Larchwood Care Homes (North) Limited

Alwoodleigh

Inspection report

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16 February 2018

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 13 and 16 February 2018 and was unannounced. The service had previously been inspected on 10 and 20 January 2017 and was in breach of the legal requirements in relation to safe care and treatment and governance. Following the last inspection, we met with the provider to confirm what they would do and by when, to improve each key question to at least good.

Alwoodleigh 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.

Alwoodleigh accommodates 40 people in one adapted building. There were 34 people living at the home during our inspection.

There was a manager in post who was in the process of registering with the Care Quality Commission. 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 had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

At our previous inspection we found improvements were required in the assessment for some risks such as the use of assistive equipment and there was not always detailed guidance for staff to follow. At this inspection although some improvements had been made, further improvements were still required and the manager had implemented an action plan to address these issues.

Staff received an induction and training to ensure they had the skills to meet the needs of the people who lived there. Staff were supported to continually develop by on-going supervision and appraisal.

People were supported to eat their meals by care staff appropriately and sensitively and people told us how much they enjoyed their meals. People's nutritional needs were met and they were encouraged to drink throughout the day. The dining experience in the main dining room was a pleasant experience although we have recommended the manager reviews the dining experience in the first floor unit.

Records showed people had regular access to healthcare professionals to help meet their wider health needs.

We found the home was well maintained, clean and tidy and people's bedrooms had been personalised.

The décor was dementia friendly with pictures and signage which helped support people living with dementia to navigate their way around the home.

The home was compliant with the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and had applied for authorisations to the local authority. Decision specific capacity assessments were in place and the home kept a record of Lasting Power of Attorney.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found all the staff to be caring in their approach to the people who lived there and treated people with dignity and respect. We observed staff to be kind and compassionate throughout our inspection.

Care provision was personalised and support plans were reviewed regularly to ensure they were relevant to the people who lived there. Families were invited to input into the reviews of their relative to ensure known preferences and views were incorporated into people's care plans.

People enjoyed the different activities available and we observed activities taking place on the residential unit. Our observations during our inspection found there were limited activities taking place on the nursing unit.

Complaints were handled appropriately and people were happy that any concerns raised had been acted upon.

The home was well led and the management team encouraged an open and transparent culture where people using the service and staff were able to make suggestions for change and improve the quality of the service.

The registered provider had undertaken a detailed audit of the service and the home had an improvement plan in place to ensure the service continued to improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Some risk reduction plans lacked information to ensure staff had the guidance to ensure risks were reduced to the lowest level.

Medicines were administered safely by trained staff who had their competencies to administer assessed.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills they needed to support people safely. Staff received training, supervision and appraisal to ensure they continued to develop.

The service was compliant with the Mental Capacity Act 2005 and mental capacity assessments had been undertaken in line with legislation.

People's nutritional and hydration needs were met and the home involved professionals as and when required.

Is the service caring?

Good

The service was caring.

People told us they were happy living at the home and were complimentary about the staff who cared for them.

We saw people were treated with dignity and respect.

People and their relatives were involved in planning their care and treatment.

Is the service responsive?

Good

The service was responsive

People were supported by staff who knew them well and were keen to enhance people's well-being and quality of life.

People were involved in their care planning when appropriate and families consulted with to ensure preferences and views were considered when devising support plans.

People's care needs were regularly reviewed to ensure changing needs were identified and responded to.

Is the service well-led?

Good

The service was well-led

There was a positive culture within the service and the management team provided strong leadership.

Staff were engaged with the changes at the service to drive up improvement to provide a quality service for the people living there.

We found a range of audits in place which were up to date and detailed, and the registered provider was monitoring improvements at the home.

Alwoodleigh

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 13 and 16 February 2018 and was unannounced.

The inspection team consisted of three adult social care inspectors 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.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

Before our inspection, we reviewed the information we held about the home. This included the intelligence we had about the service including the statutory notifications, enquiries and safeguarding referrals. We contacted the commissioners of the service and the local authority safeguarding team. We also contacted Healthwatch who had last completed an "Enter and View" in 2014. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the care provided in one of the communal areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed care interactions in the communal lounges and observed breakfast and the lunchtime meal on each unit.

We spoke with seven people living at Alwoodleigh and two relatives. We spoke with the manager, the clinical lead, the cook, and four care staff. We reviewed ten care plans, six medication administration records and

four cream charts. We looked at the audits and quality assurance systems at the home.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at Alwoodleigh whether they felt safe. We received the following comments, "Yes I do feel safe. They are friendly here, I see regulars. Meet people I know. If I needed to, I would talk to the [carer] serving out the meal here." Another said, "If there was something I was worried about, I'd speak to a senior manager. Or anything good I would say too." Another person said, "When she first started, the activities coordinator came around and said if there's anything I'm unhappy with, I must tell, as they won't know otherwise. [Person] is easy to talk to, right down to earth."

Staffing levels had been a concern previously. We reviewed the staff rota, dependency tool and spoke with people using the service and their relatives to check there were sufficient staff to provide a safe service. The dependency tool determined the number of staff required to meet the needs of the people at the home and the manager showed us how this determined they had the appropriate level of staffing. We observed call bells were answered promptly during our inspection. One person we spoke with said of the response to call bells, "Very good. During the night they come when I ring the bell."

On the second day of our inspection there was a short period when there were no staff in the upstairs lounge area. We discussed this with the manager who told us there should always be a staff member in the area and we observed this was the case after raising this issue. Staff told us mornings and lunchtimes were the busiest and although most felt there were enough staff, they told us when additional staff had been brought in when their occupancy was higher, the additional staff numbers had been helpful.

We asked staff about their understanding of safeguarding. They demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. There were posters in the building to direct people to a telephone number to contact if they had information and they wanted to 'whistleblow.'. A whistle blower is someone who reports concerns about unsafe or illegal practices in the work place.

We found risk assessments in place in the care files of people who lived at Alwoodleigh. These included standardised risk assessments such a Waterlow scale, which is a tool to assess the risk of a person developing a pressure ulcer and a Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. We found assessment of the risk of choking, an assessment in relation to the risk of people not being able to use a call bell to summon assistance, and falls. We saw where people were unable to use their call bell, daily record sheets showed they were checked hourly by carers. In addition, where one person wished not to be disturbed during the night to reposition, a risk assessment had been undertaken and their wishes respected.

At the previous inspection we found improvements were required in the assessment for some risks such as around the use of assistive equipment but there was not always detailed guidance for staff to follow. At this inspection although some improvements had been made, further improvements were still required. This included more information to guide staff to move people safely and to ensure there is a record of all equipment in use in a person's care plan. We recommended the service sought advice and guidance from a

reputable source and by the second day of our inspection they had done this. We found there was no record of the setting of pressure mattresses in people's care plans and although they were set up correctly the setting was not recorded. By the second day of our inspection the manager had implemented a system to ensure this was recorded in the care plans and in a person's room.

Risk assessments had been undertaken in relation to falls and the manager demonstrated a reduction in the number of falls. We observed some people were wearing unsuitable footwear and when we raised this with the deputy manager they showed us they had identified and purchased more suitable footwear for people and they would ensure this aspect of falls prevention was prioritised.

We found an improvement in people's personal evacuation plans (PEEPS) to guide staff how to support individual people in the event of an emergency. Fire alarms were tested regularly and equipment such as extinguishers were checked by an external contractor.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) check, reviews of people's employment history and two references had been received for each candidate. Where necessary additional risk assessments had been completed to ensure issues had been addressed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

We looked to see how the service was managing people's medicines including the ordering, storing, administering and disposal of medicines. Medicines were safely administered and securely stored; the systems in place to manage this were effective. The nurse in charge was able to describe the 28-day ordering system for medication. There was a clear record of incoming medicines, double-signed by the nurse receiving these and the pharmacist. Records were kept in relation to all medicines, creams and fortified supplements. Each person had a Medicines Administration Record (MAR) chart which contained the person's details, an ID photograph and whether they had an allergy to medicines. We saw protocols for "as required" medicines were in place. Creams were dated on opening to ensure they were used in line with the manufacturers recommendation.. Fortified supplements and thickeners were securely stored and all were individually labelled.

We observed the administration of medicines on both floors. Staff had been trained and had their competencies checked in line with good practice. The administering nurse was respectful, calm and patient and offered an explanation about what the medicine was for. They used an effective recording system to show whether the person had taken their medication or whether the medicine had been refused.

We checked the storage of medicines and found this to be safe. The medicines room and fridge temperatures were checked and recorded daily. Medication disposal was clearly recorded and medicines for return were stored securely before return. Stocks of medicines tallied with records, which meant the home had safe systems in place.

At our previous inspection we had found an issue with covert medicines (administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them). At this inspection we were advised one person had their medicines administered covertly. We checked their records, and found the registered provider had met their legal requirement to ensure they could lawfully administer without the consent of the person and they had safe systems in place for administering the medicines.

Records showed accidents and incidents were recorded and the manager undertook an analysis of accidents. We reviewed the recent accidents at the home and could see measures had been put in place to reduce the risk of the incident occurring again. This showed us staff were learning from accidents and incidents.

We observed the home was clean and staff had access to plentiful supplies of protective aprons and gloves. Carpets had been replaced and the walls had been recently painted. The home had a dedicated handyman who ensured areas were maintained as required. One person said, "They're really on the ball here. My toilet roll holder had broken, and I couldn't get it back on. I just mentioned it to someone, and when I came back from lunch, it had been fixed. They have a handyman here."

Good

Is the service effective?

Our findings

People told us they liked the food. One person said, "The food is very good here. There's enough food for me. It's on all day. There's quite an extensive menu, things you wouldn't think of, like yoghurt." Another person said, "I like the food. Good meals, breakfast, dinner and tea. Wide choice. Can't complain about the dining room, it's lovely. Excellent food. You get a good breakfast."

We saw jugs of water and fruit juice in the communal areas and people were offered these during the day in addition to tea and coffee. People told us staff encouraged them to drink. One person said, "I'm not very good at drinking water, but they bring a jug out and pour me some." Another person told us, "I'm on a special regime now, where I'm having more water."

We observed the breakfast and lunchtime dining experiences in both the upstairs and downstairs dining areas. We found the experience downstairs was very pleasant and relaxed with the tables set out nicely with table cloths and condiments and music playing in the background. However, we found the upstairs dining experience was not as pleasant and the system in place for serving people lacked organisation. We fed our observations to the manager and they agreed to look at ways to improve this experience.

We inspected the kitchen and found it well-stocked, and organised. We checked the Catering Records Book; this was reviewed and signed monthly by the manager. These checks included a record of the daily checks for fridge and freezer temperatures, cooked food temperatures, food cooling records, incoming food temperatures, and up-to-date signed schedules for daily, weekly and monthly cleaning. The kitchen had been inspected recently by the local authority but was awaiting the food hygiene rating. There was a white board on the wall in the kitchen which detailed who was on a textured diet, who had special dietary requirements or required their meals to be fortified. We spoke with the visiting dietician during our inspection who confirmed there had been improvements at the home and they always requested assistance if required from professionals, and put in place any recommendations.

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. One person had conditions attached to their DoLS, although a deterioration in their health meant it was not possible for the home to comply with this condition.

The office administrator kept a record of who had a lasting power of attorney (LPA) and whether this related to property and finance, and/or health and welfare decisions. An LPA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help make decisions or to make decisions on a person's behalf. This meant they had assured themselves of who could consent on behalf of a person living there and what decisions this related to.

The care plans we looked at contained decision specific mental capacity assessments which ensured the rights of people who lacked the mental capacity to make decisions were respected. This meant the service was compliant with the MCA.

We asked people if they were offered choice in their daily lives. One person told us they, "Can do what you want, you're not restricted." Other people told us they were able to go out without restriction to their freedom. Although not all staff could tell us confidently about the MCA, they were able to tell us how they supported people to make choices in their everyday lives. The principles of the MCA were pinned onto the notice board in the home for staff to read. Our observations and our discussions with people at the home gave us confidence people's rights and freedoms were supported.

People told us staff had the skills to care for them and had been trained if they had a specific clinical need for treatment. We asked the manager how new staff were supported to develop into their role. They told us staff who were new to care completed the Care Certificate as part of their induction and they were allowed 12 weeks to complete this, which was then signed off by their head office. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. This meant the registered provider was working to the expected standard in relation to staff induction.

Staff training was monitored by the registered provider through regular updates of the home development plan. The administrator was responsible for ensuring staff were booked onto required training and had a system in place for monitoring this. They told us all training was available online, which staff were asked to complete during their induction, with face-to-face training on the same subjects allocated as this became available. Staff records evidenced each member of staff had received individual supervision. The manager confirmed appraisals took place every 12 months with a first appraisal undertaken at the end of new staff six-month probationary period. We looked at records to confirm this.

Staff told us they were supported with their training and development. One said, "The management team are aware of everyone's capabilities." They also told us they had a discussion session to talk about areas they were struggling with and what support was available.

Staff communicated essential information about the care of a person at handover. We saw a copy of the handover notes, and a diary which indicated the tissue viability nurse was to visit two people that day, appointments reviews and also issues for the maintenance person to resolve. This showed essential information was passed on and actioned as necessary to ensure issues were resolved and staff had information about the people they were caring for.

We saw evidence people's care and support was delivered in line with legislation and evidence based guidance. For example, the National Institute for Health and Care Excellence (NICE), MCA, Health and Safety and LOLER (Lifting Operations and Lifting Equipment Regulations 1998) regulations. This demonstrated the manager was aware of their responsibility to use national guidelines to inform care and support practice at the home.

People told us staff at the home accessed health professionals when required. For example, one person said, "The doctor came out recently for my ear, gave me a prescription for ear drops." Another said, "They soon pick up on it if you're not well." Other people told us they had seen a physiotherapist and a podiatrist since they were at the home.

Alwoodleigh is a converted Victorian property with a double storey extension. Bedrooms for people with residential care needs were on the ground floor and nursing care was provided on the second floor accessed by a staircase and a lift. All bedrooms had en-suite toilet facilities and some bedrooms contained en-suite level access showers. There was an adapted bath on each floor and a level access shower on the first floor. Dining facilities were limited on the first floor. Cantilever tables had been purchased for people to use whilst seated in the communal lounge area and they had arrived on the second day of our inspection. This meant people were able to eat their meals in a dignified manner. The décor was dementia friendly with pictures and signage which helped support people living with dementia to navigate their way around the home.

Good

Is the service caring?

Our findings

We asked people using the service whether staff were kind and caring. One person told us, "They are kind. I can't think of an instance, but they have all been nice." Other comments we received included, "Very much so", "Excellent. They are good" and "Without exception, yes."

We saw staff at the home had received written compliments from family members and the manager kept a record of these. We reviewed the following comments, "Really happy with care our mum receives here at Alwoodleigh. Lovely staff, really welcoming and friendly. Thank you all." Another read, "The staff are so caring and lovely."

Staff spoke about the importance of ensuring privacy and dignity was respected; telling us how they ensured this when providing care. We observed staff respecting people's privacy and dignity by knocking on people's door before entering their bedroom. One person said, "They always knock on the door first before they come in. They are respectful. They make sure you are comfortable with who comes into your room, as it's mixed gender [carer] here.

Care plans reflected the involvement of the person or their family members in their development and were signed by the person or their representative. We saw reference in people's care plans how best to communicate with them to ensure they were fully involved in their care on a daily basis. For example, the following statement was recorded in one care plan, "I can get frustrated if I can't express myself properly. Staff to be patient and allow me time to express myself." This meant staff were provided with information to support people who had difficulty verbally communicating their needs.

People were also encouraged to retain their independence and care plans recorded what people were able to do for themselves. Staff told us they supported people to remain as independent as possible by encouraging them to do tasks for themselves.

People were supported with their religious and spiritual needs and these were recorded in their care plans. The clinical lead explained how they supported one person to follow their faith and ensured their diet met with their religious requirements. A priest also visited the home on a weekly basis.

The service accessed advocates when required. An advocate is a person who is able to speak on another person's behalf when they may not be able to, or may need assistance in doing so for themselves. This meant people had access to independent support with decision-making if they needed it.

Good

Is the service responsive?

Our findings

We reviewed ten people's care plans as part of our inspection. Pre-admission assessments had been completed in detail to ensure the home could meet the needs of the people coming to live at Alwoodleigh. Information was gathered from a variety of sources, for example, information from the person and their families as well as any health and social care professional involved. The manager told us they were very strict about admissions and even though the pressure to take people waiting to be discharged was high, their priority was to ensure they could meet people's needs. They told us they ensured they had a maximum of three people who had been assessed to be nearing the end of their life. This ensured supporting people as this time in their lives, did not have an effect on other people living at the home in terms of staff time and care planning.

We found an improvement in the recording of people's life histories to tailor care to meet the person's needs based on past life experiences, preferences and previous choices. Care plans were recorded in a person-centred way and reflected an accurate record of people's care needs and how they wanted to be cared for. People's end of life wishes were recorded in their care plans including their funeral arrangements. Where people had not made or did not wish to make the decision at the time, this was also recorded and reviewed to ensure any changes were known to staff.

Care files were regularly reviewed and evaluated to ensure care provided was meeting people's needs and they contained evidence people had been involved in these evaluations. We saw evidence people's relatives had been invited to reviews, with the consent of the person, which demonstrated the registered provider was involving relevant people to ensure care plans truly reflected people's lives.

The home employed an activities coordinator for 33 hours each week. They were on leave on the second day of our inspection. We observed care staff undertaking a game of skittles in the residential unit on this day, with most people joining in enjoying the group activity. The deputy manager told us entertainers regularly attended the home, as did a local children's nursery. They told us people at the home were always really excited to meet the young children. We saw very little activities on offer in the nursing unit during our inspection although when we raised this with the clinical lead, they explained to us how they supported people with activities and they were striving to improve this aspect of care to support a person's wellbeing.

We asked people about the activities on offer. One person said, "There's a show they do. Been to one or two of those." Another person told us, "They had someone in to sing and play music. I usually try to keep myself busy, with doing crosswords and knitting. I keep in touch with friends by writing. I do talk to them on the phone. I don't mind being on my own. I try and keep myself busy, keep my mind active, that's important. If I get lonely, I just walk down to one of the lounges. Sometimes you can't get a proper conversation, though." Another person said, "I would like more people coming in. Not every week, but I would like more music. I think they could do more to make it interesting. But I'm not grumbling. I'm satisfied here. I don't think there's any unhappiness. We have exercises once a month."

We asked the manager how they were implementing the requirements of the Accessible Information

Standard. This requires them to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. Although they were unaware of the requirements of the standard they told us and we saw a person's communication needs were recorded in their care plan with detailed instructions on how best to communicate with the person.

There was a complaints policy in place and there were signs up throughout the building on how people could complain. In the past we found not all concerns had been recorded. At this inspection we found a significant improvement in this area. Complaints had been formally recorded and we could see they were acted upon and resolved to the complainant's satisfaction. Relatives we spoke with during our inspection told us they had no hesitation discussing any concerns with the manager who they told us always acted on their concerns and issues were always resolved. One relative told us they had witnessed poor care and had reported this to the manager. They said, "They believed me, and took it very seriously." They explained what had happened following this incident which confirmed to the relative, concerns were acted upon and the primary outcome was to protect people living at the home.

Good

Is the service well-led?

Our findings

There had been a change in manager and regional manager since our last inspection. There was a manager in post who was in the process of registering with CQC. There was also a clinical lead in post and we were told the long term intention was for this person to take over as the registered manager once they had acquired the necessary skills and experience. People at the home spoke highly about both the manager and the clinical lead. We received the following comments, "The manager is fine, very helpful. Said their door's always open. See them around on the corridors." Another person said, "[Clinical lead] is the best manager they've had. They used to be the nurse here. [Name] has made the biggest difference. You only have to ask for something and it's done. Between [clinical lead's name] and [manager's name], who's one of the big bosses, they've sorted it out here."

The manager told us the management team had an 'open door' policy and were visible around the home. They undertook a daily walk around the service which provided the opportunity to observe how the home was running and to ensure people were happy. We observed a pleasant atmosphere and friendly staff. During our inspection we saw the hands on approach of both the manager and the clinical lead. Regular audits were undertaken in all aspects of service delivery and where shortfalls were highlighted actions were put in place to remedy these.

We found leadership at the service was evident and there was an emphasis on making and sustaining improvement. Both the manager and the clinical lead were proactive and constantly developing ideas to improve the service. They had developed an action plan between our two inspection dates from the comments and observations we had made. This demonstrated their commitment to making the service a "good" service.

The registered provider had completed a thorough audit of the service in September 2017. They had identified areas of good practice and areas of concern. From this a home development plan had been created which also included areas for improvement identified at the last inspection. We could see they were actively reviewing their own performance in these areas and monitoring systems were in place to ensure actions were complete. The manager had been supported by a regional manager on a weekly basis and a new regional manager had commenced the week prior to our inspection. The systems employed by the registered provider demonstrated they were driving improvements at the service.

Staff meetings were held regularly and staff were asked to add items for discussion on the agenda. We reviewed the minutes of the latest meeting held on 23 November 2017. We could see there were discussions about their local authority contract monitoring visit, mental capacity and best interest decision making, daily record keeping, training, communication, team work and staffing levels. Where issues arose from the team meeting, an action plan had been compiled detailing who would be responsible for completing the action and by when. The manager told us the registered provider rewarded staff for their hard work by paying for a Christmas meal out. Christmas gifts were also given out and they gave verbal feedback to staff when they had done well to encourage them. The clinical lead told us how important feedback was to staff.

The manager told us they consulted with people regularly through residents' and relatives' meetings and surveys. This enabled them to seek their views about the service and if there were any areas that could be improved. The list of residents and relatives meeting dates was displayed on the wall in the foyer for people and their visitors to see. We reviewed the latest meeting held on 22 November 2017 and saw discussions had been held on home improvements, staffing, activities, food and drink and management arrangements.

We also saw a 'You said. We did' board in the reception area to show the home had taken on board comments. This showed improvements to the exterior of the home such as repairs to potholes in the driveway and lighting had been initiated following comments from people living at Alwoodleigh and their relatives.

The service was meeting its registration requirements in terms of statutory notifications sent to CQC. They had displayed the ratings from the previous inspection as required in a prominent place in the reception area.