Eastleigh Care Homes - Raleigh Mead Limited

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Inspection report

Raleigh Mead
South Molton
Devon
EX36 4BT
Tel: 01769 572510
Website:**eastleighcarehomes.co.uk**

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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

Overall summary

This inspection was unannounced and took place on 24 and 28 November 2014.

Eastleigh Ralleigh Mead is registered to provide nursing and personal care for up to 60 people. The home is divided into three units, the ground and second floor provide nursing care for older people living with dementia with the first floor unit supports people with higher physical nursing needs. There were 59 people living at Eastleigh Ralleigh Mead at the time of the inspection.

At the time of the inspection the long standing registered manager had just de registered with CQC and an application for a new manager was being processed by CQC. The new manager intends to work with the previous

Summary of findings

registered manager who is staying on at the service to be part of the clinical lead team. 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.

Care was well planned and being delivered by a staff group who understood people's needs. Risks were being managed and reviewed in line with people's changing needs. People living at the home felt safe and well cared for. There was a variety of planned activities for people to participate in. These included accessing the local community where possible.

Staff were available in sufficient numbers and had the experience and competencies to work with people with complex needs. The provider had ensured for example, that all staff had up to date training in working with people who may become distressed or anxious and may require safe holding. Where people had been deprived of their liberty, this had been recorded and was in line with The Mental Capacity Act (2005) to fully protect people.

Staff understood people's needs and could describe their preferred routines. They worked as a team to provide personalised care and support for people. Health care needs were closely monitored and advice sought from GPs, community psychiatric nurses and other allied health care professionals as needed. The service had introduced a new electronic recording system for their medicines management. Staff had received training and support to manage this change and reported the new system was working well, with less chance of error.

The home was clean and free from odour. Staff understood the processes for ensuring good infection control procedures and there was a ready supply of personal protection equipment such as gloves, aprons and hand sanitizers to help reduce the risk of cross infection.

Staff reported that they felt well supported and had confidence in the management team. Staff felt their concerns, ideas and suggestions were listened to and acted upon. There was a planned training programme covering all aspects of health and safety and some more specialised areas such as working with people with dementia care needs and care of the dying. Staff had regular opportunities to discuss their work and receive support and supervision.

Systems were in place to ensure people and their family had opportunities to have their views heard both formally and informally. Relatives reported they were made to feel welcome and had opportunities to talk to staff and management about any concerns or ideas they had in relation to any aspect of the running of the service.

Summary of findings

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. There was sufficient staff who had the right skills, training and experience to meet the needs of people.

Medicines were well managed and audited to ensure people got their medicines on time.

The recruitment process ensured only people suitable to work with vulnerable people were employed. Staff understood the need to protect people from abuse and knew the processes to ensure this happened.

Is the service effective?

Good

The service was effective. Consent to care and support was considered and acted upon. Staff understood the importance of upholding peoples' rights and working within the Mental Capacity Act 2005.

Staff demonstrated skills in understanding people's ways of communicating in order to ensure choice was given where possible.

People were supported to eat and drink in an unrushed and relaxed way.

Is the service caring?

Good

The service was caring. Relatives described ways in which staff showed caring and compassion to people.

Staff worked with people in a way which showed respect and dignity was upheld.

Staff talked about how they offered care and support in a personalised and caring way. Relatives spoke highly about end of life care being a dignified process.

Is the service responsive?

Good

The service was responsive. Care and support was well planned and any changes to people's needs was quickly picked up and acted upon.

People's concerns and complaints were dealt with swiftly and comprehensively.

Is the service well-led?

Good

The service was well-led. There had been a planned change to the registered manager. There were clear lines of accountability in how the service was being managed.

Staff, people and their relatives said their views were listened to and acted upon.

Systems were in place to ensure the records, training, environment and equipment were all monitored on a regular basis. This ensured the service was safe and quality monitoring was an on going process.

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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.

Prior to the inspection we reviewed a range of information to ensure we were addressing potential areas of concern and to identify good practice. This included the Provider Information Record (PIR), which asks the provider to give some key information about the service, including what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information held by CQC, such as notifications. A notification is information about important events which the service is required to tell us about by law.This inspection took place on 24 and 28 November 2014 and was unannounced. On the first day the inspection team included two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service. During the first day we spent time observing how care and support was being delivered and talking with people, their relatives and staff. This included 37 people using the service, ten relatives and friends or other visitors, and 30 staff. This included care staff, nurses, domestic staff, registered provider, operations clinical lead, senior managers, nurses and the administrator.

On the second day, one inspector spent time looking in more detail at records relating to people's care as well as audits and records in relation to staff training and recruitment. We looked at nine care plans and daily records relating to the care and support people received. Care plans are a tool used to inform and direct staff about people's health and social care needs.

We also used pathway tracking, which meant we met with people and then looked at their care records. We looked at four recruitment files, medication administration electronic records, staff rotas and menu plans. We also looked at audit records relating to how the service maintained equipment and building.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

Not everyone was able to verbally share with us whether they felt safe. This was because of their dementia/ complex needs. One person said ''I feel much safer here, as I was having lots of falls at home and here I can call staff at any time. I feel safer at night here as staff are checking on you and I can use my call bell.''

Relatives were positive about people's safety being well managed. One relative said ''I'm in no doubt at all that my wife is safe. She rings that emergency bell and two staff come running.'' Another relative commented, ''I know she's safe here. They know what she needs before she does. I wouldn't want her to be anywhere else. My mind is at rest, knowing she is well attended to.''

People appeared at ease and relaxed on their environment. People were free to wander throughout the unit. One person constantly wandered around the unit wherever there was an open door. Staff were patient and reassuring in their communication and response gently guiding the person into other areas and diverting their attention to ensure their safety.

Staff had a good understanding of the various forms of abuse and they knew who to report any concerns or suspicions of abuse to. They were confident senior staff would take action. Senior staff were aware of their responsibilities to report safeguarding issues to the local authority and CQC. Staff had received training about safeguarding vulnerable adults. There have been a number of alerts in the last 12 months where the manager has been proactive in ensuring the right agencies have been informed and keeping CQC updated.

Risks were being managed appropriately, assessments were in place and these identified how to reduce risks. Risk of falls, pressure damage, poor nutritional intake and moving and handling were risk assessed and kept under review on a regular basis and as people's needs changed. Where a risk had been identified, measures had been put in place to reduce risks. For example, where people were assessed as being at risk of pressure damage, their assessment included clear details about the sort of equipment needed to help reduce this risk. This may include pressure relieving cushions and mattresses as well as regular checks from staff to reposition so their vulnerable skin areas were not in constant contact with surfaces. Staff were aware of people who had been assessed as being at risk from pressure damage and reminded each other to complete checks on people to ensure their pressure areas were intact, during handover times between shifts.

There were sufficient numbers of staff with the right skills and experience to meet the needs of people in each of the three units. On the ground floor and second floor there were two nurses from seven am till six pm and then one at other times. There were also seven or eight care staff across the two floors morning and evening. We have since heard from the provider that there are ten care staff covering two floors. On the middle floor there was one nurse at all times, who was supported by an assistant practitioner who had been trained to support the nurse's role in medicines management. There were also seven or eight care staff on this floor, plus one additional staff member who covered some one to one time for one person. They were supported by an activities coordinator, cooks and domestic staff.

Staff confirmed there were enough staff available to meet the needs of people on each floor. One staff member commented ''It is better now we have the assistant practitioner as this freed up the nurses time to look at people's health needs such as when we need them to look at wounds.'' Another staff member said ''Sometimes an incident can make it a bit hectic and we can get a bit behind, but generally we do well and provide the right care.''

Relatives felt there were enough staff available to meet people's needs although one relative said there were occasions on the top floor when they could do with more staff as people's needs had increased and there were more people who required two care staff to safely move them.

Medicines were stored safely in a locked medicines trolley within a locked office. They were stored in an orderly and uncluttered fashion. The trolley was clean and free from any excess stock. Systems were in place to ensure people had their medicines at the time they needed them and in a safe way. We observed a member of staff administering medicines and they used the correct procedures as detailed within the service policy. Staff confirmed they had received training and updates on administration of medication. The provider had introduced an electronic system for recording all medicines management. Staff reported they had received good training and support to get used to this new system and felt that now they were

Good

Is the service safe?

familiar with it, there was less room for error. The system flagged up when medicines were overdue and the medicine round could not be completed until all medicines had been administered.

Audits had been carried out in the receipt, administration and returns of medicines. This meant that the systems in place were safe and the quality was being regularly monitored to ensure standards were maintained including the controlled drugs. These were stored safely and control drug audit's had also been completed to show staff were ensuing they followed the correct procedure of having two signatures for any administering of controlled medicines. The clinical lead said the new electronic system allowed them to maintain more accurate audits.

There were appropriate recruitment procedures that ensured staff were safe and suitable to work in the home. Recruitment files were stored electronically, showed all staff had completed an application detailing their employment history. Each staff member had two references obtained, and had a Disclosure and Barring Service (DBS) check completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services

The home was clean and fresh throughout and free from any malodour. Care staff had responsibility for keeping equipment clean. All equipment seen was clean, in working order and appropriately stored.

A service specific infection control policy was in operation which took account of the Department of Health Code of Practice (revised January 2012). A member of staff had been appointed as the lead nurse for infection control. Hand gels were sited throughout the home with a notice on the reception desk to explain their use for visitors to the home. Staff used the hand gels as needed. Staff wore protective gloves and aprons where ever they performed personal care tasks, and there were plenty of supplies available on each of floors.

A team of cleaning staff were employed at the home. Two cleaners worked in pairs to cover every morning and afternoon. Additional help was also available from an outside contractor. The head of cleaning described the strict cleaning routines in operation which ensured the home was clean and as free from infection as possible. They described the use of virus health sprays used in bathrooms and sluices and other specific cloths and products used which provided added protection for people. Staff in the laundry room demonstrated a clear understanding of how they operated to ensure the risk of cross infection and contamination was reduced. Domestic and housekeeping staff attend relevant training in infection control and cross infection.

The Clinical Director explained that a recent outbreak of Scabies had meant the whole of home had been subject to a complete deep clean treatment to eliminate the condition, which had been successful. The staff training matrix confirmed staff had been offered and attended infection control training. This meant staff were up to date with latest policies and practice to protect people from the risk of infection. Where spillages occurred on the ground floor, staff immediately responded by clearing up.

Good

Is the service effective?

Our findings

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/ complex needs. One person said 'When I first came here, I was with my partner who died. The staff were wonderful, she had all the care and attention and now they look after me. They do the best for me every time. If my health needs change they will make sure I'm O.K. I'm sure about that.''

Relatives were positive about aspects of care and support. One said ''All of the care they gave my Mum made all the difference…we knew about the changes in her condition, we were involved in any changes to her care.'' Another told us ''My wife has had two strokes. She can't do much for herself. The staff always ask her whether they can move her or lift her. They treat her with every respect.''

People were supported to have their needs met by a staff team who understood their needs and had received training and support to work effectively. Staff confirmed they had been offered training in all aspects of their work and were given opportunities to discuss their role in a one to one supervision session with their manager. The training matrix showed staff had a range of training to ensure they could do their job safely and effectively.

Staff were skilled at working with people with complex needs, looking at ways of offering support in the least restrictive way and using diversionary tactics when people showed signs of distress. For example one person became distressed because they were confused about where they were. Staff offered gentle reassurance to them about where they were and made suggestions about what they would like to do next.

Care staff handovers showed that staff had a clear understanding of people's needs. Reference was made to amounts of food eaten at lunchtime with reminders for staff to monitor certain people's intake. Feedback from relatives was shared concerning one person who was seen to be deteriorating and the team were encouraged to enable people to participate with activities during the afternoon. Staff contributed to the discussion and made suggestions which showed how well they knew people and how they communicated with people within their care. Staff were proactive in checking people's health care.

Several staff had recognised a person was unwell and may have been suffering from an infection. The person's health was discussed during the handover session and it was agreed they would refer to the person's GP for advice.

Care records showed that health care needs were closely monitored and where needed healthcare professionals were called in. One GP confirmed the service did refer to the surgery in a timely way about people's health care needs.

There were clear instructions for staff about how to manage risks in the least restrictive way, ensuring people were given choice and control where possible. For example, one person was resistive to having their personal care needs attended to. The assessment instructed staff to try to assist at a different time, with different staff and using diversionary techniques to keep the person calm. Staff said they worked with people in the least restrictive way but that when their personal care needs were not being met due to the person's lack of capacity, they assessed whether this was a risk to their health and well-being. Where the risk was high, for example it was clear someone needed support to change their clothes and wash due to incontinence; they may need to act in the person's best interest to assist them. This was clearly documented in people's care files and risk assessments.

Three staff on the ground floor confirmed they had received training in the use of restraint. One staff member said, 'if someone is resistive, I call in other staff and check what to do'. This staff member explained the steps that could be taken to ensure appropriate breakaway techniques and hold were used. The training matrix showed all staff had attended training in restraint which was a nationally recognised and accredited course. The Clinical Director explained that all staff received restraint training to Level 1. Staff working on the ground floor and second floor with people with more complex dementia needs received additional training to Level 2. The manager and a senior staff member are trained in restraint as internal trainers and accredited for breakaway techniques, critical incidents and restraint which meant that in-house staff training was readily available for all staff working at the home which reduced risk and protected people from unsafe practice.

Where people lacked the mental capacity to make decisions staff were guided by the principles of the Mental

Good

Is the service effective?

Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. Mental capacity assessments detailed the specific decision the capacity assessment had been completed for

Care staff and the nurses on duty on all floors demonstrated an understanding of the importance of gaining consent prior to providing care and treatment. All of the people who lived on the on the ground floor and top floor had limited capacity to consent and care records showed that people's mental capacity had been assessed. Decisions regarding the use of restraint were appropriately recorded in care plans. Staff were able to describe ways in which they supported people who were resistive to care. These included various diversions techniques. Where restraint had been required one member of staff explained the general practice of having a best interest meeting followed by two or three other staff working together to provide care in an appropriate and in the least stressful manner for those who resisted care. One care plan explained how to guide a person away from situations stating, ''this is the least restrictive way care staff can move x if it is required.''

Staff said they had received some training in Deprivation of Liberty Safeguards (DoLS) and understood they should not deprive people of their liberty. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager explained they were in the process of making applications to the DoLS assessors for specific people to ensure they were providing the right care and support in the least restrictive way. There were seven people currently subject to this type of safeguard, and further applications were being made in respect of the supreme court judgement made in April 2014. This ruling made it clear that if a person lacking capacity to consent to arrangements for their care, was subject to continuous supervision and control and was not free to leave the service they are likely to be deprived of their liberty.

People were supported to eat and drink and maintain a balanced diet. Systems were in place to ensure those who were at risk of poor nutritional intake, were monitored and supported to eat and drink at regular intervals. Records were kept of the amounts people ate and drank, although these were not always completed by night staff. The manager was already aware of this and had arranged a meeting with the night staff to discuss the importance of ensuring all records were kept up to date.

One person said ''You please yourself where you eat, and what you want for meals. Sometimes I have lunch and evening meals here in my room. I'm very independent.'' People were offered a choice of meals and those who required assistance to eat and drink received this support in a kind and unhurried way. Peoples' relatives could join them for meals and one relative said ''The food is really good here. I visit most days and it is always hot, tasty and plenty of variety.''

Good

Is the service caring?

Our findings

One person said "Everyone is very kind. I'm very content here. If I ask for something the carers do it for me. I can choose where I go, I can stay in my room but I like to be with people. I like to be as independent as I can. Sometimes the staff put me in a wheelchair and take me into town, and I love it. I'm very grateful to be here, it's lovely." One relative said "I've one word to describe this place…Fantastic. Wonderful staff, wonderful food, wonderful care….wonderful. I can't grumble about anything. You can ask for something and they do it straight away. They treat my relative well, treat her with dignity. We couldn't find anywhere better…I wouldn't want her to be anywhere else."

Staff provided care and support in a kind and compassionate way. When assisting someone, staff would make sure they were at eye level to talk to them about what support they were going to offer. Where people appeared anxious, staff were quick to respond and offer comfort in a kind word, a hand stroke or a hug. One person said 'This place is fantastic. The staff are kind, they treat me with respect. The young girls come in and give me a kiss every morning. They spoil me something rotten. I wouldn't have a bad word said about the place, or the people here. I've got everything I want here, I get on with everyone, there's no-one I don't like. If the door is closed they always knock before they come in. If I ring the call bell, day or night, they are here."

Care plan information was being reviewed and updated in a more personalised way. The service had developed a document using the principles of the 'This is me' document devised by the Alzheimer's Society. This ensured staff had a pen picture of people's past history, their likes and dislikes as well as their preferred routines. Staff said they liked the new care plan format as it gave them more detail about people and how to meet their individual needs.

People's preferred routines were being honoured. For example, people were assisted to get up when they chose and breakfast was served at any time. One person was enjoying a second bowl of porridge at mid-morning. The staff member said "She really enjoys her porridge. I won't disturb her now, I will wait until she is finished, then clear up." The person was later assisted to remove food from their face and clothes to maintain their dignity. Another person was looking around for something and a care staff member offered her a toy cat, which they took and began stroking. They later wanted something else and the staff member offered them a variety of objects which were tactile and stimulating.

Staff listened to what people were trying to express and responded appropriately. Staff during handover spoke about people with respect. Two members of staff said, "it's so important to me to treat people kindly. I want to make sure it's the way I'd talk to my Mum or Gran."

Family and friends were made welcome, could eat meals with people and join in any of the social events and activities. One relative confirmed this saying "I am always offered drinks and biscuits, staff get to know you well and become like friends, asking how things are. I have found them very welcoming and a great comfort to me personally."

One relative described a really positive experience of their family receiving end of life care. They said "We have just watched as the staff here helped my mum through her 'End of Life'. They were so kind. We were involved in any changes in her care; They maintained her dignity in everything. They were sensitive to our feelings. Everyone was kind and respectful. My mum thought of this place as her home. The staff are always welcoming, we would recommend it to anybody. We were so lucky she could end her days here.'

The service were committed to having two 'champions' joining the North Devon Hospice 6-steps approach to end of life care, which is a six month - level 5 qualification. Commencing December 2014, these staff will provide awareness training to their colleagues in a structured manner supported by the Registered Manager and Hospice facilitators to enhance the skills in end of life care.

Good

Is the service responsive?

Our findings

Most people were unable to make a contribution to their review of their care plan. Some relatives described ways in which they were kept involved with their relatives care and health needs. One relative felt assured that staff would contact them if there were any changes in their relative's needs ''Staff are very good, they keep me updated on what's going on and if I haven't been in for a visit, I only have to phone and they tell me what's happening.'' Care plan information which was stored electronically, did not clearly demonstrate or evidence these were being reviewed with individuals' or their family, although it was clear from daily records people and their families had been regularly consulted on various aspects of care.

Care records covered people's personal and healthcare needs, were updated and reviewed regularly by the lead nurse which meant staff knew how to respond to individual circumstances or situations. The computerised system was used by staff to record interventions undertaken during the course of their shift. Some care staff who inputted records said they found the system easy to use, although others, less familiar with the computer, found the system cumbersome and repetitive, One staff member said it was sometimes ''difficult to negotiate the system and to find exactly what was needed easily.'' For example we noted a reference that staff should refer to a photograph of person's wound before further treatment. The nurse on duty was unable to locate the photograph easily without seeking advice from a colleague on another floor.

The record system was in the process of changing to ensure clearer person centred information about care needs and for easier access for those using the system. Comprehensive assessments were in place which were person centred and were frequently reviewed. Daily routines were based on a person's preference and choice. For example, getting up later in the morning and having breakfast at any time to suit the person. Some people on the ground floor chose to get involved in activities, either in small groups or on a one to one basis. On the day of the inspection a violinist joined people in the lounge to play music together. Where people were still in their rooms the violinist visited them individually if they wished to hear some music played. During the afternoon an impromptu activities and singing session between staff and people occurred and later the activities co-ordinator brought their dog into the unit which many people enjoyed stroking and prompted reminiscing.

There was a wide range of activities offered each day, both group activities and individual sessions. Some people said they had enjoyed trips out into the local community to visit the market or local supermarket. One relative said there had been trips out to places of interest. There were lots of festive activities planned to include people's friends and relative and to involve the local community. For example local school children were visiting to sing carols.

Staff were observed to respond promptly to call bells with response times of less than a minute on the day of the inspection. People were not left waiting and staff responded to people and their needs quickly. There was an incident where someone suddenly felt faint and staff were quick to respond and ensure their safety and then assess their health to see if emergency services were needed.

The service had a complaints policy and process which was posted in areas of the home and given to people and their relatives as part of their information pack. Relatives who visited the home at the time of the inspection said they were confident their concerns or complaints would be dealt with. We have received information from one relative who has not been satisfied with some of the responses to their concerns. The complaints log kept at the home showed all complaints were recorded as well as actions taken to address any areas of concern identified. The providers sent us a comprehensive list of areas they had improved as a result of comments or concerns expressed by people or their relatives. Some people had raised questions about the restraint practices being used, known as 'safe holding'. In response the provider had reviewed their restraint practices across each of their services. They had decided to provide accredited training to all staff on breakaway techniques as well as age, condition and risk specific restraint interventions.

Good

Is the service well-led?

Our findings

At the time of the inspection the registered manager had applied to de-register and the associate manager had applied to register with CQC as the registered manager. The plan was for the previous manager to remain as part of the senior management team and provide clinical support and governance as the associate manager is not nurse qualified. There was also an operational clinical lead who worked across the three homes owned by the same provider.

Staff reported confidence in the new management structure. They were clear about who the new manager was and that there was an 'open door policy' to go and discuss any issues or ideas for improving the service. One staff member had suggested and introduced a method to clarify staff roles while on duty which helped to ensure staff were accessible for people in all parts of the unit and gave staff a more defined role for their shift with responsibility for a particular area. Staff had also made suggestions to reduce the amount of time in repetitive recording, to enable them to spend more time with people. Staff felt confident that ideas and suggestions raised would be listened to and considered.

The management team at Eastleigh met monthly to ensure the smooth running of the service. This included all senior staff from nursing, hospitality and domestic senior staff. The service had recently given one person the role of dignity champion to look at ways of improving the service to enhance dignity for people. This will include having a dignity tree, with each person having a leaf which describes what dignity meant to them.

The manager understood their role and responsibilities and had ensured CQC were kept informed of all accident and incidents. Audits were completed on the number and nature of accidents and incidents to see if there were any trends or learning needs for staff. The manager was clear he wanted to ensure people received the best possible care at all times. They had revamped their training to include e-learning as well as face to face learning sessions. They had researched best practice in terms of working in the least restrictive way with people and ensured staff had training in this area.

Systems were in place to audit the records, building, cleaning, medications and equipment. Each month there was a management meeting held within the home that reviewed all aspects of the running of the home, including a review of people and their needs. This generated minutes and action points for senior staff to follow up on. For example where they noted a number of errors in medicines management, the service looked at how they could improve this and have now introduced electronic recording of medicines with dispensing direct from original packaging. The new system allowed management to complete more comprehensive audits and also ensured a safe and effective way for staff to administer medicines safely and effectively.

The service used annual surveys to seek the views of people and their relatives on all aspects of care delivery and the building. The results of these surveys were collated and any themes or areas for improvement were followed up. There were also six monthly 'resident and family' meetings where people were encouraged to put forward ideas for any improvements. For example in the last meeting held in October 2014, several people had raised an issue with their clothes being shrunk in the laundry. This was passed onto the domestic team to ensure garments were laundered appropriately. People also had an opportunity to discuss the activities programme, food and staff. The manager and other clinical leads had a daily presence in the home and staff, people and their relatives knew who they were and were confident they could talk to them about their concerns or suggestions.