Advinia Health Care Limited

Cloisters Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 February 2018 and was unannounced.

The last inspection was on 20 June 2017 when we rated the service Requires Improvement overall and in the key questions of Safe and Responsive. We did not find any breaches of Regulation, but we found that the provider needed to make improvements in order to achieve a Good rating overall.

At this inspection we found the provider had made the necessary improvements and we have rated the service Good in all key questions and overall.

Cloisters Care Home 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.

Cloisters Care Home is registered to accommodate up to 58 people in one building. The building has two units. The ground floor is for people living with the experience of dementia who may also have physical healthcare needs. The first floor is for people whose primary needs are physical healthcare needs, including people who are being cared for at the end of their lives. At the time of our inspection 54 people were living at the service.

The provider, Advinia Health Care Limited, is part of the Advinia Healthcare Group, who manages 16 care homes in the United Kingdom.

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 and associated Regulations about how the service is run.

People were happy living at the service. They told us their needs were met and they were treated with kindness and respect. Visitors explained they thought the service was well run and met people's needs. People were involved in planning their own care and were able to make choices about this.

The staff were happy working at the service. They felt supported. They had the training and information they needed to carry out their roles and responsibilities.

People received their medicines in a safe way. The risks to their safety and wellbeing had been assessed and planned for. The provider learnt from incidents and accidents and had made improvements at the service following these.

The environment was safely maintained, suitable and comfortable. The staff carried out checks on safety

and on equipment being used.

There were procedures designed to protect people from the risks of abuse. People knew how to make a complaint, they felt the registered manager and provider listened to their concerns and took action when needed.

People were cared for in a way which met their needs and reflected their preferences. The staff worked alongside other professionals to make sure healthcare needs were being met. People had enough to eat and drink. They were able to participate in a range of social activities. There was evidence that some people's health and wellbeing had improved since they had lived at the service. People receiving care at the end of their lives were treated with dignity and respect.

The registered manager and provider's representatives were visible and well known. They operated effective systems for monitoring the quality of the service and making improvements. These systems included asking people using the service and other stakeholders for their views and opinions.

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 received their medicines safely. There were effective systems designed to minimise the risk of medicines errors. Where these had occurred the provider had taken appropriate action to make sure people were not harmed.

There were procedures designed to protect people from the risk of abuse.

Risks to people's wellbeing and safety had been assessed and planned for.

The environment and equipment used were clean and safely maintained.

There were enough suitable staff to keep people safe and meet their needs.

There were effective systems to learn from when things went wrong and to make improvements to the service.

Is the service effective?

Good

The service was effective.

People's needs and choices had been assessed in line with current legislation and good practice guidance.

People were cared for by staff who had the skills, knowledge and experience required to deliver effective care and support.

People lived in a suitable environment which met their needs.

The provider was acting in accordance with their responsibilities under the Mental Capacity Act 2005 and sought consent for care and treatment.

People were given the healthcare support they needed and had access to healthcare services.

People's nutritional needs were being met.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion.

People were able to express their views and were actively involved in making decisions about their care.

People's privacy, dignity and independence were respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their needs.

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

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was well-led.

There was a person centred culture which was inclusive and empowering.

The provider had effective systems for assessing risks, monitoring quality and making improvements.

People using the service and other stakeholders were engaged and listened to.

The provider had systems for continuously learning and improving the service.

Cloisters Care Home

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.

This comprehensive inspection took place on 12 February 2018 and was unannounced.

The inspection team included three inspectors, a nurse specialist advisor 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.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report, notifications received from the service, information members of the public had shared with us and information about safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The provider had completed a Provider Information Return (PIR) in May 2017. The PIR 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.

Since our last inspection a coroner's inquest into the death of a person who lived at the service had resulted in specific actions the coroner required the provider to take. The provider shared their action plan with us and information about their analysis of people at risk of falling and falls which had taken place at the service. We used this information to help plan our inspection.

During the inspection we spoke with nine people who lived at the service and 10 visiting friends/relatives. We spoke with the registered manager and other staff on duty who included, nurses, assistant nurses, care assistants, activities coordinators, catering staff and domestic staff. The provider's head of quality and compliance was visiting the service and we met with them.

We observed how people were being cared for and supported. Our observations included using the Short

Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the care plans for five people and part of the care records for another 15 people, the staff recruitment records for six members of staff and other records used by the provider for managing the service, which included records of meetings, complaints and quality monitoring.

We inspected the environment and equipment being used at the service. We also looked at how medicines were stored, administered and recorded.

At the end of the inspection we gave feedback to the registered manager and head of quality and compliance outlining the key findings of our inspection.

Good

Is the service safe?

Our findings

People using the service and their representatives told us they felt safe at the service. Some of their comments included, ''I feel so safe with the staff here'', ''I do not fear abuse here'', ''I can tell that [my relative] feels comfortable and positive when [they] are being cared for by the staff here'' and ''I feel the service users are safe here because there is good accountability.''

Some visitors told us that they were concerned that their relative was at risk from other people who lived at the service. We discussed this with the registered manager, who had identified that some people's conduct had caused anxiety for others. They explained that they were in the process of working with the commissioning authority to reassess the needs of these individuals to ensure they were getting the right support to keep themselves and others safe. In the meantime, staff supporting these people were aware of the areas of concern and were providing additional supervision when needed.

During the inspection we found that the processes for administering and monitoring medical patches were not always effective. For example, one person was prescribed a pain relieving patch every seven days. We found that this person had not been administered the most recent patch. In addition, we found that staff did not record where on a person's body they had applied patches or when these were removed. We discussed this with the registered manager. They undertook an investigation into the incident which included speaking with the person's GP to ensure no harm had been caused. The staff monitored the person's wellbeing and they did not show signs of discomfort or pain. The provider also introduced more effective systems for monitoring the application and use of medical patches so that the risk of errors was reduced in the future.

With the exception of the above incident, we found that medicines were managed safely. There were appropriate procedures relating to medicines management. Medicines were stored safely and securely. The staff undertook checks on the temperature and cleanliness of medicines storage and these were recorded.

The staff responsible for medicines administration had received relevant training. The registered manager assessed their competency in this area regularly and following any incidents. Staff wore distinctive tabards stating they should not be disturbed whilst they were administering medicines. During the inspection the staff on duty administered medicines in a safe way. They explained what they were doing to people and made sure people had swallowed tablets and liquids before leaving them.

The provider had recently started using an electronic system for recording medicine administration. We saw that this worked well and that staff had to check the supply of medicines using bar codes when administering these. This reduced the risk of the wrong medicine being administered. The staff told us the system worked well and they felt it had improved the way in which medicines were managed.

The provider undertook regular audits of medicines supplies and records. We saw that action had been taken where problems were identified, such as discrepancies in records.

Some people received their medicines covertly (without their knowledge). We saw that there were multidisciplinary assessments and agreements relating to this. There was clear information for the staff about how to administer these medicines and when it might be necessary.

There were procedures designed to safeguard people from abuse. The staff received training in these and there was a range of information about abuse and how to report this on display around the home. The staff were able to explain what they would do if they were concerned someone was being abused. The provider had taken appropriate action following safeguarding alerts, working with the local safeguarding authority to help protect people and to investigate allegations.

The risks to people had been assessed and planned for to help keep them safe. The staff had completed individual risk assessments for each person. These included risks to their physical and mental health, risks of falling, nutritional risks, skin integrity and the equipment they used. The assessments were clearly recorded and up to date. The registered manager had undertaken additional work assessing risks relating to people falling. They had analysed the number of falls, trips or slips each person had experienced and the likelihood of these reoccurring. We saw that equipment was in place to help prevent further accidents. This included beds which could be lowered, sensor mats which alerted the staff to people moving and bed rails where people needed these. The assessments were comprehensive and included information about people's capacity and wishes. There was evidence these assessments were regularly updated and had been changed when needed.

Some people were at risk of choking. The staff had consulted with other healthcare professionals to make sure they had the correct arrangements for supporting people to eat and drink. Where people required texture modified food and drink there were additional instructions for the staff about the person's requirements placed in their rooms, the kitchen and tea trolleys, so that the risk of a person receiving the wrong consistency of food and drink was minimised. The staff had a good understanding regarding this having received training and discussions in team and individual meetings, as well as written guidance.

The environment and equipment used by people was safely maintained. There were regular checks on health and safety, cleanliness and whether equipment was in good working order. We saw that these had been recorded and action had been taken when concerns were identified. There was an up to date fire risk assessment for the building and information about fire safety had been shared with people living at the service and visitors as well as staff. There were regular checks on fire safety equipment, gas and electrical safety, water supplies and window restricting devices. We saw that the provider's contingency plan was available in the home's foyer along with an emergency equipment box and fire safety information.

There were enough suitable staff to keep people safe and meet their needs. People using the service and visitors told us that staff were always available when they needed them and were prompt to answer call bells. The staff agreed that there were sufficient numbers the majority of the time. They explained that they were busy but that they could meet people's needs. The provider undertook a monthly analysis of people's needs and whether the staffing levels were appropriate. The staff wore uniforms and name badges to identify who they were and their role at the service.

The provider had procedures for the recruitment and selection of staff which were designed to ensure they were suitable. Potential staff were invited for an interview at the service. The interview included scenarios designed to test their knowledge and attitude. The provider requested references from previous employers, asked the staff for proof of identity and eligibility to work in the United Kingdom, a full employment history and checks on any criminal records from the Disclosure and Barring Service. The staff undertook an induction into the home and had to complete a successful probationary period of work. The provider had

systems to risk assess any staff where the checks identified previous concerns. The assessments included employing staff with specific conditions or extending probationary periods.

There were systems designed to prevent and control the spread of infection. The domestic staff were aware of their protocols for work, responsibilities and schedules of cleaning. The equipment they used for cleaning was colour coded. We observed that the environment was clean and odour free during our inspection. There were sufficient domestic staff and they busy throughout the day. The provider carried out infection control audits where any concerns were identified. These had been acted on. All staff wore personal protective equipment, such as gloves and aprons. These were disposed of after use. There was a schedule for checking and cleaning equipment, such as mattresses, hoists, slings and commodes; and the provider checked that staff were following these.

The provider learnt from when things went wrong and made improvements following these. All accidents and incidents were recorded and analysed. The analysis considered whether things could have been done differently to prevent the accident or incident. Following an incident in 2017 the provider had taken action to review people at risk of falling and whether the staffing levels and equipment used were right for each person. They regularly reviewed this information. The registered manager analysed all changes affecting people each month, for example looking at infections, hospital admissions, medicines errors, changes in weight and skin integrity. This information was shared with operations managers who asked what action had been taken in response to each incident. This was recorded and the provider shared the experience of each service with registered managers so they could learn from others as well as the events in the service they managed. The staff took part in daily handovers of information where they shared learning about any changes in the home and reflected on their practice to see if improvements could be made.

Good

Is the service effective?

Our findings

People's needs and choices had been assessed in line with current legislation and good practice guidance. The registered manager or senior staff met with people before they moved to the service to discuss their needs. The assessments were clearly recorded and incorporated information about their preferences and wishes. The provider used a series of standard assessments to establish people's needs with regards to health, skin integrity, nutritional needs, assisted moving and mental capacity. These helped determine people's base line care needs. The assessments were enhanced with personalised information which had been provided by the person themselves and their representatives. The staff used these assessments and additional initial observations to create care plans so that people received the care and support which was right for them. Assessments were reviewed each month and following any changes in people's needs.

People were cared for by staff who had the skills, knowledge and experience required to deliver effective care and support. One person using the service told us, ''The staff are well trained.'' Another person commented, ''They are top rate the staff here, anything that needs doing they handle it well.'' New staff received an induction into the home to make sure they understood about people's needs and the home's policies and procedures. They shadowed experienced staff and undertook a range of training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The provider assessed the staff competencies in different aspects of their roles. The induction, assessments and training were recorded.

The staff were required to undertake additional training at regular intervals to refresh their knowledge. The registered manager oversaw this to make sure training was up to date. The staff explained that the training they had undertaken was useful and that they could request additional training or opportunities to undertake vocational qualifications. The nurses told us they were supported to update their clinical expertise through additional training. The provider had created a new role at the service, nurse assistants, since the last inspection. The nurse assistants were provided with specific training so they could undertake some of the traditional nursing tasks. We spoke with one nursing assistant who told us they were well supported and had enjoyed opportunities to learn new tasks. The registered manager explained that the creation of the new role had helped to alleviate some of the pressures faced by the nurses during busy periods.

There was enough information for the staff, including employee handbooks and information about their roles and responsibilities. The provider had created guides for temporary staff so that they had access to important information. These were available in the nurses' stations.

The staff told us they had regular opportunities to meet with their manager as a team and individually. These meetings included themed supervisions where they discussed specific topics relevant to the service. The staff also took part in annual appraisals of their work. All the staff who we spoke with commented that they were well supported and were able to ask for additional help and support when needed.

The staff had good systems for communicating with each other and sharing their experience. These included written and verbal handovers of information and using communication books and diaries.

People lived in a suitable environment which met their needs. People had individual bedrooms with en-suite facilities. They had personalised their rooms with their own belongings and furniture. They had access to the equipment they needed to live safe and healthy lives. The communal areas were safely maintained with hand rails along corridors and appropriate signage for bathrooms, toilets and lounges. The provider had considered best practice guidance on dementia friendly environments when updating and decorating the building. There were attractive themed communal rooms designed to promote interaction and interest. There were appropriately placed notice boards with information for people about the service, activities and menu options.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.

The provider had undertaken capacity assessments for each aspect of people's care. These included information about how the person communicated and how best to present information to them to support understanding. The assessments were linked to care plans. Where people had capacity to consent they had been involved in planning their own care and had agreed to these plans. In instances where people lacked capacity the provider consulted others, such as family members, to make decisions in their best interests. The provider had made applications to the local authority for DoLS when needed and had a register to make sure these were renewed when they were due for expiry.

The staff had a good understanding about the importance of getting consent before assisting people with daily care and were able to explain how they communicated with people when they lacked capacity or were unable to verbalise. For example they talked about recognising facial expressions, body language and communication through sounds.

People were given the healthcare support they needed and had access to healthcare services. The provider employed nurses throughout the day and night who monitored people's health and wellbeing. They worked closely with other healthcare professionals to make sure people's needs were met. We saw evidence that referrals for specific healthcare needs were made in a timely fashion. The staff on duty explained that they chased these up if they did not receive a response from the health service. There was evidence of regular consultations with healthcare professionals and these were recorded in detail in people's care notes. The guidance and advice from professionals was incorporated into care plans.

Care plans included detailed information about specific healthcare needs and how these should be managed. We looked at the care files for people with complex and multiple healthcare conditions. We saw that there was good information about how to care for people and evidence their conditions were being closely monitored. The staff demonstrated a good understanding about individual healthcare needs.

People's nutritional needs were being met. People told us they liked the food at the services with comments which included, ''I like the choices we have here'', ''I like the food and enjoy my mealtimes'' and ''The food is

good.'' There was a choice of food for all mealtimes. We saw that people were offered regular snacks and hot drinks. Cold drinks were always available in communal rooms and bedrooms.

The kitchen was appropriately managed with schedules for ordering food, cleaning and planning menus. The chef met with people using the service and their representatives to find out about their preferences and to gain feedback about the food. The kitchen had recently received a five star food hygiene rating. Food was freshly prepared each day. The chef had a good understanding about individual needs and specialist diets, such as diabetic diets, pureed food, vegetarian and fortified diets.

People's nutritional needs had been assessed and recorded. We saw that food and fluid intake was recorded and that action had been taken when people's weight or intake had changed. There were appropriate regimes which were followed for people who received food and fluid via a Percutaneous Endoscopic Gastrostomy (PEG) feeding system.

Good

Is the service caring?

Our findings

People using the service and their representatives told us that staff treated them with respect and were kind, caring and compassionate. Some of their comments included, ''They treat me with respect and dignity'', ''They treat [person] very well'', ''I do not have any complaints because the care workers are very devoted'', ''They speak to [person] nicely and [they are] well cared for'', ''We are very happy with the way in which the staff treat [person]'', ''The carers are very good, there is such a diverse group of people who work here and I am happy to see that'', ''The girls are very nice and good to me'', ''They are very kind and caring'' and ''All the care is delivered very well.''

People told us their privacy was respected. They said that the staff addressed them by their chosen name, that they knocked before entering rooms and provided care behind closed doors. People explained that they had been asked if they had any preference for same gender care workers and their choices were respected.

We observed that the staff were kind and caring towards people. They offered them choices and addressed them in a respectful manner. The staff spent time sitting with people and talking when they were able. They listened and responded appropriately when people spoke with them and talked about people's interests and likes. At mealtimes people were offered support which was paced to match their needs and the staff explained what they were doing and allowed people to make choices.

People were supported to maintain independence where they were able. Care plans described when people had the skills and abilities to do something for themselves. People and their visitors confirmed they were able to stay as independent as they wanted. People were provided with equipment to help promote independence, such as specialist crockery so they could eat without assistance if they were able.

People using the service and their relatives told us that they had been involved in making decisions about their care. They explained that they had discussed their needs and preferences with the registered manger or nurses when they first moved to the home. They said that these preferences were respected. People told us that the staff offered choices each day about what they wanted to eat, wear and how they wanted to spend their time. One person commented, ''They always run everything through me first before taking action.'' Another person said, ''I am involved in decisions, the staff always ask me.''

During the day we saw that people were offered choices. For example, they were asked where they wanted to spend time. When people left communal areas to spend time in their rooms the staff supported them to do this. People were given choices about what they wanted to eat. They had been asked for their choice from the menu in advance, and we saw that when people changed their minds once they had been served a meal, this was respected and the staff found them an alternative.

Care plans included information about people's lives before they lived at Cloisters Care Home and about things that were important to them. The staff had asked families and other representatives to contribute to

this information. Specific wishes were reflected in care plans, such as how people liked to be addressed, what their interests were and the importance of their culture and religion. We read one person's care plan which stated how important it was for them to maintain active worship. During the inspection we observed a member of staff of the same faith discussing this with the person, talking about important festivals. The person appeared to draw comfort and interest from this conversation. Another person described that they were supported to continue active worship because a priest regularly visited them.

The service accommodated a number of Asian people. The menu included an Asian vegetarian option for all meals and we saw people eating traditional Asian meals at breakfast and lunch time. The staff spoke a variety of different languages. They communicated with people using the person's first language if this was the person's preference.

The staff spoke positively about the people they cared for. They were able to describe people's interests and individual personalities as well as their needs. They explained they had received training around privacy, dignity and customer care.

Good

Is the service responsive?

Our findings

People received personalised care which was responsive to their needs. People using the service and their visitors confirmed this. Some of their comments included, ''The staff help me with my needs'', ''They are very helpful and always here if I need them'' and ''The staff do everything and my needs are being met.'' One visitor explained that their relative's health had improved due to the care at the service. They also told us the person's appetite and weight had improved.

People's needs were recorded in care plans. They had been involved in the development and review of these and their wishes and preferences were recorded. The staff reviewed these regularly and changes in people's needs were recorded. The staff completed records each day to show how the person had been cared for and any changes in their condition. Some of the records of care provided and the care plans were unclear and it was not always easy to access information about people's current needs. The registered manager was aware of this and was working with the staff to improve record keeping. We found that the staff demonstrated a good understanding about individual needs and how people liked to be cared for.

Where people required additional assistance or supervision we saw that records were in place to monitor this and make sure they received this support.

The families of people told us they were involved in planning and reviewing care needs. They said that the staff were good at communicating with them and let them know straight away if their relative was unwell or had an accident.

People wore clean clothes and looked well cared for. They told us they could have showers or a wash when they wanted. They explained they were able to rise and retire at a time of their choosing. During our visit we saw that people were able to spend time in bed, in their rooms or in communal areas and were not restricted. When one person asked to be escorted to their room for a rest they were supported to do this.

The provider employed two activity coordinators who planned and facilitated a number of group and individual social activities. There was a plan of special events and activities and these were advertised. We saw the activities coordinators encouraging people to take part. People who did not want to join in group activities were offered individual support according to their needs and choices. The staff used computerised tablets to access different activities such as reminiscence quizzes which they supported people to take part in. There was a range of resources for people to use, such as games, craft activities, books, DVDs, puzzles and toys.

People told us they knew how to make a complaint. They said that they were given information about the provider's complaints procedure. People who had raised a concern told us the provider had responded to these immediately and they were happy with the response. The provider kept a record of complaints and how these were investigated. We saw that action had been taken to learn from these and make improvements to the service.

People being cared for at the end of their lives were kept comfortable and pain free. Care plans included information about people's wishes and preferences for care at this time. The staff worked closely with palliative care teams to make sure each person had the individual support they needed. They were able to request a visit from palliative care professionals if they needed any advice or people required changes to their care plan. There was clear guidance regarding management of pain and the staff had access to additional support and medicines for people who had been assessed as potentially needing these in the last few days of their lives. In a card received at the home from a relative of a person who had died there shortly before our inspection, the relative had written to say how the staff were ''so loving'' and that their relative was in ''good hands spending [their] last days loved and taken care of.''

Good

Is the service well-led?

Our findings

People using the service and their representatives told us they felt the home was well run and they were happy with the service. Their comments included, ''[Person] is very happy here'', ''I am very happy here, I was in hospital for a long time before I moved here and since I have been here [my health] has improved'', ''I am happy with the care and support afforded to me'', ''I looked at other homes for [person] and this was the best of them all'' and ''We are so happy, the staff treat [person] very well.''

People who had lived at or visited the home for some time explained that things had improved there. They told us that the improvements included staffing levels, the environment and the general atmosphere.

The staff spoke positively about the service. They said that they enjoyed working there and were well supported.

The provider had recently asked people using the service and other stakeholders to complete surveys about their experiences. The response from these showed that people were happy with the service. People said they felt safe, were happy and well cared for. Some of the comments people made in the surveys and in cards to the provider included, ''I am very happy staying here with all the beautiful staff'', ''This is my home now and I am happy with the lovely people'', ''We will always be grateful for the help and support you gave us'', ''[Person] had a smile on his face and always said how well looked after he was'' and ''I cannot express in words how grateful I am for all the love and care you gave [person].''

The provider had a notice board showing how they listened to people's ideas for improvement and what they had done about this. The board included photographs showing how they had offered more choice, introduced new activities and improved communication techniques as a result of feedback from stakeholders.

The provider's principles of care, aims and objectives and the most recent inspection report were displayed in the main foyer along with a range of leaflets about topics of interest for people. The provider's website also contained useful information about the service and the most recent CQC rating.

People using the service, visitors and staff told us the registered manager was visible and approachable. They told us the registered manager listened to them and was supportive. Some of the comments from people using the service and visitors included, ''The manager is very good and she has explained to me about my illness and how they will help me'', ''If I need her she responds positively and she always comes to say hello'', ''The manager seems very helpful if I have any concern'' and ''The manager and staff are very nice and attend to everyone nicely and are very appreciative of our feelings.''

The registered manager told us they spent time on the units each day meeting people and observing care. They completed records to show their findings and any actions they required for improvements. We saw a sample of these records. They also audited mealtime experiences and specific areas of care and treatment,

such as medicines administration. The registered manager completed an audit of the service each month highlighting any changes in people's condition. This was shared with the operations manager who analysed the registered manager's planned actions for improvements if any concerns were identified.

There were other effective systems for assessing risks and monitoring the quality of the service. These included checks by the staff and registered manager which were recorded. The provider's operations manager completed a monthly quality inspection and the head of quality carried out an assessment based on the Care Quality Commission's Key Questions every six months. Where they identified areas of concern the registered manager had completed an action plan stating how and when improvements would be made.

There were regular meetings for people using the service, visitors and staff. Minutes of these showed that they were well informed and had opportunities to have their say.

The provider's policies and procedures were regularly reviewed and were shared with the staff to make sure they worked in line with the provider's aims and objectives.

The registered manager worked closely with other organisations such as the commissioning authorities and other providers to make sure they were up to date with best practice and legislation. The provider had made improvements to the service since the last inspection. There was evidence they had responded to areas identified in the last inspection report and feedback from others. They had recorded an action plan to state how improvements would be made and we saw that this had been acted on.