's needs were met in a timely manner. All interactions we observed were unrushed. One person told us, "They come quickly when I ring my bell." Another person said, "They are always there when I need someone."

There was a sense of calm throughout the home and staff had quality time to spend interacting with people. People could choose where in the home they wished to spend their time and they were socially included as staff had time to sit and chat with people. We observed carers and activity staff sat at the dining table or in the lounge, with a group of people, enjoying conversations and sharing laughter. A new initiative to encourage care staff to think about social time with people had been introduced, called 'The 3 T's'. This stood for 'Time for Tea at Three'. We saw in the afternoons on both days of the inspection, the care staff time were focussed on encouraging social interactions and engaging with people.

Social interactions and friendships between people were supported. The home's newsletter advertised for people who wished to volunteer themselves to spend time with others, visiting people for a chat, or joining them to attend an activity together. One person told us, "We have lots of fun here, it is good quality fun too." We observed people who live on different floors of the service coming together for activities and arranging to meet up the following day to attend the next session together.

During the summer weather, the ground floor doors opened up into a large, user friendly garden. Staff told us that they would often lay the tables outside for meals during nice weather, so that people could choose

to dine in the garden. Two staff members pointed out the shaded areas in the garden with benches and said these were popular places for people to spend time during the nice weather. They also said the garden spaces were used for people who wished to "stretch their legs", or "go for a walk", as they could do so in a safe environment.

People were supported with their communication needs. One person with a hearing impairment was confident and comfortable in using their personal white boards to write messages in communication with staff. There were photographic menu choices displayed on the dining tables. Also, there were large print 'flash cards' with questions and phrases. One staff member told us these were used for people who sometimes found that reading what was being asked or offered made the information more understandable.

Staff told us they enjoyed their role and working for the service and spoke with enthusiasm about working in care. One staff member said, "It was a complete career change for me, but from the first time I came here I got such a positive feeling for the service and now I love what I do." Another staff member said, "The best thing about working here is getting to support people and being able to make people smile." One staff member said they like to spend their break supporting a person who enjoys jigsaw puzzles, so they chat and work through the puzzle together. One senior staff member told us, "It is important as a senior to lead by example and model good care."

Good

Is the service responsive?

Our findings

The service continued to be responsive. People and their relatives were involved in creating and reviewing people's care and support plans. One staff member said, "We have a key worker system. Being a key worker means you are responsible for making sure the care plan is up to date. You speak with the person and their families to make sure the care plan has all the right information." Care plans contained a one page profile, which was personalised to include details about what was important to a person and how best to support them. There were documents called 'Meal Mats' in place which presented what is important to a person during their individual dining experience. For example, a person's food or drink preferences, any allergies or intolerances, as well as what cutlery or equipment they may need. We saw staff refer to these for guidance to ensure they delivered person centred care.

People who displayed behaviours that required intervention from staff to prevent harm to the person and their wellbeing, were supported by staff that understood their complex need. We observed staff using personalised diversion techniques for people who were becoming anxious or agitated. For example, when one person's level of agitation was rising, the staff asked if the person would like to write down how they were feeling, and this worked well to divert the person's attentions. There were detailed behavioural support plans in place which provided guidance for staff in supporting people's wellbeing.

People told us they would feel comfortable raising a complaint if they needed to. One person said, "I could complain to any staff if I needed to." Staff also knew how to support people to raise complaints and one staff member told us, "There is a complaints procedure in place – I would follow that." The registered manager explained that there isn't an easy-read complaints procedure or tool to support people who may not know how to make a complaint. The registered manager told us that they had raised this with the organisation after researching different tools that could be used. The service has received comments and complaints. These included two complaints about access into the service after the reception staff had finished work, as care staff were required to authorise entry after this point. The registered manager was responsive in following up complaints thoroughly and taking action. To respond to this complaint, the registered manager had recruited for extra reception staff hours, to provide a quicker response time for visitors at the front door.

There was a feeling of community within the home. There were two activities coordinators at the service and a full activities programme in place. We saw an activities coordinator delivering the weekly skittles event. This was well attended by an enthusiastic large group of people. People cheered each other on and discussed the friendly competition; one person told us they were a "team captain." We also saw the activities coordinators delivering a music quiz and spending time chatting with people. There was a photography club and we saw some of the photographs the club had taken during the snowy weather. The photography club meet to discuss photography, reminisce using old photographs and to try out their skills in digital photography and editing. The care staff were involved in activities as well. We saw one carer sat with two people and supporting them to play a board game. We saw staff engaged in conversations with groups of people in the lounges. In one conversation people were talking about what they had done in their life and achieved by certain ages. Laughter was being shared and people enjoyed the company of the staff.

The service employed eleven part-time volunteers. The volunteers spent time with people in the communal areas, or visited people in their bedrooms to see if they would like some company. The volunteers were trained by the organisation and had been recruited either through recommendations from relatives, or because they had previously had a family member cared for at the service. Two of the volunteers had Pets As Therapy (PAT) dogs, which visited the service. The registered manager explained that lots of people had previously had dogs or pets and that they loved seeing the PAT dogs when they visit. During our inspection the volunteers brought in three puppies to visit people on each floor and we observed that this had a positive impact on people. For example, one person had been sat very quietly at the table, not engaging with other people. When the puppy was on their lap, they embraced it and engaged in the interaction, speaking with other people about how puppy "feels like a baby."

People's cultural and religious needs and wishes were respected and supported. People attended church services and there were services held within the home. Staff understood the importance of respecting people's diversity and treating people with equality. One member of staff told us, "We know that there will be people with different cultural beliefs living at the home in the future and we will always be happy to accommodate people's needs and wishes as part of providing person centred care."

We reviewed monitoring charts for observations, repositioning, as well as food and fluid intake. Charts were completed consistently and only when records documented that there was a need for them to be in place. For example, people had fluid monitoring charts in place while on antibiotics for a chest infection to ensure their intake supported their healthy recovery.

The registered manager spoke passionately about wanting to ensure the service provided quality end of life care for people. Staff received training from nurses at the local hospice. Care plans were in place documenting people's future life wishes. For one person, their care plan included that they would like to have flowers in their bedroom and their family present. The registered manager said families are welcomed to spend as much time as they can with their relatives and are offered food and drinks. The registered manager said they wanted families to feel comfortable at the service. A range of cards and compliment letters were received from families who had relatives receive end of life care at Ashwood Care Centre.

Good

Is the service well-led?

Our findings

The service was well-led. The registered manager ensured that each person felt listened to. We saw the registered manager in conversation with one person, they were discussing the person's feedback about the service. The registered manager listened and responded effectively to each query the person had. We also saw the registered manager greeting people, chatting with them and sharing laughter together. This reflected the sociable atmosphere within the service and each interaction we had observed between people and care staff.

People told us, "I would go to any member of staff, but especially [the registered manager] if I had any concerns." Also, "The [registered] manager is very good, really approachable for us and our families."

Staff spoke positively about the registered manager and praised them for the support they received. One staff member said, "The [registered] manager is very approachable and they are really hands on. You know if you need help with supporting someone you can ask the [registered] manager and they will always help." Staff told us the registered manager was approachable. One staff member said, "I know I could go to [the registered manager] with any problems and they are really fair and will work with me." Staff were also keen to explain they felt the senior staff team, including the deputy manager and head of care were very supportive. One member of staff told us, "I feel I can go to them for advice or if I am unsure, but also I feel they know we know the residents well, they trust us, it is mutual respect." The registered manager said, "I will always make time for people and staff, if there are any issues I prefer to nip them in the bud."

A range of quality monitoring systems were in place. This included audits from the provider for areas of the service such as infection prevention and control, medicines, and equipment. The information from the audits fed into a whole home action plan, which evidenced that there had been improvements at the service. The action plan ensured the registered manager, regional manager and the providers quality assurance team had an overarching view of where the service was in terms of their quality performance rating. In addition to the providers audits and following up on concerns raised at previous CQC inspections, the registered manager had taken action to ensure the quality of the auditing systems. The registered manager completed audits of specific issues that the main audit had picked up, but could then be explored in more detail to ensure that actions robustly addressed the issue. For example, the medicines audit identified that the administration recordings for creams and lotions were inconsistent. The registered manager then made a focus on introducing new systems, auditing and reviewing how well these worked, before making any changes that were needed.

People's weight loss and the number of falls people had were audited and the data was analysed. People at high risk were identified from the data and support systems were put in place, such as food monitoring charts, or increased observations to reduce the risk of falls.

The registered manager had a clear vision for the service and a credible strategy to achieve continual improvements. The registered manager understood themes and trends in the care sector and maintained a self-driven up to date knowledge of new initiatives. They told us that they had seen an increasing trend in

focus around community involvement and were keen to develop this part of the service further. The service had been in contact with local schools to promote involvement with the service. They had also contacted the local military bases to enquire about servicemen and women visiting the service to spend time with people and speak about their military careers. There were regular events at the service where the community were invited to spend time and interact with people. For example, fete's and parties, facilitated alongside the Lions Club (a worldwide charitable society devoted to social and international service.) The registered manager attended health and social care networking meetings, where they had the opportunity to meet with other professionals, share ideas and learn from one another.

People and their relatives were welcomed to share their feedback. The registered manager explained they have an "open door policy" and said because of the office location they will frequently have relatives visiting them to discuss any concerns. Regular meetings took place for people and their relatives. This gave people the opportunity to discuss any updates at the service and to raise any issues for discussion. There were also comment cards available and being used for people to record any feedback they had. For example, one person had misplaced their slippers. There was evidence that each of these comment cards were followed up on and responded to.

Staff had the opportunity to share their feedback with the manager. Regular meetings took place with the different staff teams. These meetings were an opportunity to discuss updates and any issues. We saw evidence of reflective meetings following on from incidents. These gave staff the opportunity to discuss what could be done better next time and to prevent recurrence of the incident.