Care Quality Commission

Tamaris Healthcare (England) Limited

Eastbourne Care Home

Inspection report

5-7 Cobden Street
Darlington
DL1 4JF

Date of inspection visit: 10th and 16th December 2014
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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

We carried out this unannounced inspection on the 10th and 16th December 2014.

We last inspected this service on the 18th August 2014 and found they were in breach of one or more of the regulations associated with the Care Homes Act 2008. This was due to care records being confusing and lacking attention to detail, we found that information was duplicated, incorrectly dated and did not provide staff with clear, accessible information about people's care needs. We found induction training to be poor, staff were not clear about their roles and responsibilities and due to staff leaving, they were short staffed. Assessing and Monitoring the quality of the service we found the then peripatetic manager had no effective quality assurances or processes in place.

Following our last inspection the provider sent us an action plan outlining their plans to improve. We carried out this inspection to check that improvements had been made and found that action had been taken to ensure Eastbourne Care Home complied with the regulations associated with the Health and Social Care Act 2008

Eastbourne Care Home is a 42 place care service. It provides 24 nursing places on the first floor and 2 nursing places on the ground floor. It has a separate unit on the ground floor with 15 intermediate places that are funded

Summary of findings

by the Clinical Commissioning Group. These places are for people who need a short rehabilitation service to recover following illness or injury. The service is on a residential street a short distance from Darlington town centre.

At the time of our inspection Eastbourne Care Home had a peripatetic manager in place. A peripatetic manager works with the operations team to manage a service without a permanent manager. The peripatetic manager at Eastbourne Care home was in the process of transferring their current registration to become the registered manager. 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.

People living at the service were receiving good care and support that was tailored to meet their individual needs. Staff ensured they were kept safe from abuse and avoidable harm. People we spoke with were positive about the service they received. People told us they felt safe and included in decisions about their care.

We observed interactions between staff and people living in the home and staff were kind and respectful to people when they were supporting them. Staff were aware of the values of the service and knew how to respect people's privacy and dignity.

Medicines were properly managed and stored safely.

The registered manager and staff had been trained and had a good knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The peripatetic manager understood when an application should be made, and how to submit one. This meant people were safeguarded and their human rights respected.

The service now had an activity coordinator. A range of activities were provided both in-house and in the community. We saw people were involved and consulted about all aspects of the service including what improvements they would like to see and suggestions for activities. We saw evidence that people were encouraged to maintain contact with friends and family.

The culture within the service was person centred and open. From listening to people's views we established the leadership within the service was now more consistent and the peripatetic manager was readily accessible for staff and people who used the service. Relatives we spoke with still felt they did not know the peripatetic manager.

We found the peripatetic manager took steps to ensure the service learnt from mistakes, incidents and complaints.

We discussed concerns raised from people who used the service about lack of showers, with the regional operations manager and the peripatetic manager. People said they were only showered once a week. Both managers said they would rectify this immediately.

Suitable arrangements were in place and people were provided with a choice of healthy food and drinks ensuring their nutritional needs were met.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. We recognised care plans had improved since out last inspection, although there was still a lot of work to make them more person centred.

Staff received training to enable them to perform their roles and the service looked at ways to increase knowledge to ensure people's individual needs were met. Staff had regular supervisions and appraisals to monitor their performance and told us they felt supported by the management team.

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

People living at the service told us they felt safe. Staff were clear on what constituted abuse and had a clear understanding of the procedures in place to safeguard vulnerable people.

Individual risks had been assessed and identified as part of the support and care planning process.

Staffing levels were appropriate. New staff had been recruited and team work was now very apparent.

There were procedures in place to ensure the safe handling of medicines.

Is the service effective?

Good

Staff now received training appropriate to their job role This meant that they had the skills and knowledge to meet people's needs.

People were provided with choice at meal times and the dining experience had improved.

People had regular access to healthcare professionals as need dictated, such as GP's, district nurses and Speech and Language Therapist (SALT).

The registered manager and staff had a good understanding of the Mental Capacity Act 2005 and Deprivations of Liberties (DoLS) and they understood their responsibilities.

Is the service caring?

Good

People told us they were happy with the care and support they received and their needs had been met.

It was clear from our observations and from speaking with staff they had a good understanding of people's care and support needs and knew the people they cared for well.

Wherever possible, people were involved in making decisions about their care and independence was promoted. We saw people's privacy and dignity was respected by staff.

Is the service responsive?

Good

People's care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative.

We saw people's plans had been updated regularly and when there were any changes in their care and support needs.

The service had a complaints policy. Since our last inspection the service had received seven complaints these were all handled appropriately with good outcomes and lessons learnt.

People were supported to access the community. On the day of inspection people enjoyed a Christmas lunch at the local pub.

Is the service well-led?

Good

From our observations and speaking with people who used the service, staff and relatives we found the culture within the service was becoming open and inclusive.

Summary of findings

The peripatetic manager had placed a focus on improving the service, and to deliver high level person centred care that incorporated the values expected by the provider.

A process was in place for managing accidents and incidents. The peripatetic manager reviewed all accidents and incidents in order to look for any emerging themes or patterns. The peripatetic manager also carried out audits to assess and monitor the quality of the service.

Eastbourne Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 the 10th and 16th December 2014 and was unannounced.

The inspection team consisted of one adult social care inspector 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 expert by experience had experience in caring for older people.

Before our inspection, we reviewed the information we held about the home and also had regular contact with the commissioners of the service. We looked at notifications that had been submitted by the home. We reviewed the action plan the service had submitted after the last inspection. This information was reviewed and used to assist with our inspection. We also attended a relative/ resident meeting.

During the visit we spoke with 12 people who used the service, seven relatives, the regional operations director, the peripatetic manager and nine members of staff. We undertook general observations and reviewed relevant records. These included four people's care records, four staff files, audits and other relevant information such as policies and procedures. We looked round the home and saw some people's bedrooms, bathrooms, the kitchen and communal areas.

Good

Is the service safe?

Our findings

At our last inspection we had concerns about the safety of people who used the service due to staff attitudes. At this inspection all the people we spoke with who used the service said they now felt safe. People said, "I would say if there are any concerns but the problem nurse has left now." "The staff are lovely they are very kind to us" And "I am happy here."

Relatives we spoke with said, "She is well looked after I wouldn't want her anywhere else." And "The home is making extreme efforts to improve"

From our observations, staff were taking steps to ensure people living at the service were safe. We spoke with staff about safeguarding and the steps they would take if they felt they witnessed abuse. We asked staff to tell us about their understanding of the safeguarding process. Staff gave us appropriate responses and told us they would report any incident to the person in charge and they knew how to take it further if need be. Staff we spoke with were able to describe how they would ensure the welfare of vulnerable people was protected through the organisation's whistle blowing and safeguarding procedures.

There were risk assessments in place, supported by plans which detailed what might trigger each person's behaviour, what behaviour the person may display and how staff should respond to this. For example one person shouts for help if distressed and the care file documented what steps to take if this happened. This meant people were protected against the risk of harm because the provider had suitable arrangements in place.

We looked at staffing levels and each day they had two nurses, one senior carer and six carers on duty. The service used a dependency tool which worked out how many staff should be on duty at any one time. The regional director said they always put more staff on than the dependency tool says. There was a mixed reaction as to whether there was enough staff on duty. Staff we spoke with said, "There are not enough staff, we are rushing to do tasks and therefore have no interaction with the residents." "We do not have time to spend with people on a one to one basis." "Staffing levels have improved, we have a lot more experienced staff, the only thing that lets us down is sickness." And "We now have enough staff." All relatives we spoke with said there was not enough staff on duty, comments made were, "there are never enough," And "There are not enough staff, they all have varying needs and the bells go all the time and there are only 2 staff on" Another relative said, ""Generally there are enough staff, but if there are hospital visits or sickness that has an effect but I am happy the way she is cared for"

On the first day of our inspection we spoke to one person who used the service, they said they were desperate to use the toilet and had been waiting for about ten minutes. We asked staff why this person had to wait so long and we were told they only had one hoist as the other hoist was waiting for a part. We discussed this with the regional operations director and the peripatetic manager; they were not aware of this problem and quickly rectified it by moving a hoist from downstairs that was never used to upstairs. We saw this working on our second day of inspection.

We looked at the recruitment records for four staff members. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. We saw evidence to show they had attended an interview, had given reference information and confirmed a Disclosure and Barring Service (DBS) check had been completed before they started work in the home, (The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults). Concerns were raised at the previous inspection about induction training for new staff, they were only provided with one day induction and were then on the floor and part of the team compliment. New staff were now fully trained in common induction standards and did four days induction. One relative we spoke with said, "I have noticed they have employed older staff, this is really, really good, they want to be here."

The peripatetic manager said they were going through the recruitment process for a new senior carer.

During our discussions with the peripatetic manager we asked what would happen if the building needed to be evacuated in the event of an emergency such as a fire. The peripatetic manager showed us the Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to

Good

Is the service safe?

evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEP's were all individually personalised to each person who used the service.

We looked through the medication administration records (MARs) and it was clear all medicines had been administered and recorded correctly, with full explanations if they had refused. We did see a few missing signatures which we highlighted to the regional operations director and the peripatetic manager.

The medicine trolley was stored safely when not in use and the temperature was checked and recorded daily. Although there were some gaps in the recording of temperatures. We looked at the storage and administration of drugs liable to misuse called controlled drugs. We saw these were stored and recorded safely. The services ordering procedure allowed plenty of time to sort out any discrepancies before the prescriptions went to the pharmacy.

We looked at the early morning rack of medicines and saw that dividers were missing to separate one person's medicines from another; some dividers that were in place did not have the person's name on. We discussed this with the regional operations director and the potential for error, they said they were experiencing issues with their current pharmacy supplier and were arranging a meeting to discuss this. They also planned to contact the pharmacy for dividers and name labels.

The service had protocols for when required medicines (PRN) and these were individual to each person, explaining why and how each PRN should be administered.

Medicine training was up to date and the peripatetic manager now checked people's competency to administer medicines every year.

We spent time looking around the service and found the service to be comfortable and furnished to meet the needs of people who used the service. Bedrooms were individualised to how each person wanted them and everyone had now been offered their own key. Some people's rooms were also starting to be decorated for Christmas. One person who used the service was keen for their tree to be put up and decorated in their room. We went back to see it after the carer had finished and they jokingly said they thought it would have been at least 8ft.

The service was clean and tidy. We saw there was plenty of personal protection equipment (PPE) such as gloves and aprons. Staff we spoke to confirmed they always had enough PPE. One member of staff said they were finding it difficult to order due to budgets. The service had recently had an infection prevention and control audit, with positive results.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced such as boiler safety and water temperature checks.

Good

Is the service effective?

Our findings

People were now supported by staff that was trained to deliver care safely and to an appropriate standard. Staff had a programme of training, supervision and appraisal. Staff we spoke with felt they had received the training they required. One staff member said, "I am open to all training but I am not keen on e-learning, I feel it is just sitting and listening, I prefer interaction." Another staff member said, "I have asked to do my level 3, I am really looking forward to that."

Relatives we spoke with said, "The staff know how to care for my relative" "Most know what they are doing but there is a language barrier, some need support." And "They do not always understand my relative"

All training was up to date; we saw evidence of this on the training matrix and backed up with certificates. Training staff had received included end of life, venepuncture and emotional piggy banking. We were told the emotional piggy bank training centres on the 'Emotional Bank' of the people who used the service, therefore how the actions and words of staff can make the person using the service feel. It puts staff in the shoes of the person who used the service so that they can experience and think about how they would feel. Staff we spoke with confirmed that they had access to further training as required.

We found staff received good support through supervision. Topics discussed during supervision were policies, performance, training needs, attitude and professionalism. Group supervisions also took place where topics discussed were feedback from any recent strategy meetings, CQC reports, whistleblowing, infection control, dignity, breaks, care plans, team work and moving the home forward. The peripatetic manager had also planned in yearly appraisals for all staff.

We observed a lunch time and the expert by experience ate with the residents, their comment was, "The main course was acceptable but the pudding was not good, tinned apples and paper thin pastry." People were offered choice and supported where needed. One staff member did not seem to know how to communicate with the residents; we passed this observation onto the peripatetic manager. The majority of the people we spoke with said the food was fine, one person said "it is nice." One relative said "The food seems okay."

The layout of the dining room had changed since our last inspection and rather than one long table they had split the room into five smaller tables, making the dining experience more pleasurable.

We observed one person who stayed in their room, of their own choice, and ate their meals in there. We saw they were not eating much. A carer offered an alternative but they refused. We looked in this persons care file and it stated they preferred small meals. The meal we observed was quite large. We passed on this observation to the peripatetic manager and suggested they may need more support during meal times.

The peripatetic manager stated they had recently carried out a food survey and the main feedback from this was the presentation of the food. They had worked on rectifying this.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. We recognised care plans had improved since out last inspection, although still a lot of work to make them more person centred. Person-centred care sees people who use the service as equal partners in planning, developing and assessing care to make sure it is most appropriate for their needs. It involves putting people at the heart of all decisions. We discussed this with the operations director and they said, "New care plans have been trialled at one of our other homes and are about to be rolled out to all homes, they are such an improvement on the care plans we have at present."

One person who we raised concerns about during our last inspection had been reassessed. At the last inspection this person was on a soft diet but was provided with biscuits. At this inspection we saw that the Speech and Language Therapy (SALT) team had been out to reassess and although they still wanted this person on a soft diet they recognised their love for biscuits and this person's quality of life. This was all included in their care plan.

The peripatetic manager demonstrated a good understanding of the Mental Capacity Act (2005). In discussion with staff, we found they were clear about the principles and their responsibilities in accordance with the Mental Capacity Act (2005). The Mental Capacity Act (2005) protects people who lack capacity to make a decision for themselves because of permanent or temporary problems

Good

Is the service effective?

such as mental illness, brain impairment or a learning disability. If a person lacks the capacity to make a decision for themselves, the decision must be made in their best interests.

The staff we spoke with were aware of the Mental Capacity Act (2005) and had recently received training on this and Deprivation of Liberty Safeguards (DoLS).

We asked staff why one of the people who used the service was offered a shower, rather than the bath they preferred. Staff explained that the bath hoist did not support this person correctly and it would put them at risk to use it. We discussed this with the regional operations director who said they would look into having the hoist adapted as a priority for this person.

Good

Is the service caring?

Our findings

We observed and chatted to people in the communal areas and in their own rooms. We asked people who used the service if they thought staff were caring, they said, "Yes they treat me well they are wonderful" And "Yes there are lots of laughs." We asked if staff understood their needs and they said, ""Yes I am sure they do, the bullies have left" "I think so or I tell them, I keep my own journal" "The staff are interested in what I do." And "Yes I feel they listen to me."

Relatives we spoke with said "The care is really good, it is fantastic caring." And "It has improved a bit, a way to go yet, I discuss her care with the staff" When asked if care was appropriate she said: "Very much so, the staff discuss it in detail to meet everyone's wishes." Another relative said, "It's getting better slowly, it now feels like the right staff are here who want to be here." And "X (carer) is amazing, so much better since they have come back, they reassure and make a difference to me." And "I am thrilled X (carer) is back, I now leave happy."

Relatives raised concerns about the attitude of night staff and them not always being visible. We raised these concerns with the regional operations director and peripatetic manager. They said they would take action to look into this.

Staff we spoke with said, "I love this place, I love the residents ,they come first and we have to provide for them." And "People should be happy, if they are not happy, I am not happy." Another staff member said, "I have seen a lot of changes, we are like one big family now."

We observed the care between staff and people who used the service. People were treated with kindness and compassion. Staff were attentive and interacted well with people. We watched people being hoisted and each step was explained to the person, there was lots of laughing and joking. The staff said they also had been hoisted as part of their training. One staff member said, "It made me realise what it is like to be in their shoes and how scary hoisting can be if not done or explained properly."

At the time of the inspection there were 20 people who used the service upstairs and 15 people on RIACT. RIACT is the name for Intermediate Care services, where local health and social care services work together to support people with short term rehabilitation or recovery needs. During our visit we reviewed the care records of four people. Each person had an assessment, which highlighted their needs. Following assessment, care plans had been developed. Care records reviewed were starting to contain information about the person's likes, dislikes and personal choices. This helped to ensure that the care and treatment needs of people who used the service were delivered in the way they wanted them to be.

People were supported to be involved in their care as much as they were able or wanted to. Only one person we spoke with wanted to be involved in their care planning but all said that things were explained to them.

At a recent resident/relative meeting, the peripatetic manager asked the relatives to be involved in the care planning especially the life history part. We discussed this with one relative who was really keen to get involved, they asked where the care plans were stored, at that time we were not sure but said they may be in the manager's office downstairs. The relative looked concerned that they may have to go to the office and said they did not like to go in there and were also not sure who the manager was. We discussed this with the peripatetic manager and they agreed the office does not lend itself to being welcoming and is hidden. They have since made plans to move the office to the front of the building in the new year, this will make it more visual and hopefully more inviting for people to enter.

We since learned that the care files were locked in the nurses/carers office upstairs.

We saw the services advocacy policy and information on advocates was on the notice board if and when needed.

We asked staff how they promote privacy and dignity. Staff explained they always knock on doors before entering. On the afternoon of our second day of inspection, new carpet was being laid in the communal lounge. We observed that people who preferred to stay in their rooms near the lounge had their door closed during this operation.

Generally the environment supported people's privacy and dignity. All bedrooms doors were lockable and people were now being asked if they wanted a key. One person had refused stating, "No I don't want a key, I leave my room and come back and it is all lovely and clean and tidy, why would I want to lock it."

Good

Is the service caring?

There were policies and procedures in place to make sure staff understood how to respect people's privacy, dignity and human rights in the care setting.

People were encouraged and supported to maintain and build relationships with their friends and family. There were no restrictions placed on visitors to the home.

Good

Is the service responsive?

Our findings

We saw that people's needs were now regularly assessed and reviews of their care and support were going to be held annually or more frequently if necessary.

The home had recently employed an activity coordinator and this person was having a real positive effect on people. A range of activities were provided both in-house and in the community. We saw people were involved and consulted about all aspects of the service including what improvements they would like to see and suggestions for activities. People who used the service said, "I love it here it is a laugh a day."

They had arranged for the local church to come in and sing carols. They were trying to arrange for the local primary school to also come in and sing carols. On the second day of our inspection people and relatives who wanted to, went out for a Christmas lunch at the local pub. Everyone was in high spirits when they returned saying how much fun they had. The activity coordinator said the staff at the pub were so helpful and kind, that they have now agreed to use this venue more often. The activity coordinator had also arranged for Santa to come for tea on Christmas day, people who used the service were excited about this.

We could see that the activity coordinator had already found out peoples likes, dislikes, hobbies etc. and found out one person loved flower arranging. It was arranged that this person would help make the Christmas table decorations and show others who were interested how to do them. During our inspection in August, people were just left alone and were quiet, now we saw there was fun, laughter and singing throughout the day.

One staff member said, "Since X (activity coordinator) came everyone is a lot brighter, they are so cheerful."

One person had recently been on holiday abroad and told us all about it saying, "I had a lovely time, it was hot and the flight was fun."

We did see some people were still sitting alone in their rooms, one person said it is their choice and they preferred this, another said they would like to join in but when offered this person refused.

One staff member we spoke with recognised that if people go for a hospital visit, they can be there for quite some time, they have now arranged for each person to take a sandwich bag with them.

We looked at the most recent complaints the service had received, they had received seven since our last inspection. We found the peripatetic manager took steps to ensure the service learnt from mistakes, incidents and complaints. People who used the service said. "I say if there are any concerns but the problem nurse has left now." None of the residents had had any complaints about the standard of care, "They are pretty good in fact very good I have no complaints."

Complaints received included not receiving the morning newspaper, agency staff being sharp and dentures going missing. The peripatetic manager said they no longer used agency staff and the dentures that went missing they knew about and were trying to sort before the complaint came in.

A complaint we received during our last inspection was that clothes were going missing, since then the laundry had been given an extra hour a day to put clothes away. The laundry staff said, "I now put peoples clothes away, I know who the clothes belong to. I enjoy doing it and get chance to chat to the residents and feel like part of the home."

Since the concerns raised from our last inspection the service had since held two resident/relatives meetings. The CQC inspector attended the most recent one. The topics discussed were staffing and recruitment, the registered manager, senior role development, environmental issues including a recent positive infection control audit and purchases, care documentation/relative involvement, the complaints procedure, staff training and communication issues. There was an extremely good turnout for the meeting and when asked if people could see improvements and change to the service one person said no and three people said yes.

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a peripatetic manager in place; this person had been registered with the Care Quality Commission at another of the company's services and was in the process of transferring their registration. A peripatetic manager works with the operations team to manage a home without a permanent manager. The service had no deputy manager in place.

The peripatetic manager made sure they kept up to date with current practice and research. For example, they were fully aware of the recent supreme court ruling regarding Deprivation of Liberty safeguards.

There was a system of audits that were completed daily, weekly and monthly which included infection control, medicines, mealtimes, health and safety, care planning and safeguarding. Where an issue had been identified an action plan had been implemented and the person responsible for completing the task had been identified plus when the task needed to be completed by. This assured us the quality assurance system was effective because it continuously identified and promoted any areas for improvement.

The regional operations director also carried out quality monitoring visits. During these visits there checks included care files, room files, health and safety and finance.

We asked residents and relatives about the management of the home. They did recognise an improvement since the new peripatetic manager came to Eastbourne. One relative said, "It's alright and I am happy to speak out, 2/3 months ago I came in at 8pm there was no one on duty upstairs, they were all downstairs. When I went down to speak to them the staff just answered back unpleasantly." We asked if the peripatetic manager was open & honest and they said:

"Yes they are because I demand it."

We saw evidence that staff meetings are now taking place regularly, since our last inspection in August 2014 there had been two meetings. The topics discussed included new roles, care documentation and medication.

Staff we spoke with said, "I feel listened to and supported now, I see a difference since the new peripatetic manager came." "I not get much more support from the management team." And "There is much more structure to the workload, we work as a team, the atmosphere is fantastic at present, residents and staff are great."

Since the activity coordinator joined the team the peripatetic manager explained that they are building links with the community. They said, "X has established links with Age UK and our residents will be attending events and engaging in fundraising opportunities with them, they have also established links with St Herbert's Church who will offering the opportunity to attend services the church will be visiting us weekly to offer communion." And "Heathfield Primary School who are also coming in to sing carols over Christmas."

The peripatetic manager told us about a wish tree they were putting in place, staff, residents and relatives could place a wish on the tree and give a donation, the donation would go into the activity fund.

We saw evidence of a staff survey that was completed in September 2014. A lot of comments have been acted upon such as employing more experienced staff and the need for more training. One staff member said they have not received any feedback from this survey. We passed these comments onto the peripatetic manager.

A process was in place for managing accidents and incidents. The peripatetic manager reviewed all accidents and incidents in order to look for any emerging themes or patterns.

The peripatetic manager had placed a focus on improving the service, and to deliver high level person centred care that incorporated the values expected by the provider. The peripatetic manager said they were about to do a relative and resident survey and they were also going to continue with the resident and relative meetings, to seek the views of people who used the service.