Quantum Care Limited

Margaret House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Margaret House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Margaret House provides care and support to up to 51 people some of who live with dementia. At the time of our inspection 49 people were living at the service. The home is split across five self-contained bungalows, each with its own communal areas and kitchenette.

At our last inspection on 05 November 2015 we rated the service good. At this unannounced inspection we found evidence that demonstrated concerns. These were in relation to management of risks to people's safety, staff deployment, inaccurate completion of care records and governance of the service. The overall rating for the service has changed to requires improvement.

The service had 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.

People felt safe at the service, staff had received relevant training on how to safeguard people and understood their responsibilities to report any concerns. However, risks to people's safety and well-being were identified but not always managed to keep them safe from harm. People were not always supported by sufficient numbers of staff on one specific unit. Relevant pre-employment checks had been completed for all staff and safe recruitment practices followed. Medicines were stored appropriately, and administered to people as the prescriber intended, managed safely and audits completed. People lived in a clean and hygienic environment and were cared for by staff who followed robust infection control procedures.

People felt staff were well trained. Staff had attended relevant training to undertake their role and spoke positively about the training they were provided. Staff felt supported and attended regular supervisions and appraisals. The registered manager was in the process of reviewing people's consent. However, staff were aware of how to support those people who may not be able to provide their consent. People's nutritional needs were met and responded to when people were at risk of weight loss. The environment of the home was in need of redecoration and a plan was in place to address this.

People told us that staff were friendly and respected their privacy. Staff knew people well and were knowledgeable about people's individual needs. People felt staff knew what was important to them and knew how people chose to spend their day. People's privacy and dignity was promoted.

People's received care that responded to their individual choices and promoted their independence. People and their relatives were involved in planning how their, their family members support would be delivered.

Staff were aware of people's choices and preferences and delivered care accordingly. Care records were in the process of being reviewed, however staff were aware of people's current needs. People were able to have visitors without restriction and able to see them in privacy. People were encouraged to provide feedback on the service they received and knew how to make a complaint.

Although being reviewed, we found people's care records were not always updated in a timely manner when people's needs changed. Audits completed by the registered manager and provider did not identify the issues with people's care records and consent documentation. The registered manager had not delivered the improvements they told us about in their annual improvement plan. People were aware of who the registered manager was and felt they were visible and approachable. Staff were encouraged to attend team meetings which were held regularly. People's feedback was used to improve the quality of care they received. Notifications required to be sent to us were made in a timely manner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to peoples safety and wellbeing were identified, but not consistently well managed and reviewed.

Staffing on one unit was not always sufficient to support people when they needed this.

People felt safe and staff reviewed their practise when things went wrong.

People received their medicines as the prescriber intended.

People lived in a clean environment and care was provided in a hygienic manner.

Is the service effective?

Good

The service was effective.

The home required re-decoration throughout to ensure people lived in a well-maintained environment.

People's consent was sought prior to care was in the process of being reviewed.

Staff were provided with a sufficient induction and received ongoing training and personal development.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were cared for in a kind and sensitive manner that protected their dignity.

People felt staff valued their opinion about their care and listened to them.

People and staff had developed close professional relationships.

People's confidentiality was protected.

Is the service responsive?

Good

The service was responsive.

Peoples contributed to their care plan based upon their view of their needs, wishes and independence.

Staff were aware of people's choices and preferences and delivered care accordingly.

People were supported to pursue activity and hobbies, and were part of a wider community.

People had visitors freely see them without restriction.

People felt confident in raising a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People's care records were not accurately maintained.

Plans for improvements in the service had not been completed within the agreed time frame.

Documents relating to consent had not been seen but were in the process of being reviewed.

Audits although completed had not identified some of the concerns we found.

People were positive about the management of the service and felt the registered manager was approachable.

People's views and opinions were sought to improve the quality of care they received.

Margaret House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 10 October 2018 and was unannounced.

The inspection was undertaken 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 using this type of service. The expert used for this inspection had experience of a family member using this type of service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us about the service such as information from the local authority, and notifications submitted to us. A notification is information about important events which the provider is required to send us by law. Following this inspection the registered manager sent us further information. This was in relation to plans for renovation and improvements to governance.

During the inspection we reviewed the care records and risk assessments of four people who used the service, to ensure these were reflective of people's current needs. We also reviewed records relating to the management of the service and sought people's views about how the service was managed. We spoke with nine people, three relatives, six staff members, the deputy manager, the registered manager and a representative of the provider. We also 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.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and well-being were identified but not consistently well managed. We saw that staff completed a range of assessments in areas such as mobility, skin integrity, risk of falls and these had all been reviewed regularly. The registered manager was able to demonstrate to us how they had worked in partnership with the health authority to reduce the number of hospital admissions. Those people at risk of developing pressure wounds had an appropriate care plan in place and equipment such as pressure relieving mattresses and cushions were routinely used. Where people were admitted from hospital with a pressure wound, staff had worked with district nursing teams to ensure these healed swiftly.

Appropriate equipment was in place for people to mobilise such as walking frames and hoists to enable them to transfer themselves with support from staff. Those people at risk of falls had a sensor mat in their room to alert staff when the person got up.
However, the review of some people's care plans, particularly in relation to risk of falls did not review and respond to people's changing needs. For example, one person was seen to have an unwitnessed fall on 18 September 2018. The risk assessment was not reviewed until 02 October 2018, however further falls had occurred before to this review and after this date. Given the number of falls the person had, we noted that their risk assessment was not accurate. We were unable to see where staff had referred the person during this time for investigation of possible urine infection, review of medicines or referral to healthcare professional such as an occupational therapist.

Where people displayed behaviours that challenged, we found inconsistencies in the way these were managed, responded to and monitored. We were told about two people who at times became aggressive towards staff. One example was a person who struck a staff member. This had occurred on a number of occasions. Although staff had documented the incident, monitoring of the person after the incident, and a review of potential triggers of the behaviour had not been carried out. On one unit at lunchtime we saw four people sat at the dining table in their wheelchairs. None had the handbrake applied. One person was seen to then use their feet to propel themselves to the toilet. This placed people at risk of either falling from the chair when stationary or developing skin tears when self-mobilising with their feet.

People who felt low in mood or who had been diagnosed with depression did not feel the staff were able to support them effectively. One person said, "They don't seem to understand me or why I feel lonely." We spoke with two people who told us they felt depressed, and reviewed their care records, and found little information to direct staff with how to support their mental health positively. Staff were not aware of how to support people and the language used by people to explain they were potentially feeling low was misinterpreted. For example, one person said when they said to staff they felt unwell, staff asked if they would like a paracetamol. They meant they felt low in mood but staff misinterpreted this, resulting in the person being left alone.

People told us there were sufficient numbers of staff available. One person said, "I think there are enough staff, I never have to wait long for them when I call." A second person said, "I rang it [call bell] yesterday when a resident fell in the lounge, the [staff] were there in a matter of seconds."

However, staff gave a varying view of staffing levels. Some staff felt there were enough. One said, "Yes, staffing levels are fine, we get done what we need to." Although, some staff felt there were times when staffing levels were not enough. One said, "If someone [staff member] doesn't turn up, they try to cover with agency." We asked if this was always covered and they told us it was not always. A second staff member said, "Normally it's 10 [Staff numbers]. That's enough to get through what we need to. The only thing I would say is when [named person] is getting agitated we need more support, they are literally one to one most days so take up a lot of time that other people don't then get on the bungalow. [Second person] will just stand up when they want and it can be difficult. It would be great to have one extra in the evening on bungalow five so we can give them the attention they need."

A second staff member went on to further tell us that, "Three people need two staff to hoist and there have been occasions when there are no staff in the lounge and there were two [People] who are at risk of falls and are always standing up." This left these people on this one bungalow at risk of falls as staff were not present to keep them safe from harm.

People felt safe at the service. One person said, "I do feel safe because I have got to know all the carers, they are kind and that makes me feel secure." A second person said, "I feel very safe the [Staff] are lovely, I have been here a couple of years, I have never seen anything that would make me feel un-safe, everything seems to run smoothly."

People were protected from the risk of harm by staff who knew how to identify abuse and knew how to report any concerns they may have. Training records confirmed that all staff had undertaken appropriate training and staff were aware of how to report their concerns to external agencies. One staff member said, "[People's] behaviour may change, they become down and withdrawn, possible marks on them. If I saw a mark, I would report to the manager, check the care plan, if not I would do one, then get the manager to ask who was on before me. I would just report it. In handover they [Manager] would say someone had a mark, fall or whatever, and what they have done."

Lessons learned from safeguarding was an area that was discussed with staff with examples of lessons being shared and learned and improvements made when things go wrong. One staff member described to us a recent incident. "What happened was the staff member had been through training, but gave the wrong medicine to the wrong person. Lessons learned have led to the medicine charts being updated to record very clearly in bright bold ink to identify people with a similar name or initial are identified clearly."

The registered manager had recently supported a staff member to train to be the safeguarding champion and they had attended their first meeting. They told us this staff member would be able to share with staff the outcome of the meetings in future and develop safe practise based on lessons learned.

Plans and guidance were available to help staff deal with unforeseen events and emergencies which included relevant training such as first aid and fire safety. Regular checks were carried out to ensure that both the environment and the equipment used were well maintained to keep people, staff and their visitors safe. People had personal evacuation plans and staff we spoke with confirmed there were regular fire alarm checks and drills. Staff demonstrated they understood what to do in the event of a fire. There was a fire marshal on duty at each shift and staff knew the responsible fire marshal for that day.

We looked at the recruitment files for three staff members who had recently started work at the service. We saw that relevant pre-employment checks had been completed for these staff. This ensured that staff employed were of sufficient good character to work with people using the service.

People's received their medicines in accordance with the prescriber's instructions. We checked people's medication administration records (MAR) and found these were complete with no errors or omissions. Physical medicines stocks tallied with the stock records demonstrating people had received their medicines when required. People's preferences and allergies were clearly recorded, and a review of people's medicines, particularly those to manage behaviours that challenge were regularly carried out.

Staff maintained accurate records for receipt and disposal of medicines, and stocks were regularly checked. Where people required their medicines to be given covertly [disguised in food or drink] staff had sought the advice of the GP, relatives and asked the pharmacist to authorise the use of covert medicines to ensure this was safe, and a liquid alternative was not available.

People told us that staff assisted them with their personal care using appropriate personal protective equipment. We observed throughout that staff used aprons and gloves when assisting people. The home was bright, clean and presentable. People told us they lived in a clean environment. One person said, "It's not one of those places that smells, I think the cleaners do an exemplary job."

Good

Is the service effective?

Our findings

People's needs and choices were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Comprehensive assessments and pre-admission assessments were carried out, which included any surgical history. The person's needs were identified with their input and a person-centred care plan created, which was reviewed and updated regularly. Care plans included details of personal care, pressure care and other health related needs, along with equipment required to help a person communicate (for example glasses and hearing aids).

People told us staff competently supported them with their care and support needs. One person told us, "Staff seem very skilled."

Staff confirmed they completed an induction programme, during which they received training relevant to their roles, and had their competencies observed and assessed in the work place. They received regular training and updates in a range of subjects such as moving and handling, safeguarding, medicines management and infection control. One staff member said, "I had a three-day induction, I felt it was very informative. I have completed my care certificate training." The care certificate is a nationally recognised training programme. It supports staff to develop and demonstrate key skills, knowledge, values and behaviours that enable them to provide people with safe, effective, compassionate care.

Staff told us they received regular supervision with their line manager. They were able to discuss matters relating to their work performance, or concerns they had. They were also able to discuss any personal issues that affected them. Staff felt supported and told us they could always find a member of management who would support them. One staff member said, "They always ask if I want to do extra training or develop a bit higher. I would probably want more training on things like mental health because it's nice to know more things about it and they will sort that for me." The registered manager told us this training was being planned to be delivered in the coming months.

Staff received the training they needed to help them do their jobs effectively. Staff told us they had opportunities for on-going training and the provider was developing their training program further. Staff said they had been booked onto specialist training courses to better enable them to support people's needs. The registered manager said, "There is ongoing partnership work with the local health authority where they provided additional training and support with things like continence care and wound care. The wound care was with the emergency care practitioner so under the instruction of 111 we can dress minor wounds until they can be seen by the GP or Nurse." The registered manager told us further development was planned to provide staff with additional training relevant to their role. For example in advanced mental capacity act training, to assist with the completion of assessments and mental health awareness.

We observed throughout the inspection staff obtaining people's verbal consent prior to assisting them. Staff explained how they wished to assist and waited for the person to respond. Where people declined and were not ready or did not wish to be helped, staff acknowledged this and returned later. Staff were aware of the importance of obtaining people's consent. One staff member said, "I will hold up different items of clothing

so that they can choose what they want to wear. I always assume people have [mental] capacity."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that for people who had a DoLS authorisation in place these ensured that the least restrictive methods were used when people were deprived of their liberty.

Staff had completed MCA and DoLs training that helped them understand issues around capacity and supporting people effectively with decision making. We saw that written consent had been obtained from people relating to the support they received. The registered manager was in the process of reviewing the consent arrangements for people who held legal authority to make decisions on people's behalf.

Peoples nutritional needs were supported. People were satisfied with the food provided to them. People's specific dietary needs were documented, and these needs were met. For example, where people required a soft or pureed diet following the advice of a dietician, or where people had an allergy. People's weights were regularly reviewed, and where people were at risk of weight loss, appropriate action and referral to the GP was taken. One person said, "Then food is very good, they offer a vegetarian option as well. If you don't like what's on the menu you can choose anything else and they will accommodate you. They usually come around the day before in the afternoon to ask what we would like for the following day, plenty of tea, coffee and squash to drink there is always a jug of two flavours in the lounges."

Visual prompts (either pictorial or plated up food) to prompt people with short term memory loss to make a meal choice were not available. This was considered to be good practise to help people make an informed choice about the meal they choose. They told us they would review this and follow best practise in relation to this area.

In each of the bungalows the dining tables were nicely laid with flowers and soft music playing. This helped make the meal time experience more enjoyable and a sociable experience. There was sufficient choice of drinks offered to people, and the usual condiments to accompany the meal were available. Where staff needed to assist people they did so sensitively, patiently and gave appropriate encouragement. Throughout the day we saw a range of fresh and healthy snacks provided to people. Where needed, people's meals were fortified to promote weight gain, and where people were at risk of weight loss the chef was proactive in providing additional high calorie foods.

People's health needs were met by a range of external health professionals. Care plans addressed people's health needs and records confirmed that people were supported as appropriate to make and attend health appointments. A range of health professionals visited to support people such as district nurses, chiropodists, speech and language therapists and dieticians.

Margaret House is a purpose built residential care home that is fully accessible. The design and layout of the home supports peoples' independence. However, the decoration of the home has not been sufficiently maintained and the building at this inspection required redecoration. The registered manager and provider assured us that there was a program of decoration planned. This was due to commence shortly that would address the issues found and also follow best practise in areas such as dementia care environments.

Good

Is the service caring?

Our findings

People told us that staff were caring and respectful to them. One person told us, "Their care and kindness settled me back nicely when I came out of hospital, it's their care that keeps us going." A second person said, "You can tell they [Staff] are naturally caring and kind people by the way they go about their job. You have to be a good person to do what they do, and they do it like its second nature to be kind."

Staff supported people's dignity and respected their privacy. One staff member said, "I always explain what we are doing and asking [people] what they want." We saw staff knocking on people's doors before entering to maintain the persons privacy. Staff had developed positive and caring relationships with people they supported and were knowledgeable about their individual needs and preferences. One staff member said, "I love working here I really do I love working with the residents." However, this was not always promoted by all staff. Comments made by two staff members suggested people were, "Liars and rude to staff, " or "Psychotic." These staff views were not shared by the majority of staff, and when reported to the registered manager appropriate disciplinary actions were taken. Although not said to people directly, this did not promote an inclusive and respectful attitude to people by all staff.

Staff knew people well and were familiar with their daily needs and routines. People appeared comfortable in the company of staff and interactions between staff and people were friendly and relaxed. Staff spent time with people and engage them in meaningful conversation and sharing jokes among themselves. One person said, "I do think they know me as an individual, when I arrive in this lounge area in the mornings a blackcurrant drink is ready for me, they know which chair I like to sit in, then by lunch time staff know I like orange squash with my meals. When I want a bath they go and warm the bathroom first for me, so it's nice and hot, they are very respectful, they cover me with towels, and dry me properly, they say to me we have dried between your toes [named person]. I can ask them for anything, they know me better than I know myself, let me just say this they are more caring towards me than proper nurses were when I was in the hospital."

People were able to express their views and make their own decisions about their care. One person said, "They wouldn't do anything in any way I didn't like, we have built up a rapport and understanding. That is through me talking and them [Staff] listening to how things are done. People were encouraged to remain independent. One person said, ""I can wash myself, but they help with a bath." A second person said, "I do the bits I can do, like washing my body but not my hair. Even the cleaning staff give me the space I need to have my own little tidy up. I don't feel like a burden to them [Staff] and that's because they want me to do things myself."

People told us they could meet their visitors in private and were supported by staff to maintain contact with their relatives. We observed numerous people's relatives visiting, who were free to choose whether they sat in communal areas or whether they met in privacy.

Confidentiality was well maintained throughout the service and information held about people's health, support needs and medical histories was kept secure. Information about advocacy services was made

available to people and their relatives should this be required. Advocacy supports people via an independent person to ensure their views and wishes are heard.

Good

Is the service responsive?

Our findings

People told us the care they received was focused on them and centred on their levels of independence, choices and how people wanted to live their own lives. One person said, "[Staff member] said to me at the beginning of the week, we need to have a little meeting. That's when they will review anything that needs changing. It could be the choice of food, or how I feel, or if I want something changing about my care. They do support me to keep my independence, they know I like to wash myself as best I can, they are on hand if I need them, and they always say don't hesitate to ask for help."

A second person said, "A couple of staff usually sit and chat with me, asking about my care, likes and dislikes. It's that kind of place where you can voice any opinion and it would be looked at, they promote you to be confident in saying anything."

Staff had a good knowledge of what was important to people which enabled them to provide care in a way that was appropriate and personalised to the person. Staff were able to tell us about people's personal history, individual preferences, interests and aspirations to help ensure people have as much choice and control as possible.

People said they were supported to follow their interests and take part in activities. Staff encouraged people to engage as part of a wider community, but would also support them individually when needed. One person said, "I haven't been here that long, but long enough to know it's a nice place, and you can ask for anything. The entertainment is good, you're never left out, they go around everybody and invite them and if you don't go, there is always someone [staff] you can talk to." A second person said, "I don't have any hobbies, and I am very happy with the entertainment, they always come and ask us to play bingo, or listen to music, and we go out on trips, we have a [Religious service] come as well."

An activity planner was displayed which had been developed from discussion with people at resident meetings. This meant people were able to provide ideas together for outings and what they would like to do. People could go for day trips to places such as garden centres, parks and shopping. Within the home we saw a range of activity was provided, which included quizzes and sensory activity to support people living with dementia. On the day of the inspection, a regular singer visited. The event was lively and exceptionally well attended by both people and staff. People sang along and clearly enjoyed the sociable and friendly environment provided.

People and their relatives were encouraged to visit anytime without restrictions. Relatives were seen to visit throughout the day and were warmly greeted by staff. It was clear from these interactions close relationships had been formed between staff and people's relatives. One person's relative told us, "I feel very comfortable in coming anytime, I never phone ahead I just turn up and am made to feel as if I am visiting my [Relative] in their own home."

People felt able to talk to staff if they had a concern or complaint. One person told us, "I am asked if everything is ok with me, I do feel confident in saying something if I need to." There was a complaints

procedure in place to manage any concerns or complaints which was made available to people. Records including the outcome of any concerns or complaints were recorded and monitored by the provider to ensure they were responded to promptly and to address any developing issues.

Requires Improvement

Is the service well-led?

Our findings

People's care records were not accurately maintained, or completed as required. For example, we found in some mental capacity assessments that these were simply copied and pasted from another person's, meaning a person's individual needs had not been considered. Power of attorney [POA] forms that gave peoples relatives legal right to make decisions on their behalf had not been verified. The registered manager was in the process of writing to people's families to verify the POA was valid, however this had not been completed at the time of the inspection.

Life histories had not been completed in some people's records. These had been given to people's relatives to complete, but then not followed up on. These had been identified as an area for improvement in a provider visit in August 2018 but remained outstanding. Where people displayed behaviours that challenged, staff recorded the incident, but did not ensure a behavioural chart or monitoring chart was documented to monitor the person after the incident. Again, this was identified as an area requiring improvement during a quality visit by the provider in August 2018? but remained outstanding.

Some care records we looked at lacked relevant details about people's health conditions and assessed risks. We also found some information was incorrect. For example, in one person's care plan it said this person forgets to use their hearing aid. However, it had been over a year since this person wanted to use them. It also asked staff to ensure [Persons] dentures were put in a pot to soak overnight, but this person did not have dentures. A second persons care record information as guidance for staff, was very basic. They moved to the home on a respite basis for six weeks as of the end of July 2018?. The care plan identified there were challenging behaviours but there was no action plan in place with guidance for staff on how to manage these behaviours. Staff were aware of people's care needs, however the records required further improvement to ensure they were reflective of people's current needs. This is an area that requires improvement to ensure all records relating to people's needs are updated, completed and an accurate depiction of their needs at that time.

The registered manager submitted to us a plan of the improvements they wanted to make from August 2017. In this plan they told us the building would be refurbished to include themed areas in the home, redecoration and specially developed relaxation areas. We found at this inspection that very little had been achieved in terms of developing and decorating the service.

The registered manager told us people's MCA assessments would be embedded as part of team meetings and learning. However, we found ongoing concerns with the quality of assessments completed. This increased the risk of people's views and opinions not being sought, and the legal requirements of the MCA 2005 not being followed.

Staff told us that they had regular meetings, and these were important to them to raise their concerns or hear about matters relating to the running of the home. One staff member said, "We have staff meetings monthly. If you can't attend, they leave the notes of the meeting in the signing on sheets for us to read." A second staff member said, "Meetings are useful to talk about changes in the home or if we need to talk

about particular residents". However, staff were not aware of some of the recent accolades or initiatives by the provider. For example, staff were being recognised at an awards ceremony for the care provided. The provider also operated an innovative 'silver wishes' scheme. This was designed to give people a unique experience just for them, such as attending a sporting event or flying. The scheme had been nominated for a dementia award, however staff were not aware of the scheme, or the values of the provider.

People, staff and relatives were positive about the registered manager, telling us they were visible, approachable and supportive. One person said, "I know the manager they are very friendly even with the families that visit. They are approachable, you can go and knock on the door and ask for anything. I couldn't think of anything to improve I am happy as I am." A second person said, "The manager and her deputy are hands on people, they lead from the front and are always on hand. They are proper managers who don't hide away."

People's feedback about the quality of care they received had been sought, in addition to the views of staff and health professionals. At the time of the inspection this information was being analysed, and the results would be shared with staff, people, relatives and visitors to the service. Where feedback suggested improvements were required, the registered manager told us they would form part of the overall improvement plan for the service.

The provider had systems in place to monitor the quality of care provided to people. The registered manager and senior staff carried out a range of weekly and monthly audits of the quality of care provided. These included areas such as infection control, health and safety, care records and food. Where improvements were identified these were recorded in a service improvement plan and then regularly reviewed. In addition to the visits by the providers quality team, the registered manager submitted key performance information to the provider for monitoring the quality of care, such as staffing and incidents and accidents.

Notifications that are required to be made to CQC of particular events had been made in a timely manner. Where necessary the registered manager had also referred incidents, accidents, safeguarding to the local authority and had positively supported any investigation in a timely manner.