Sisters of the Cross and Passion

Cross and Passion Convent

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 18 May 2016 and was unannounced.

The service was last inspected 29 October 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

The service was formerly known as Sisters of the Cross and Passion. In July 2015 the provider requested to cancel their registration with the Care Quality Commission (CQC) in error. This was because they believed the service no longer met the requirements to be registered. However, as some people receive public funding the service does fall within the scope of registration. The provider was re-registered in September 2015 and the service was renamed Cross and Passion Convent.

Cross and Passion Convent offers nursing care for up to sixteen people. All the people belong to the same religious order. The home is situated overlooking Lytham Green and close to community facilities. Communal accommodation is spacious and individual bedrooms are provided with an adapted en-suite facility. The residential and nursing unit is purpose built and based on the ground floor of the building. There is a chapel on the ground floor and an outer building used for activities and a craft centre. There is a passenger lift and staircase providing access to the upper floors where people who do not receive personal care live. There are two cottages adjacent to the forecourt used to accommodate visitors and relatives who wish to stay overnight. Comfortable communal areas, such as lounges and a dining room are available. A limited number of car parking spaces are available to the front and back of the building on a private forecourt, but on road parking is also permitted however this is limited.

The registered manager was present throughout our inspection. 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 and associated regulations about how the service is run.

At the time of this inspection there were eleven people who lived at Cross and Passion Convent. People told us that they felt safe, blessed and content living at the home.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found that staff had received training in safeguarding adults and demonstrated a good understanding about what abuse meant.
The provider had recorded accidents and incidents and documented the support people were getting after experiencing falls. We found evidence staff had sought advice from health professionals. We have made a recommendation about improving analysis of incidents.

We found people's medication had been managed safely. People had care plans for 'as and when' medication (PRN). Staff had received appropriate medication training and had been competence tested to

ensure they were administering the medication as recommended.

There was a building fire risk assessment on the premises and emergency plans were in place in case people needed to be evacuated from the premises urgently. People had personal emergency evacuation plans (PEEPS) to enable safe evacuation in case of emergency.

We found there were effective infection control measures in place and high standards of hygiene had been maintained throughout the premises.

Staff had been safely recruited and there were enough staff to ensure that people's needs were met. There was scope within the staffing levels to keep checks on people's welfare and, where necessary, to provide extra care and support using bank staff or agency staff.

We found care planning was done in line with Mental Capacity Act 2005. Some staff showed awareness of the Mental Capacity Act 2005 and how to support people who lacked capacity to make particular decisions. However we found the knowledge of Mental Capacity among staff needed some improvement. We made a recommendation about this.
Appropriate applications for Deprivation of Liberty Safeguards had been made and authorised.

People using the service had access to healthcare professionals as required to meet their needs.

Consent was sought from people however we recommended the registered manager to ensure their paperwork clearly showing this. Best interest decisions were considered where care provision included restrictive practice and where people lacked the ability to make their own decisions. People were involved people in decisions made around the care they received. Care plans demonstrated people's involvement. People and their relatives told us they were consulted about their care.
We made a recommendation about this.

The service demonstrated how they sought people's opinions on the quality of care and service being provided. People informed us they were asked about their opinions.

We found evidence of robust management systems in the home. There were quality assurance systems in place. These were used to identify areas that needed improvement. We found audits had been undertaken for areas such as medication, care plans, kitchen and the premises.

People felt they received a good service and spoke highly of their staff and the registered manager. They told us the staff were kind, caring and respectful.
Staff were provided with effective support, supervision, appraisal and training. Staff were positive and we observed a positive culture within the staff team.

We found the service had a policy on how people could raise complaints about care and treatment and complaints had been made aware of how to complain.

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.

People we spoke with said they felt safe using the service and records showed that people's care needs and risks had been carefully considered during care assessments and care planning.

Staff were aware of safeguarding policies and procedures.

There were enough staffing levels to meet the needs of people who lived at the service and robust systems were in place for recruitment of staff. People had personal emergency evacuation plans to facilitate safe evacuation in cases of emergency. Fire risk assessment had been undertaken and emergency planning had been done.

People's medicines were safely managed and infection control measures were effectively implemented.

Is the service effective?

Good

The service was effective.

Mental Capacity was considered before care was provided. Staff knowledge of the Mental Capacity Act 2005 needed further development. Consent was sought before care provision and best interest decisions were carried out for those who could not make decisions independently.

There were effective systems in place to ensure that people received nutrition and hydration appropriate to their needs.

Staff had received training in various areas of care and had received supervision and appraisal regularly.

Is the service caring?

Good

This service was caring

People were treated with care and compassion. There was positive engagement between staff and people who lived at the service. The standard of personal care people received was good.

The systems and procedures operated at the home were designed to enable people to live their lives in the way they chose, so they could be as independent as possible. People's dignity and respect were promoted.

People were cared for in a compassionate manner towards the end of their life.

Is the service responsive?

Good

The service was responsive.

Care planning was person centred. People's care plans were well detailed and provided their social background, likes and dislikes as well as their journeys through life.

There were a variety of meaningful daytime activities and people's independence was promoted. Social Inclusion was widely promoted. People's religious needs were met and where possible innovations and technology was used to ensure spiritual needs were met.

Complaints procedures were in place and people were aware of how to raise concerns. We saw examples of how a complaint had been dealt with.

Transition between services was adequately facilitated and Care plans were amended accurately to show people's changing needs. People were referred to Specialist professionals where necessary.

Is the service well-led?

Good

The service was well-led.

There was a positive staff culture. We found the management structure had in depth awareness of people's needs and evidence of management oversight. Staff felt supported by management.

Staff complimented the changes that the registered manager had brought and how they had improved the service.

Staff and residents' meetings were taking place and actions had been taken on suggestions made by both residents and staff.

There were formal audits and monitoring systems in place. Areas for improvement had been identified and acted on. Policies had been updated to reflect current practice and policy guidance.

The service was sending statutory notifications to CQC.	

Cross and Passion Convent

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 18 May 2016, and was unannounced.

The inspection team consisted of two adult social care inspectors including the lead inspector for the service. Before the inspection, we reviewed information from our own systems, which included notifications from the provider and safeguarding alerts from the local authority.

We gained feedback from external health and social care professionals who visited the home. We had received safeguarding alerts from Lancashire County Council Safeguarding Enquiries Team and regular updates from other associated professionals at the local authority. Comments about this service are included throughout the report.

Before the inspection, the 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 spent time talking with people who lived at the home. We reviewed records and management systems and also undertook observations of care delivery. We spoke with four relatives, seven people who used service, the registered manager, deputy manager, catering manager, handyman, four professionals who had visited the service and four care staff. We looked at five people's care records, staff duty rosters, five recruitment files, the accident and incident reports book, handover sheets, records of residents' and staff meetings, medication audits, service policies, medication records and service maintenance records.

Good

Is the service safe?

Our findings

We asked people who lived at the home whether they felt safe. People told us they felt safe living at the home. One person told us, "We are blessed here." Another person told us, "We are in safe hands and feel safe with the staff that we have here." Another person told us, "We cannot ask for more, we are safe here."

We spoke to relatives and they told us, "It's a family; they look after their own well."

We spoke to professionals who told us, "They provide high quality care and have excellent standards it's always a pleasure to work with the staff." Another professional told us, "It's an appropriate environment very calm."

We found risks to people were sufficiently managed to avoid harm. Risk assessments had been undertaken in keys areas of people's care such as nutrition, skin integrity, moving handling as well as behaviours that could pose a risk to self and others. We saw evidence of how the risk assessments had been followed to ensure that risks were minimised. For example, we found one person's records showed they had been assessed as being at high risk of skin damage. There was clear documentation which instructed staff what measures to take and which parts of this person's body were more vulnerable and what aids to give them to minimise the risk of skin breakdown.

People's medicines were managed and medication administration was safe and robust. People had received their medication as prescribed. Staff had been trained to administer medication safely and had been regularly observed and their competence tested. There was clear documentation about people's allergies. People who had been prescribed 'as and when required medication' (PRN) had plans to guide staff. The plans provided staff with adequate guidance on, what this medication was for, when to offer the medication and where people could not say they were in pain there was guidance for signs to look for. Medication audits had been undertaken on a regular basis and issues and concerns were highlighted and actions taken to ensure the issues were resolved.

Risks around the premises were managed and the premises had been well maintained. We found building and fire risk assessments had been undertaken and provided sufficient information to guide staff on how to react in the event of fire. We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested regularly and fire evacuation drills were also undertaken periodically to ensure staff and people were familiar with what to do in the event of a fire.

People had personal emergency evacuation plans (PEEPS) in place for staff to follow should there be an emergency. There were detailed emergency planning and emergency supplies to keep people warm and safe had been stocked in the emergency shelter. This meant people could be assured they could be evacuated in a safe and timely manner during an emergency.

Risks from infections had been managed and risk assessments were in place. For example the service had established a separate laundry room for contaminated items. We also found the service had employed an

independent contractor to manage the environment including cleaning and safety maintenance and catering.

Staff knew how to keep people safe and how to recognise safeguarding concerns. They had a clear understanding of the process or procedure to raise any safeguarding concerns for people. We found staff had received training in safeguarding adults and demonstrated a good understanding about what abuse meant. They told us they would report incidents of abuse if they suspected or witnessed it. This meant people could be assured that staff would raise safeguarding concerns if they noticed someone being ill-treated.

We saw evidence of actions that had been taken when staff had been alleged to provide unsafe care. Investigations had been undertaken and where necessary staff had been provided with support in line with the organisation's own policies.

We looked at how accidents, falls and near misses were managed. We found processes for reporting or recording accidents or incidents had been put in place and staff had recorded the support they provided people after the incidents. Accidents and incidents were recorded and staff sought advice from health professionals to ensure people had appropriate after care. Records we saw showed observations had been carried out after unwitnessed falls. This meant people could be monitored for signs injuries that may not seem obvious at the time of the fall.

We found no evidence of accident and incident analysis. The registered manager had recorded fall accidents and incidents and looked at the causes and actions to reduce the risks. However they had not analysed the records to identify patterns.

We recommended the registered manager to consider best practice around management of accidents and incidents.

We looked at whether the service had sufficient staff to meet people's needs. On the day of the inspection there were sufficient numbers of staff. We asked people about staffing levels and people told us there were sufficient numbers of staff at all times. We asked staff if they felt the home was staffed sufficiently enough to meet the needs of people they cared for. Staff told us the service was well staffed and there were no staffing issues. We found staff at the home had been employed for a long time and turnover was low. Professionals who visit the home informed us they always felt there was more than enough staff.

We found the service followed safe recruitment practices. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider followed safe recruitment procedures that helped to protect vulnerable adults.

Good

Is the service effective?

Our findings

We asked people who lived at the service if they felt staff were competent and suitably trained to meet their needs. One person told us, "We are blessed with this set of staff." and "From the care staff to the matron [registered manager] they are all great to us."

We asked a visiting professional for feedback. They told us, "Staff know residents very well." Another professional told us, "My experience of visiting patients at The Cross and Passion, have always been a positive experience."

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 make 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 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. We found the service was working in line with the key principles of the MCA.

We found evidence of mental capacity assessments carried out for key decisions such as receiving personal care and medication administration. We found evidence of best interest decision making that had been documented for people who had been assessed as lacking mental capacity. Evidence we saw demonstrated people's relatives had been consulted and advance decisions had also been considered.

We recommend the registered manager to refer to current guidance on documenting best interest decisions as some files had not been sufficiently completed to provide adequate information.

We saw evidence that people whose care involved restrictive practice and people who were not free to leave the home had been referred to Lancashire County Council. This ensured care staff were authorised to provide care lawfully with deprivation of liberties authorisations as required by the law. This meant that the provider had took necessary steps to ensure that peoples' right had been protected. We found evidence of mental capacity assessments and consent in relation to the use of restrictive aids such as bedrails.

We looked at training records and found care staff had not completed training to help them understand the principles of the Mental Capacity Act 2005. Some staff however showed awareness of mental capacity and Deprivation of Liberties legislation and requirements as they had trained in their previous roles. We spoke to the registered manager who informed us staff had received introductory training as part of the Care Certificate and that they would consider arranging training for all staff. They advised they would be making arrangements for this. Regardless of lack of training in MCA we found people's care was delivered in line with

the legislation.

We recommended the provider to consider best practice staff development around MCA.

Staff had received supervision and appraisal regularly and in line with the organisation's policy. Staff meetings had been undertaken regularly and staff told us they found these helpful in understanding service developments. Training had been undertaken for key areas of the service, for example moving and handling, safeguarding, managing nutrition, fire safety and first aid training. Staff we spoke with showed awareness of people's needs and how to respond. Staff's knowledge of people's needs was detailed.

We looked at how people's nutrition was managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. We found snacks and drinks were readily available throughout the home and people were helping themselves. The service had provided a side kitchen with some hot drink making facilities to ensure people could help themselves with drinks, soups and snacks. This this also supported people to maintain their independence.

People who required special diet such as diabetic were offered choice. There were three regular choices of meals. We spoke to the chef who had worked at the service for a long time. They informed us they had a dietician who oversaw all their menus to ensure the food they served was meeting recommended nutritional needs. We observed people eating during lunch time. We saw people were offered choice and encouraged to eat. Menus were available for people the day before and offered choices. The atmosphere during lunchtime was relaxed and people seemed to enjoy their meals. People's views on meals were positive. One person told us, "The food is plenty, we get more of it." On special occasion people had what they referred to as 'feasts' where special meals were cooked to celebrate events, a separate budget had been provided for this.

We found evidence surveys were completed for people to have a say about the food and menu. There were changes of menus in line with seasons. We saw people had contributed to the menus.

We looked at how people were supported to maintain good health, access health care services and received on going health care support. We found the service had measures in place to ensure people were referred to specialist professionals. We saw evidence of referrals to dieticians, and people's doctors. We found referrals had been done in a timely manner to ensure people received suitable care. There were links with the local primary health services and professionals such as practice nurses came into the service to offer support regularly.

Good

Is the service caring?

Our findings

We asked people if the staff team were caring. People told us, "I'm blessed; we are blessed with a good set of staff." Another person told us "People here go out of their way to help you." A relative told us, "They look after their own very well." Feedback from people who lived at the home, their families and professionals was overwhelmingly positive.

During the inspection, we observed some warm and genuine interactions between people and staff. Conversations showed kindness and compassion. We heard warm and meaningful conversations taking place between people and staff. People appeared to be very comfortable with staff and staff knew people well. We observed members of staff working, providing consistent care and support to people. We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance promptly. People were referred to by their preferred religious titles. All people were referred to as 'Sisters' in line with their religious beliefs.

We spoke to professionals who visit the home and they informed us they felt staff were caring and they witnessed warm relationships between care staff and people when they visited.

We looked at how the service supported people to express their views and how people were actively involved in decisions about their care treatment and support. We saw people had been actively involved in planning their care. Where people had not been able to express themselves efforts had been made to use other members of the religious order who had known the person for a long time to advocate for them. Care plans, minutes of meetings, and people's daily records showed people had been actively involved and consulted about their care and treatment.

Some people had made advance decisions on how they wanted to be cared for, these wishes had been respected. We spoke to a relative who told us they were kept informed of what was happening with their loved one. Relatives had been involved in their care planning and reviewing for those who lacked capacity.

We looked at how people's privacy and dignity was respected and promoted. People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. Plans of care we saw outlined the importance of respecting people's privacy and dignity and promoting their independence. A staff member we spoke with told us how they would respect people's dignity.

We spoke to relatives and they told us, "They are very respectful and people's dignity is respected." Another person said, "It's a family here." People were given choice whether they were willing to receive care from male care staff. They said, "Our residents are our family" and "We knock on doors and we do not talk about other residents with others."

The registered manager informed us, they ensured they visited people when they are admitted into hospital

and they would accompany them in the car to attend hospital appointments.

People who were towards the end of their life had been cared for in a dignified manner. Staff and people told us they ensured someone stayed with people at all times if they are were reaching the end of life. Any advance decisions that people had made had been respected. People who were bed bound had received regular visits from other members of the religious order who were not receiving care to ensure that they were not isolated in their bedrooms.

We looked at people's bedrooms and found they were clean, warm, well presented and people had personalised their bedrooms with their own possessions.

Good

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to. One person told us, "They listen and respond I have made suggestions about food and they changed it, they try their best." Another person told us, "Its great here, I do my own thing." Another person told us, "We get involved in the community here; we are out and about whenever we want."

We spoke to a professional who visited the home and they told us, "Whenever I visited the staff were very helpful and more than happy to discuss the patient's. progress."

We looked at how the service provided person centred care. We found assessments had been undertaken before people were admitted to the home to ensure the service was the right place for them. A person centred care plan had then been developed outlining how these needs were to be met. We saw evidence of person centred care by the way staff were interacting with people during our inspection. People were treated as individuals.

The care staff and the registered manager had a clear knowledge of each person's needs. We looked at care plan reviews and found these had been completed regularly and showed changes in people's needs. We looked at care records of four people. The care records were informative and enabled us to identify how staff supported people with their daily routines and personal care needs. Care plans were regularly reviewed for their effectiveness and changed in recognition of the changing needs of the person. The registered manager had audited the care plans and discussed areas that required improvement with staff involved.

Personal care tasks had been recorded along with fluid and nutritional intake where required. We looked at the plans of care to see if they were written in a person centred way. The care records included detailed information on what support people needed their likes and dislikes and what worked for them. There was detailed information on what care staff should try before they gave people medication and the likely side effects of the medication.

We found people's care plans contained important information they needed if they were being transferred to hospital or other services. These are also known as hospital passports. This meant people were assured they could be effectively supported if they were to be transferred to another service or hospital.

We found examples of spiritual care planning which had been adopted specifically for people due to their religious background. These plans were very specific in terms of how people's spiritual needs were to be continued to be met. The planning was very person centred. Where people had been identified as unable to take part in religious activities, all efforts had been made to ensure that the other members of the religious order in the home could meet spiritual needs of these people.

People's social backgrounds and their life history had been clearly documented to provide a clear history of their personal background, person and professional achievements. Staff encouraged people to share their history and talk about their achievements.

We looked at how people were assured they would receive consistent coordinated, person centred care when they used, or moved between different services. We found evidence of information that had been completed to facilitate information sharing when people moved between services. These are sometimes referred to as Hospital Passports.

We looked at how people were supported to maintain local connections and take part in social activities. People were actively encouraged and supported to maintain local community links. For example some people visited local schools to provide support around religious teaching and speak to young people about their life. There was active involvement with the local church and local hospitals. The registered manager informed us people had been involved in knitting blankets for a charity for newborn babies and homeless charities. This ensured that people continued to make a positive contribution to the local community and society at large.

The service had established a craft centre in an outer building. This was used as an activity room where people could go and do activities such as card making, knitting and also have their hair and nails done. There were two designated activities coordinators within the home. On the day of inspection we observed people undertaking physical exercises. People told us they enjoyed this as it kept them active and fit. Activities we observed were well suited to people and allowed all people to participate regardless of their abilities. One person told us, "We have a choice whether to join activities or not."

Due to the strong religious background of people living in the home, we wanted to know how people's religious needs continue to be met. We found people attended mass on a daily basis. However due to the difficulties in finding priests who could deliver the mass daily the home had found an innovative way of ensuring people continue to have masses. We found people could tune in to live masses that were streamed on the internet. These were delivered through a big television screen. People could choose masses in different countries of their choice. We also found people had hand held computers that they could use if they wanted to access different services from countries of their choice.

The service had a complaints procedure which was made available to people. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and the Care Quality Commission (CQC) had been provided should people wish to refer their concerns to those organisations. We saw evidence of how a complaint had been dealt with and we were assured people's complaints were dealt.

Good

Is the service well-led?

Our findings

People we spoke with spoke highly of the management. They told us: "The matron [registered manager] is excellent; we are blessed to have her." Another person said, "She had brought some significant improvement in the home."

There was a positive staff culture within the home. This was reported by all the staff members that we spoke with. Staff told us: "I enjoy working here." And: "We have a good atmosphere and staff team are friendly." Staff spoke highly of the organisation. They told us: "We are not short of anything here, any equipment we need we get." And: "I love it here, I wish I had come sooner."

Staff told us that they felt well supported by management. They said: "Management support is really good, they listen and act", And: "Management are approachable and very understanding." Staff team and people who lived at the home spoke highly of the changes that were brought by the registered manager. Staff felt that the changes had brought the care home 'into the twenty first century'.

We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager and her deputy were experienced and had an extensive nursing background. They were experienced, knowledgeable and familiar with the needs of the people they supported. The care staff had been delegated individual responsibilities such as Safeguarding Champions, activities and moving and handling leads. Each person took responsibility of their role and had been provided oversight by the registered manager.

People were involved in decisions made about the general running of the home. We looked at various documents including meetings that people had with the catering manager to discuss changes in the menu. Evidence showed these meetings were regular. We spoke to people who lived at the home and they told us they talked to the matron and the catering manager whenever they had suggestions and they felt listened to. This meant the service had demonstrated that people's voices were heard and their opinions used to shape how their care was delivered.

There were up to date policies and procedures relating to the running of the service. These had been reviewed annually. Staff had access to up to date information and guidance procedures were based on best practice and in line with current legislation. Staff were made aware of the policies at the time of their induction and when new changes came into place. When errors and incidents occurred staff were clearly informed which part of the organisation's own policy they had not followed, how this related to health and social care legislation (government regulations) and how this related to their professional registration code of conduct and people's welfare and rights. This ensured that staff had adequate guidance on the impact of their actions.

We found the registered manager was familiar with people who used the service and their needs. When we discussed people's needs the manager showed good knowledge about the people in her care. For example, the registered manager was able to identify people with very complex needs and the risks associated to

these individuals. This showed the registered manager took time to understand people as individuals and ensured their needs were met in a person centred way.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was robust. We found the handover system used in the home was effective, informative and kept staff informed of people's daily needs and any changes. Information was clearly documented on the handover sheets. Staff had been kept informed in a variety of ways including staff meetings and supervision. We found the registered manager had set different meetings for night staff to ensure that she could meet with them and share information and developments.

We found there were quality assurance systems in place. The registered manager carried out audits to monitor the quality of the service. Environmental audits had been carried out by a contractor who dealt with catering, cleaning and health and safety issues. Medication audits care record audits and accident and incidents had been undertaken. An audit of care records was completed monthly.

Reviews were carried out and signed off by the registered manager. We however asked the registered manager to consider having regular audits of her own work to ensure robust oversight. The service had a business improvement plan. Feedback and suggestions from people were considered for example in organising activities and outings as well as changes in menus. We saw people were informed of what actions were being undertaken following their feedback.

We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as 'Investors in People' and local commissioning groups, pharmacies, local schools, charities and local doctors. We found the registered manager receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

We checked to see if the provider was meeting CQC registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had fulfilled their regulatory responsibilities and submitted notifications to CQC. This meant that CQC received information about the service timely to exercise our regulatory role effectively.