North Yorkshire County Council

Prospect Mount Road

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 14 and 15 March 2017 and was unannounced. At our last inspection on 17 November 2015 we found a breach of Regulation 17 because there was not an effective quality assurance system in place. The registered provider had sent us an action plan in August 2016 and at this inspection we saw that improvements had been made. There was no longer a breach of regulation.

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Prospect Mount Road is in Scarborough and provides personal care and accommodation for up to 39 people. The service is divided into four units; the Homeward unit providing rehabilitation for up to six weeks before people return home or move to another service, Willow a dementia care unit, a respite unit that accommodates people whose carers require a break and a day unit. During the inspection only the respite unit and Willow were in use. Any people who were at the service for rehabilitation were accommodated in the respite unit and all the staff from the homeward unit had been redeployed to the respite unit. There were 13 people using the respite unit and eight people in Willow unit on the day of our inspection. The service is one of thirty services run by North Yorkshire County Council.

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

People felt safe at the service. Staff had been trained in safeguarding of adults and knew what to do if they had any concerns and how to report any incidents. We saw that one person had a safeguarding plan in place whilst an alleged incident was investigated and this was being followed by staff.

Assessments identified areas where people's health and safety may be at risk and these were acted upon. Medicines were managed safely. Accidents and incidents were managed appropriately by the service and reviewed regularly by the care services manager.

The premises were well maintained. Checks of services and equipment had been completed. The building had been adapted as far as possible to accommodate people's needs. Where people were living with dementia adaptations to the environment had been made to assist people in way finding.

Recruitment was robust with all relevant checks completed by the registered provider before people started work. Staff numbers were sufficient to meet the needs of people who used the service and staff had the skills and knowledge to meet people's needs.

Staff had been trained in areas which supported their role. Where further training was due it had been planned with dates booked. Staff were supported through supervision and annual appraisals.

People's communication needs were clearly identified in care records. Information was shared at regular

staff, resident and managers meetings.

The service was working within the principles of the Mental Capacity Act 2005.

People had a choice of what to eat and drink. Specific needs relating to nutrition were identified. Fluids were available to people throughout the day.

Staff were caring and compassionate and their approach was kind and friendly. They involved people in their care and gave them information and support where appropriate. People were treated with dignity.

Advocacy services were available if people needed them. One person had an independent mental capacity advocate supporting them.

Care plans reflected individuals needs clearly. They were reviewed regularly.

People took part in a variety of activities of their choice.

Complaints had been dealt with in line with the registered provider's policy and procedure.

Where necessary the registered manager had made notifications to CQC. They worked together with other agencies to promote people's health and wellbeing.

There was an effective quality assurance system in place which identified areas for improvement.

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 were trained in safeguarding adults and were proactive in reporting any concerns. We saw that one person had a safeguarding plan in place whilst an alleged incident was investigated and this was been followed by staff.

Recruitment processes were robust. There were sufficient staff on duty to meet people's needs.

Risks to people's health and safety had been identified and risk assessments carried out. Where risks were identified management plans were in place. People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff working at the service had the skills and knowledge required to care for people. They had been trained in subjects relevant to their role and were supported through supervision and appraisals.

People had access to healthcare services and a physiotherapist and occupational therapist visited regularly to provide rehabilitation support.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate. Feedback from people about the staff was positive.

People were treated with dignity and respect by staff described as 'friendly'.

People were encouraged to maintain their independence and

were involved in planning their care.

Is the service responsive?

Good

The service was responsive.

Initial assessments were used as the basis for developing care plans that reflected each person as an individual. They were reviewed regularly.

People took part in a variety of activities bot in and out of the service.

Complaints were managed according to the registered providers policy and procedure. People knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

There was a registered manager employed at the service. They were aware of their responsibilities around notifying CQC of incidents that affected the running of the service.

The quality assurance systems in place were effective in identifying areas for improvement.

Feedback had been sought and received from people who used the service and their relatives.

Prospect Mount Road

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 checked 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.

Although this inspection was scheduled it was carried out in part because we had received a notification of a safeguarding incident. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk for one person's safety. This inspection examined those risks.

This inspection took place on 14 and 15 February 2017 and was unannounced. The inspection was carried out by an adult social care inspector, a specialist advisor who had experience as a registered nurse and as a manager of services, particularly in the care of people living with dementia, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience of mental and physical health issues and physical disability.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all notifications and contacts we had received from or about the service. This information helped us to plan the inspection.

During the inspection we spoke with fourteen people who used the service. We used the short observational framework for inspection tool (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed practice throughout the inspection.

The registered manager and deputy manager made themselves available throughout the day to answer any questions we had and supply any documents we requested. We interviewed the deputy manager; four care workers, the independent living facilitator (ILF) who organised activities and we spoke with three domestic staff, the cook and the maintenance person. We were able to speak to a GP, district nurse and occupational

therapist who were visiting the service on the day of the inspection.

We reviewed the care plans, risk assessments and medicine records of three people in detail and looked at three other care plans. We observed medicines being administered on the respite unit and Willow unit. Members of the team ate with people in order to observe their experience at lunch time.

We inspected records relating to the running of the service. These included six staff recruitment and training files, the training matrix, maintenance and servicing documents and the quality assurance system.

Good

Is the service safe?

Our findings

Every person we spoke with told us that they felt safe. We spoke with a group of six people who all commented that they felt safe because of the environment they were in. Their comments included, "Staff are friendly and there is always someone around if you need help" and "I feel safe because the staff are friendly and concerned about me." Another person told us, "You get a good sense of security here; there is always someone to help you and people [staff] are always around." One person said, "No-one comes wandering in and I feel very safe." Our observations confirmed these views.

Staff had been trained to recognise the different kinds of abuse that may occur and knew what action to take if the suspected abuse or poor care had taken place. One member of staff said, "If I saw anything; physical, mental abuse, I would immediately report to the manager." Another member of staff speaking about Willow unit said, "On this unit I believe the residents are safe."

There was a safeguarding policy in place and practice guidance was available for the registered manager and staff to follow if they had any concerns or witnessed any abuse. We looked at whether or not this guidance had been followed in the case of the most recent safeguarding concern and saw that it had. The person had a safeguarding plan in place which was being followed by staff. This demonstrated that the staff were proactive in dealing with any safeguarding concerns. Safeguarding training was undertaken by all staff.

Recruitment processes at the service were robust to ensure prospective staff were suitable to work at the service. We checked five staff files and saw that all staff had been interviewed, provided proof of identity and had undertaken a Disclosure and Barring Service (DBS) check before being offered a role within the service. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

There were four care workers on the respite unit and two care workers on Willow unit. They were supported by the registered manager and the deputy manager. In addition there was an activity organiser, three domestic staff carrying out cleaning and laundry duties, a chef, two kitchen assistants and a maintenance person at the service when we carried out this inspection. Three staff worked across the service at night. When we looked at the rotas we saw that over the last month staffing had reflected the numbers and needs of people in the service and was safe. This was because people who would normally be admitted to the Homeward unit were now cared for on the respite unit. All of the staff from that unit had been moved to the respite unit and so the registered manager told us that there were no current issues with staffing.

People received their medicines safely. There were clear, detailed policies and procedures covering the different aspects of medicines management. If people wished they were able to self-medicate. We saw in one person's care plan a risk assessment had been completed to check the person's safety and practical ability to carry out such tasks as removing the lids of medicine bottles. The staff monitored people who were self-medicating. This was less often as they became more competent. People who chose to self-medicate signed a declaration to say they wished to be solely responsible for their medicines. One person told us, "We are encouraged to self-medicate. The trolley [medicine trolley] is locked as soon as staff have finished with

medication. That makes you feel safe and that staff care about what they are doing."

Medicines were stored securely. When medicines were being administered we saw that the member of staff locked the cabinet to prevent any unauthorised access. Medicines were administered by senior staff or managers. They had received training and they were monitored until they were competent.

Staff were encouraged to report medicine errors so lessons could be learnt and practices made safer. Incidents involving medicines were recorded and appropriate action was taken. If a member of staff had been involved in more than one medicine error they had to complete further training and complete competency checks to ensure people's safety.

Medicine administration records were completed with no gaps. The nature and purpose of each medication was explained to people. We noticed that this also applied to those with limited or variable capacity through explanations by staff so that they understood why their medicines were necessary.

Risks to people's health and safety were identified and acted upon. There was a fire risk assessment and personal evacuation plans (PEEPs) in place. One person told us, "They update our records on how we would get out if there was a fire; state whether we'd use a stick or need a chair so they know what to do." A second person said, "When they have an emergency staff know exactly what they are doing."

Checks of fire safety equipment had been completed and fire drills carried out. Servicing and maintenance of fire fighting equipment had been carried out. There were clear instructions displayed for staff to follow if they needed to call for emergency services.

Gas, electrical wiring, electrical equipment and water had been checked for safety and compliance with health and safety legislation. The environmental health officer had awarded the service a rating of five. This was the highest rating in relation to food safety.

People had risk assessments relating to their health in their care records. For example, we saw that one person was at risk of falls. This had been identified following a falls risk assessment. This was added to a general risk assessment for the person along with any actions undertaken.

Accidents and incidents had been recorded in people's care records. All incidents were collated and sent to the care services manager for analysis to identify trends and ways in which accidents could be prevented.

Good

Is the service effective?

Our findings

People who used the service felt they were supported by staff that had the skills and experience to carry out their roles effectively. A relative had provided recent feedback saying, "Staff work hard to present an informal and friendly environment yet at the same time they respond efficiently and professionally to issues which have troubled [name of relative]. One person who used the service said, "They really promote independence and get us ready to go home."

We observed a handover in the Willow unit and saw that each person was discussed in depth. Staff gave a short history and outlined their condition over past days and during the last shift. Current needs were identified and positive feedback about what the person had achieved during the shift. This demonstrated staffs knowledge of each person's specific needs.

Staff had completed training to ensure they could meet people's needs effectively. Training records provided evidence staff had undertaken training which included fire safety, safeguarding vulnerable adults, health and safety, infection prevention and control and The Mental Capacity Act (2005). We saw that the majority of staff had also completed a nationally recognised qualification in care. We saw that updates in manual handling had been planned for some staff whose training was out of date.

Most of the staff had received an induction but one member of staff told us that their induction period was very short. We discussed this with the registered manager who told us that they were aware of this. They explained that everyone now had an induction which allowed them time to get to know their role, the service, staff and people who used the service as well as completing any training they needed.

Staff were supported through supervision and appraisal. One member of staff said, "My supervision and appraisal happen regularly and are both up to date." We saw records showing that supervision had taken place. Appraisals were carried out annually and were due to be completed.

Records showed a range of healthcare professionals were involved in people's care and treatment which ensured they received the most effective support to meet their needs. We saw that advice and guidance was recorded in each person's care records and used to develop individual plans of care as required. A district nurse we spoke with said, "My patient is very well looked after" and an occupational therapist told us, "Staff are proactive. They will check things and then call when they have eliminated any everyday issues. We are very pleased with the way patients are cared for. Staff are supportive of the GP and the occupational therapist."

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 are called the Deprivation of Liberty Safeguards (DoLS). Where needed people had a DoLS authorisation in place. There were nine DoLS authorised at the time of the inspection. The service was working within the principles of the MCA.

Staff displayed a good understanding of the MCA and DOLS. They were conscientious in seeking consent from people and understood the need for best interest decision making. We heard staff throughout the inspection asking people what they wanted to eat, where they wanted to go, did they want staff to assist with personal care and other such questions to get people's permission before assisting anyone. One person told us, "I get to do what I want when I want; I can speak for myself and won't do things I don't like."

People's capacity to consent to care and treatment was assessed and recorded in the care plans. Best interest meetings were held when people lacked the capacity to make informed decisions themselves, which were attended by a range of healthcare professionals and people's relatives when possible.

People were supported to eat a varied and balanced diet of their choosing. There were menus displayed in the dining rooms and people were offered choices at each meal. The cook confirmed they were aware of people's dietary requirements such as special diets, textured food and any allergies which we saw were catered for.

We spent time observing the lunch time experience in both the respite unit and the Willow unit. In Willow unit large photographs of the meals were displayed so that people knew what they were eating. It was an enjoyable and inclusive experience for the people who used the service in both dining rooms where most people chose to eat. The tables were set with serviettes and condiments. We saw people engaging in conversation with each other, sharing jokes and stories with staff. We saw people were supported to eat their meals when required by staff who sat at the table with them. The support that people needed to eat and drink was clearly outlined in their care records with clear details of likes and dislikes. One person told us, "The food is very good" and another said, "Most of the time the food is good, it's never awful and sometimes very tasty."

Action had been taken to provide orientation for people living with dementia on Willow unit. Contrasting coloured bedroom doors assisted people in finding their rooms. Outside bedrooms there were photograph boards to further assist people with orientation. The décor was dated but clean. However, the ambience of the unit was therapeutic and calm. There were wide corridors for walking which were clear of obstacles. There were colour contrasting toilet seats to assist people with continence. Further changes to enhance the unit's dementia friendliness were planned but the service had made good progress.

The building was designed with some quiet areas in mind and there were areas where residents could sit away from others if they chose to. Floors in the respite unit were clear of obstacles and one person said, "The floors are much better now, no carpets to struggle over when you need a walking frame and the floors look cleaner as well." This was important because some people had walking practice with the physiotherapist.

One person said, "It's free and easy without being lax; it's not institutionalized, more like a family and when our families come we can do what we like and they feel ok when they leave us."

Residents meetings were held and one resident said, "We are encouraged to say whatever we like, we can also write things down that we want discussed."

Good

Is the service caring?

Our findings

Throughout the inspection we saw compassionate interventions and support being delivered by staff to people. Every person we spoke with considered the staff to be friendly and caring. One person told us, "The staff are lovely and very gentle. I would rather be home but it is nice enough here" and another said, "Staff do a good job here, willingly and happily." A relative said, "The staff are good and very caring." The occupational therapist commented that there were, "Very friendly staff" and that they were, "Very approachable."

We spent time observing how care and support was provided to people who used the service. Staff knew people well calling them by name. They took the time to sit with people and talk about their past experiences and family lives. We saw one member of staff sit with a person colouring pictures ready for Easter. This interaction had an uplifting effect on the person and enabled the member of staff to engage them in a meaningful conversation. We spoke with one person who was clean, neat and well dressed. Their nails were clean and manicured. Although they were sleepy they were communicative when awake. They smiled when staff interacted with them, responding to their name and enjoying staff making references to their personal history and achievements.

People were treated with dignity and respect by staff who had received training in relation to equality and diversity and delivering person centred care. One person told us, "The staff are always nice and kind, they listen to me." A relative sent an email on the day we inspected which said, "I need to add how impressed I was with the caring approach I witnessed to [relative] and others residents; small kindnesses tailored to each person, and the strong sense of respect for each person."

People's privacy was respected. A member of staff we spoke with said, "I treat people as I would like to be treated. I close doors and curtains if I am helping them with personal care."

People were encouraged to maintain their independence. A member of staff told us, "I try and make sure people do as much as they can for themselves. Some people can wash themselves and choose what they want to wear. I will ask if they need help." People's ability to self-medicate was assessed to ensure they could maintain their independence in this area if they chose to.

The people we spoke with were not all aware of advocacy services but they had family to support them apart from one person who had a relevant person's representative(RPR). An RPR is appointed when a person, known as the relevant person is deprived of their liberty. They are an independent person whose role is to maintain contact with the relevant person and to represent and support them in all matters relating to their DoLS. This person had an independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live. This demonstrated that when necessary people were provided with the necessary safeguards to ensure their human rights were protected.

People were involved in planning their care when they were able. Several people told us that when they had

arrived at the service they were too ill to be involved with their care plans. Others had been involved in planning their care. One person said, "I was very involved with my care plan and they update them. They even note down what I can do this fortnight that I could not do two weeks ago."

Good

Is the service responsive?

Our findings

People who used the service confirmed they received personalised care that was responsive to their needs. One relative had recently provided feedback which said, "[Name of person] attends regularly and he gets most excellent care. The whole ambience of Willow unit is so good" and one person who used the service said, "I have trouble walking but the staff try to make it easier for me so as I can go home. They are very good."

We saw that people used the service for respite, rehabilitation, day care and some people lived in Willow unit. Before people were admitted to the service their needs had been assessed by a care co-ordinator and shared with the registered manager. This ensured people's needs could be met before they were offered a place within the service.

The information gathered during the initial assessment was then used to develop a number of individualised care plans. Care plans were very detailed and reflected people's needs. They were holistic and reflective of the person. We saw that they had been reviewed. For example, we saw at one person's review they had identified that they would like to self-medicate and this was discussed with them. In another case the registered manager had written to the local hospital for an explanation of the results of a medical investigation which had been sent to a person.

People told us they were involved in their care. They said that their independence was promoted and work done to get them back home. We saw that people who were at the service for rehabilitation had regular visits from occupational therapists and physiotherapists in order to ensure they were safe to return home. On the day of the inspection an occupational therapist and a GP visited one person. They told us that they were very happy with the way in which patients were cared for.

Reviews of people's care and support were undertaken regularly. We saw that the daily notes were thorough and reflected any changes to people's care. Records of visits by healthcare professionals were also kept. A district nurse visited a person on the respite unit. They had been working with them to be able to give their medicine safely. They told us, "Staff follow my instructions and my patient is very well looked after. They [staff] have got them [person] into a good routine [with their medicine]."

We saw that people's care and support needs were evaluated on a monthly basis as were accidents, incidents and any safeguarding issues. We cross referenced these records with people's care records to check they corresponded and found that any incidents had been clearly recorded. This provided assurance that staff were aware of people's needs as they changed and developed.

People who used the service were encouraged to follow their choice of interests and take part in activities inside and outside of the service. We saw photographs were displayed showing people enjoying activities. The service employed one activities co-ordinator. They organised all the activities, took people on public transport to appointments to encourage their rehabilitation and organised special events such as the Christmas fair. They went with another member of staff from the day centre to take people to singing for the

brain. They had a plan for activities on each day and when they were unavailable it was expected that staff would lead these activities. We discussed the role of the activities organiser with the registered manager who told us that they would like to develop this further.

A group of people we spoke with said, "Christmas was brilliant" and they said, "We coloured things and made lots of things for Christmas. We are now doing things for Easter. We can play scrabble and [name of staff] does quizzes and picks up on what everyone likes. [Name of staff] listens to us and brings things in that he thinks we'd like." One person said, "We do chair exercises with [name of staff]; she is good and knows what she is doing. It motivates us and we do feel better after the exercises."

In Willow unit we saw a member of staff supporting one person to make a cake for lunch. Another member of staff led a group discussion. We saw that the activities included table top games, regular outings to singing for the brain group at a local church, regular attendance at a social group at the YMCA and an outing had been planned for the following week to the Sea life centre. There was a secure garden and patio area that people could access directly from Willow unit. One person smiled when staff interacted with them, responding to their name. Staff conversations with them included references to their personal history and achievements. This demonstrated that staff were using the life journey document that had been completed for this person to make interactions meaningful.

Complaints were managed according to the registered providers policy and procedure. The registered provider had a complaints policy which was displayed at in the main entrance of the building to ensure it was accessible to the people who used the service and visitors. There had been one complaint since the registered manager started working at the service which had been resolved within timescales outlined in the complaints procedure. One complaint had been received by CQC from a relative relating to communication by the service. We looked at this person's records during the inspection to see if there had been any communication with the family following a recent event. We could see that another family member was noted as first point of contact and they had been notified of the event.

People we spoke with told us they knew how to raise concerns and would not hesitate to complain if the need arose. One person said, "If I have any concerns the manager comes to see me and sorts it out" and another said, "On balance I can't complain." One relative did raise concerns with us, but these were about the processes around accessing health and social care services and not about this particular service. Everyone felt that staff listened to them and that any concerns would be dealt with properly.

Good

Is the service well-led?

Our findings

Prospect Mount Road is one of thirty services run by North Yorkshire County Council. The provider has a history of compliance in the majority of its services. The service had a registered manager in post which met legal requirements. They were managed by a care services manager who oversaw a number of services in the area. They carried out visits to the service and provided one to one support for the registered manager. The registered manager was supported by a deputy manager and senior support workers within the service.

At our last inspection on 17 November 2015 we had found that the quality assurance system was not effective. At this inspection we saw that improvements had been made.

There was an effective quality assurance system in place. The registered provider's quality assurance system consisted of audits, checks, questionnaires and visits by the care services manager. Records showed that checks of the environment had been completed regularly by the registered manager and any areas for improvement identified. These were added to a master action plan and required actions identified. For example, one carpet had been identified as needing replacement. We saw that a request had been made for a replacement. Other audits had been completed which included medicines, mattress and infection control, with actions identified.

People's views were captured through satisfaction surveys and we saw that comments were positive. One relative had raised issues about communication by the registered manager with CQC. We saw that the registered manager had communicated with one member of a family but other siblings had not been informed about an incident. We saw that this had now been resolved and each sibling had been informed by email about the progress of this matter. The registered manager had not made changes to the way they communicated with the family initially but this had now been addressed.

There was a maintenance person employed at the service to carry out checks relating to safety such as fire alarm checks and visual checks of wheelchairs. For more complex work external contractors were employed. We saw that gas and electrical safety had been checked. Servicing of equipment had been carried out by external providers. This included servicing of fire safety equipment, lifts and hoists.

The registered manager and the deputy manager had been employed within the last twelve months and this had given the service some stability after a period of management changes. Improvements to the service were evident although the registered manager and deputy manager were clear there was more to be done. We observed a good working relationship between the registered manager and the deputy manager which was mutually supportive. The deputy manager told us, "The culture here is one of working together with open and approachable management and caring staff."

People who used the service told us that the registered manager had, "Certainly changed things for the better." We saw recent feedback from one person who had said, "Everything is well run." A relative who had previously visited the unit said, "My [relative] was in here a year ago and we now have a new manager and everything has improved." Several staff told us that they found the registered manager supported them.

However, one member of staff felt that the registered manager was not supportive of them. One member of staff told us, "The best thing about working here are the approachable staff and managers" and another said, "The registered manager is visible and shares information. [Name of registered manager] has inspired change and thought of things that I wouldn't have." A third member of staff said, "I find [Name], the manager is not supportive." However, after reviewing all comments and our observations of the changes at the service overall we considered the service was well led.

The registered manager was aware of their responsibilities to report accidents, incidents and other notifiable events that occurred within the service. We reviewed records within the service and found that the CQC had been made aware of specific events as required. The registered manager had worked in partnership with the local authority, police and an independent mental capacity advocate in relation to a recent safeguarding event which was currently being investigated.

The registered provider held managers meetings which the registered manager attended in order to share good practice and receive updates. The registered manager told us, "We share things we have learned and learn from each other to improve the way we work." This provided assurance that the registered provider influenced the day to day management of the service using good practice.

We saw that resident meetings had recently restarted on a monthly basis where topics such as daily meal choices, activities and events were discussed. Staff meetings were currently held every two months. Staff were asked to sign to say they had read the minutes which meant that if people were unable to attend they were still able to access the information and discussions.

Staff were encouraged to involve people in community events. The independent living facilitator organised charity events to benefit local charities that people who used the service and their relatives supported and attended. This had recently included Remembrance Sunday and the poppy appeal and a local hospice. Along with a member of staff from the day centre people who wanted to attend were taken to an Alzheimer's society event and a local social club. To aid their rehabilitation people were taken out using local transport and amenities.