Tanglewood (Lincolnshire) Limited

Cedar Falls Care Home with Nursing

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 23 August and was unannounced.

The home provides residential and nursing care for up to 91 people. Some of the people at the home were living with a dementia. The home was purpose built and is set over two floors with the upstairs being a secure dementia area. There is a main lounge and dining area on each floor as well as smaller areas with comfortable seating. In addition there are a number of bungalows in the grounds for people who wish to remain more independent.

There was a registered manager for the home. 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.

Staff were kind and caring and supported people to be happy and contented. They knew people's likes and dislikes and were able to offer suggestions for food or activities that would please the person. People's privacy and dignity were supported and they were able to personalise their rooms to make them feel more like home. People were supported to make choices about how they received their care and could specify if they preferred male or female staff to assist them with their personal care.

People told us they felt safe living at the home and staff had received training in how to keep people safe from harm. Staff were protected against the risks associated with medicines, as staff ensured that medicines were stored, administered and destroyed safely and were available to people when needed.

There were enough staff available to meet people's needs and the provider completed appropriate checks to ensure that they were safe to work with people living at the home. Staff had access to training which supported them to have the skills needed to provide safe appropriate care for people. They were also supported to gain nationally recognised qualifications in care. Staff received support and guidance from their line manager in regular supervisions and annual appraisals.

People's rights were protected under the Mental Capacity Act 2005(MCA) and people has been appropriately referred to the local Deprivation of Liberty Safeguards authority when they were unable to make decisions about where they lived and were under constant supervision. Where people were able to make decisions for themselves their choices were respected.

People received care which met their needs and had been assessed so that risks to them had been identified and appropriate care and equipment was in place to keep them safe and healthy. However, review periods for risks were not always clearly identified and records did not always reflect people's current needs. People were supported to maintain a healthy weight and to access plenty of fluids. People's ability to eat safely was assessed and advice from healthcare professionals was followed. People were offered a choice of meals and

were always offered an alternative if they did not like the meal they had chosen.

The provider had systems in place to monitor the quality of care people received and to gather the views of people using the service. The registered manager worked with a research organisation to ensure that the care provided reflected the latest guidance and used the guidance to make changes to the environment to support people's wellbeing. They also worked with the local community to promote the needs of people living with a dementia and to help relatives understand people's needs better.

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 felt safe living at the home and staff knew how to keep people safe from abuse.

People's risks were assessed and care was in place to keep people safe.

There were enough staff to meet people's needs and appropriate pre-employment checks had been completed.

People's medicines were ordered, administered and disposed of safely and were available to people when needed.

Is the service effective?

Good

The service was effective.

Staff received the training needed to care for people safely and effectively.

People's rights under the Mental Capacity Act 2005 had been respected.

People were supported to maintain a healthy weight and were offered a choice of meals.

People were able to access healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

People were involved in making choices around the care they received.

People privacy and dignity were respected and promoted.

Is the service responsive?

Good

The service was responsive.

The care provided met people's needs.

People were supported to live happy lives with a variety of activities on offered to engage people.

People were supported to make complaints and they were investigated.

Is the service well-led?

Good

The service was well led.

The registered manager was approachable and learnt from past mistakes.

People and their relatives had been able to feedback their thoughts on the care they received.

The provider had an effective systems to monitor the quality of care people received.

The registered manager engaged with research and developed the service to ensure that the care provided reflected the latest guidance.

Cedar Falls Care Home with Nursing

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 23 August 2016 and was unannounced. The inspection team consisted of an inspector, a specialist advisor, who was a nurse, 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 we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home.

During the inspection we spoke with nine people living at the home and eight relatives who visited during our inspection. We also spoke with a doctor who was at the home to review some of the people in their care. We spoke with two nurses and four other members of the care staff, the registered manager and the providers. We also spent time observing care.

We looked at eight care plans and other records which recorded the care people received. In addition we examined records relating to how the service was run including staffing, training and quality assurance.

Good

Is the service safe?

Our findings

People living at the home told us they felt safe and that their possessions were safe and could be locked away. People living in the bungalows said that staff ensured that they were safe and their bungalows were secured before leaving them. Staff had received training in keeping people safe from abuse and were able to tell us how they could raise concerns about anything that worried them both within the organisation and with the local authority who investigated safeguarding concerns. A relative told us how staff were quick to support people who were becoming distressed. They said staff kept other people safe by moving them away from the distressed person to give them some time and space to calm down.

Staff were also aware that they could raise any concerns about anything they had seen at the home anonymously using the provider's whistle blowing procedure. This allowed them to raise concerns without the worry that it could affect their employment.

Risks to people while receiving care were fully assessed and care was planned to keep people safe. Risk assessments had clear recording of risk, impact and action to be taken. For example, people's falls risks were identified and care put into place to keep people safe such as being monitored and using equipment. People's risk of developing skin damage such as pressure sores was identified and care and equipment was in place to keep them safe. For example, we saw a number of people were using special mattresses to reduce the pressure in key areas and people were also regularly repositioned so that they did not spend too long lying on one area of the body.

Where people needed equipment to move we saw that their care had been personalised to take account of their needs. For example, we saw one care plan noted that the person was anxious when being supported to move using equipment and would need a lot of reassurance. It also noted that the person was stiff with limited range of movement so that special care and attention was needed when moving them to ensure that it did not cause them unnecessary pain.

At times it was not always clear when risk assessments should have been reviewed to ensure that they still reflected people's needs. We also saw that staff had not always recorded that they had provided care in line with the risk assessments. However, we saw that these were issues with recording the information and that the actual care provided to people had met their needs.

Accidents and incidents were recorded and appropriate action had been taken. Relatives confirmed they were informed of any incidents that had occurred.

The provider had identified a national staffing tool which helped them monitor if they had enough staff to meet people's needs. This was based on people's abilities and the amount of care they depended upon staff to provide. Records showed that the provider routinely exceeded the identified staffing levels. The provider also looked at internal audits to ensure that the staffing levels were providing people with safe care. For example, the record of falls in the home were used to see if more people were falling at a particular time of day which may of indicated a need to review staffing levels.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the service.

People told us that their medicines were administered to them on time and they were all aware what medicine they were taking and what condition it was for.

We observed staff giving people their medicines. We saw that they took their time with people and explained to them what tablets they were being offered and why. We saw that they took time with people to gently encourage them to take their medicines. An example of this was when a member of staff offered a person several different drinks to get them to take their medicines. Where some medicines had been prescribed to be taken only when needed, such as pain relief, staff discussed with people if they wanted to take it or not.

Medicine records were fully completed and had been annotated to help staff administer medicines safely. An example of this was where medicine only needed to be taken on certain days. We saw staff had highlighted the day it needed to be administered to ensure it was not missed. Medicines were stored safely and returned to pharmacy when no longer in use.

When people regularly refused their medicines this was documented and if appropriate, staff informed their relative. Staff told us if the person had capacity they would get one of the nurses to speak to the person and to explain why it was important to take their medicines. Following this any decision the person made would be respected. If the person did not have capacity then staff would arrange a best interest decision to see if covert medicines were appropriate. Covert medicines are where medicines are hidden in food so that people are not aware they are taking their medicine.

Good

Is the service effective?

Our findings

Staff told us and records showed that they had been supported to access appropriate training to ensure they had the skills needed to care for people living at the home. One member of staff told us that they had been offered lots of training and had recently completed training which helped them to support new members of staff. They told us that there was a training plan in place and the training manager monitored if training had not been completed. Staff also told us that they had been supported to undertake training which led to nationally recognised qualifications.

There was a structured induction in place to support new staff. This consisted of some time spent learning about the provider's policies and procedures as well as time shadowing an experienced member of staff. All new staff completed a probationary period and had their competencies checked during their probation to ensure they were learning the skills needed to care for people safely. As part of the probation staff were expected to complete the care certificate. This is a national set of standards that the government have defined as the basics staff need to provide appropriate care for people.

We saw that staff provided safe care for people which met their needs. For example, we saw that when people were distressed staff were able to engage them in conversation and calm them down. People living at the home also told us that staff would adhere to infection control processes such as wearing gloves and aprons while providing care.

Staff told us they were supported with regular individual supervisions meetings with their line manager. This allowed them time to review the care they provided and if they needed any more guidance or training to meet people's needs. Staff also confirmed that they had an annual appraisal where they could discuss their future career developments and any related training needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We 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 saw that where people had been assessed as not being able to make a decision about where they lived and were under constant supervision, the registered manager had completed the appropriate paperwork for them to be assessed under the deprivation of liberty safeguards. However, while a number of applications had been submitted at the time of our inspection no one had been assessed.

Some people had made legal arrangements for family member or friends to be able to make decisions on their behalf when they were not longer able to make the decision themselves. We saw that this was clearly recorded in their care plan, along with copies of the legal paperwork confirming this. This meant that the registered manager and their staff were clear on who was able to make decisions for each person.

Where people needed to use equipment which may be deemed as a restraint, for example, bedrails, the use of the equipment was assessed to ensure that it would be safe for people. People were asked to sign if they were happy for bedrails to be used. Where people were unable to make this decision a best interest decision was made for them.

Where people had capacity and were able to make decisions that may put them at risk, their wishes were respected. For example, we saw that there was a positive risk taking agreement in place regarding one person not using bed rails.

All the people we spoke with told us they were happy with the quality of meals they were offered. One person told us, "The food is very good; I can choose something else if I want. I like fish and I can have it when I want." People's dietary preferences were recorded and they and their relatives told us that staff were good at offering them food they would want to eat.

People's dietary risks were identified and where people needed a pureed diet this was recognised. One relative told us that their mother needed their food pureed. They told us how staff ensured that it still looked appetising and how each item of food was pureed separately so their mother could still choose what she wanted to eat. Care was also personalised to meet people's individual needs. For example, we saw one care plan noted that a person would sometimes fall asleep while eating which increased their risk of choking. Therefore, staff needed to ensure that they consistently prompted them to swallow each mouthful.

Where people were losing weight action staff took action to help the person maintain a healthy weight. For example, by monitoring their food intake. When necessary people were referred to healthcare professionals for advice and if needed were on calorie rich nutritional supplements.

People's needs around staying hydrated were also identified and where necessary their fluid intake was monitored and fluids thickened. For example, we saw one person was prone to developing urinary infections and their care plan noted that at times they were reluctant to drink. As this would increase their risk of infection their care plan noted that staff should ensure that they had access to drink and were encouraged to have regular drinks. People we spoke with told us that they were offered tea and coffee between meals and squash and water were also available.

Where people needed equipment to help them maintain their independence while eating we saw that this was noted in their care plan and available to people. For example, some people used a plate guard, while others needed a beaker with a lid to drink from.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other healthcare professionals such as GP's and the community mental health team had been included in people's care when needed.

We saw that the registered manager supported the healthcare professionals and family members to discuss people's healthcare needs. An example of this was when relatives, doctors and other appropriate healthcare professionals were invited to attend palliative care meetings to discuss how the home supported people to

have dignified pain free deaths.

Good

Is the service caring?

Our findings

People living at the home and their relatives all told us that the staff were caring, kind and gentle. One relative said, "It takes a lot to beat this place. I looked at about eight homes before and this was the best." A person living at the home said, "I have no complaints, the staff are kind with a good sense of humour. Staff are very helpful and respect your privacy and dignity." Staff provided care to people with calm, respectful, friendly interaction and had a good knowledge of the people's preferences. For example, one person who was getting anxious was offered the opportunity to draw as this was something they enjoyed. They were reassured and drew a picture and gave it back to staff.

People were asked about food choices a day in advance but alternatives always available if the person changed their mind and chef would always make something different for people. For example, on the day we inspected one person had chosen to have fish instead of the planned menu items, another had macaroni cheese and a third person had an omelette. We saw people's preferences around their food were respected as one person wanted to eat their pudding first and staff supported them with this. The chef told us that they planed the menu with the registered manager and would discuss any changes people wanted to see at the residents' meeting. In addition they would trail different dishes to get people's feedback.

People living at the home and their relatives told us staff were responsive to their needs and if they asked staff to assist with something they did not have to wait long at all. One person told us they were often assisted instantaneously' but wouldn't usually wait longer than 20 minutes. We saw one person request to have their window opened as they said they were too hot in their room. Staff responded immediately by going to open their window.

We saw and people told us that staff had the skills to help people remain calm and settled. We saw the registered manager reassured a distressed person at lunchtime. The registered manager knelt down to talk to them and gave them a drink. We also saw one person became upset with someone they were sat with and staff calmly supported the person to a part of the room that was further away from other people but where they could still see the activities.

People told us how they had been supported to make their room feel like home with pictures and ornaments. They told us that they had been able to bring their own furniture in as well. People were able to take their friends and relatives to their bedroom for a private chat if they wanted to and there were also smaller more intimate seating areas in the home available for people to use. People were also able to have space to have a private birthday party so that they could invite friends and relatives in for a visit.

We saw one person had chosen to speak in their first language instead of English. We saw at one stage they were distressed. The staff spend time reassuring and spoke to them in their preferred language.

All the people we spoke with felt that they were treated with dignity and respect and they were allowed privacy. One lady told us how they had a male member of staff assigned to assist with bathing. As she had felt uncomfortable she had requested that only female staff assist her and this was agreed.

People's end of life wishes were recorded. For example, we saw that it was clearly recorded where people, or their relatives if they were unable to make the decision, had identified that they did not wish to be resuscitated. Records also recorded when people did not which to be taken to hospital as they neared the end of their life as they would prefer to die at their home. People's wishes after their death were also recorded and included information on when their family were to be informed and which funeral director to call. When people pass away if the family so desired they are supported to have the wake at the home as it was the person's home.

Care plans showed that people had been supported to maintain their dignity as long as they were able to and that their independence was supported for as long as possible. An example of this was where when a person was no longer able to use the commode they were supported to remain continent by using the bed pan. When the person was no longer able to use the bed pan they moved to using continence pads and finally as the pads were causing them skin damage the person was catheterised. This showed the care provided was tailored to their needs at each stage and every effort was made to help them remain independent.

People had a privacy and dignity section in their care plan. This covered issues such as their non-verbal communication, any confusion and how it should be responded to calmly and with reassurance. The home had a small shop with toiletries on display for people who were unable to visit the shops. This helped the person maintain their independence and make choices about the products they wanted to use.

We saw that some people had needed the support of an advocate. An advocate is an independent person who can speak for a person when they are unable to do so. They spend time with the person to get to know their needs and wishes and can represent them in formal and informal meetings. The registered manager had supported people to access an advocate.

Good

Is the service responsive?

Our findings

All the people we spoke with and their relatives were aware of their care plan and the information it contained. All stated that it was reviewed on a regular basis and any changes of a person's needs were taken into account. Where people had been unable to make decisions about their care needs the appropriate individuals were involved in discussing the care plan. One family member told us that they knew who their relative's named nurse was and confirmed, "Yes, I am included in [name's] care. All relatives are consulted in the planning of care."

We saw that people's care plans were well organised in clear sections making the information easy to find. When people's needs changed this was communicated verbally to staff coming on shift in a handover meeting in the morning and evening and the information was recorded on a handover sheet so that staff could review the details if needed.

Healthcare professionals we spoke with told us that the staff's knowledge of people and their health was good which enabled them to have the information needed to treat the person. They said that staff raised concerns with them in a timely fashion and also related any concerns that people's relatives had. They also said that they had discussed their visiting schedule with the home and now contacted the home to let them know what time they would be there. This allowed people to be in their room waiting and ensured their privacy.

We saw that people's mental health as well as their physical health was monitored and action taken to help people remain positive and contented. For example, records showed that one person had been feeling a bit down and their care plan noted that they should have some extra input from the activities co-ordinator. We saw that this extra support had been put in place.

It was evident the registered manager and provider had undertaken a number of positive steps to ensure they could meet the needs of people living with a dementia. For example, people could walk freely around without too many restrictions and most doors were 'open' apart from those required to be locked. Each person's room had a memory box outside, which people were supported to fill with photographs and other memorabilia from their past. This helped them recognise which room they lived in. Signage around the home was good and assisted people to finding their way to key areas, for example, the dining room and toilets. All this supported people living with a dementia to retain their independence for as long as possible.

The people living at the home were supported by two activity coordinators. For example, on the day of our visit people were taking part in a movement to music exercise session to help them maintain their physical abilities. All the people who had expressed a desire to take part were gathered in a circle so all could see the activity and join in if they wished to. One person told us that there were a number of activities to get involved in, music, games, quizzes, reminiscing, indoor bowling and newspapers were delivered if they wished to order one. In the afternoon some people from the upstairs dementia unit had been outside in the garden with the activities coordinator. We saw that they walked back in laughing and singing. People felt they were able to choose which activity they wanted to get involved in. They told us they were free to go out with

friends and family as and when they wished, they could go outside into the gardens; they could have private time and use the hair salon.

As well as structured activities the registered manager and staff had placed small activities and rummage boxes in shared areas. People could also access board games and arts and crafts materials. People were also supported to carry on with activities which had made their life meaningful. One person told us they were occupied within the home and had plenty to do and was encouraged to be part of the home as he was a priest so had offered comfort to relatives and was organising a choir of residents.

We saw there was a notice telling people how to complain in the main entrance. People told us they were happy to raise complaints with the registered manager or other staff. Relatives we spoke with said they knew who to go to if they had any worries or complaints. They felt the registered manager had a good strong presence and was often seen about the home and they could go to them with any issues. Staff told us that if people raised a concern with them they would ensure that it was raised with their line manager and recorded in the person's daily notes and as an incident. Before our inspection we had been contacted by a person who had complained to the provider. The provider was able to demonstrated that they had fully investigated the complaint and had taken appropriate professional advice to ensure they gave the complainant a full answer.

Good

Is the service well-led?

Our findings

There was a registered manager for the home. They had been referred to the Nursing and Midwifery Council for making an error on a reference for a nurse and had their registration with the council suspended for three months from 22 June 2016. This meant that they were unable to complete any nursing duties or provide clinical guidance and support to the nurses working at the home for the same period.

We discussed this with both the registered manager and provider. The registered manager admitted that they had made an error in judgement and understood that it did not reflect well on their professional standing. However, we saw that they had been open and honest with the people living at the home, their relatives and other healthcare professionals and had explained the situation and had received support from them during the process. The registered manager had also spoken to staff and their colleagues in other homes to use the situation as a learning experience to help prevent others making the same mistake. Following our inspection the registered manager informed us that they had been fully reinstated on the Nursing and Midwifery register.

The provider had fully supported the registered manager through the process and told us that they were confident in their abilities to run a safe home and to ensure people's needs were met. During the registered manager's suspension they had arranged for the area manager to provider clinical guidance and support for the nurses working at the home. In addition they had reviewed the process for completing reference within the company to prevent any similar issues within any of their homes.

The registered manager was well regarded by people living at the home and their relatives. One person told us, "Manager is approachable; she listens and is very informal. She knows her staff well." A relative told us, "You can't find anywhere better, it is top of my list." People told us that they saw the registered manager everyday as she goes around and speaks to people. We saw that she knew each person and their relatives.

Staff also told us that they had confidence in the registered manager's abilities to run a good home. One member of staff said, "If I had any concerns I could raise them with the manager or nurse. [The registered manager] will back you 100% and you can talk to her." Another member of staff told us, "You can talk to [the registered manager] all the time and we have regular staff meetings."

People living at the home and their relatives had been able to share their views on the home with the provider and the registered manager at regular residents' and relatives' meetings and a monthly coffee morning. The registered manager chaired the meetings and people living at the home told us that they took action on issues raised and would give feedback on any changes they had made. At the meetings the chef and activity staff were present to answer any questions.

People using the service, their relatives and visiting health care professionals had been asked for their views on the service. We saw that the results were displayed on the notice board for people living at the service, relatives and visitors to see. The registered manger told us they were working on an action plan.

The provider had an effective suite of audits which monitored the quality of care people received. For example, we saw the provider audited the care plans to ensure they accurately reflected people's needs. In addition they had reviewed the number of falls they had each month and people's weight to see if any action was needed. The provider had also arranged for an external agency to visit and review the quality of care people received and the environment. This meant they had the view of a person external to the organisation of the care they provided for people.

The registered manager was continuing to work to improve the quality of life for people living with dementia and their relatives. The registered manager had worked with the National Institute of Health Research involving the home in research into how to improve the care for people living with dementia and the training staff needed to meet people's needs. At our previous inspection they were working on some research around a nationally recognised training programme for staff supporting people who live with dementia. This was still ongoing and the registered manager had also joined a programme looking at advance communication for people with dementia and their ability to understand easy read documentation. This would support people to be more involved in their care and help them express their wishes when planning care.

The registered manager had taken part in a study which looked at the environment that people lived in and how that impacted on their health and wellbeing. This recognised that the longer corridors in the homes were an issue for people living with dementia. The provider had made changes based on the registered managers recommendations and each of the corridors in the dementia unit had been decorated in a different theme. For example, one corridor was given a holiday feel and another had been designed around a garden theme and a third had a wedding theme. In each corridor there were items for people to interact with. The registered manager told us that his had helped to orientate people and that it could be used to distract people when they were distressed.

By distracting people they would often become calmer and begin to interact with the staff. This meant that there were fewer occasions where people needed additional support or medicine to help them remain calm and safe and could enjoy their day more. In addition the changes had reduced the number of falls as people stopped to look instead of continually walking around. It had also supported people's privacy, as with so much to look at in the corridors there had been a reduction in the number of people going into rooms.

The registered manager had also continued the themes into the small seating areas with rummage boxes for people to look through and a basket of washing for people to hang on the line. We saw that a number of people were occupying themselves with these items. Doll therapy was available and had proved successful in occupying several people who were happy and contented to be looking after their babies giving them a purpose in life.

Following feedback from people and their relatives that while they liked going out for a drink and something to eat, at times they felt people in the community did not understand their needs, the registered manager had introduced a monthly Dementia café. The registered manager had supported relatives to set up the downstairs dining room into a Dementia café and invite friends, relatives and people from the community to have afternoon tea with them. One of the relatives had become the café manager and others were waiters. The event had been advertised in the local paper and was run by the relatives. Photographs showed that it was very popular and that people enjoyed themselves at the event.

The registered manager was also engaging with relatives and the local community to help them understand the needs of people with dementia and how they can be supported. They local dementia group met regularly at the home and the registered manager supported and participated in the training of dementia

friends in the community.

The registered manager had also arranged for the local college to deliver some dementia training to relatives so that they understand more about the disease and the impact that it had on people. Following the training people were given a certificate. This supported relatives to understand that when people were distressed and angry that it was the disease and not an indication of a failure of their relationship. The registered manager told us that this had helped relatives remain calm with people and had improved family relationships as relatives understood that their loved ones behaviour was not in their control. The registered manager had also arranged for occupational therapist to visit the home to work with people and their relatives to help people understand what abilities they still have and how they can be supported to move and complete tasks safely.