

Sanctuary Care Limited

Shaftesbury House Residential Care Home

Inspection report

5 Cowper Street
Ipswich
Suffolk
IP4 5JD

Tel: 01473271987

Website: www.sanctuary-care.co.uk/care-homes-east-and-south-east/shaftesbury-house-residential-care-home

Date of inspection visit:
30 January 2019

Date of publication:
15 March 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Shaftesbury House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. This service does not provide nursing care. Shaftesbury House Residential Care Home accommodates up to 28 older people in one adapted building. During our comprehensive unannounced inspection of 30 January 2019, there were 23 people using the service, some living with dementia.

At our previous inspection of 27 November 2017, this service was rated requires improvement overall. The key questions safe, effective, responsive and well-led were rated requires improvement and the key question caring was rated good. There was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service wrote to us to tell us what improvements they had implemented to meet the requirements of Regulation 12.

At this inspection of 30 January 2019, we found that the service had made some improvements, but we found further shortfalls during our inspection. The service continued to be rated requires improvement overall and in safe, responsive and well-led. The rating of good had been sustained in caring and improvements had been made in effective which was now rated good. The service was no longer in breach of Regulation 12.

There was a registered manager in place. 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.

There had been changes in the management team for the service. There was a programme of audits which assessed and monitored the service provided. However, whilst some improvements had been made since our last inspection, further improvements were needed.

Improvements had been made in how risks of pressure ulcers developing were assessed and staff were guided how to reduce these risks. However, risks associated with choking were not robustly assessed and reduced.

There were systems in place designed to safeguarding people from abuse, however, we had received a concern from a person which had not been appropriately acted upon. This was addressed swiftly by the registered manager when we had reported what we had been told.

Improvements were needed in how people's care was planned for and met. People's choices were not always documented about how they wanted to be cared for at the end of their life.

People's had access to social activities to reduce the risks of isolation and boredom. However, there was limited information about the one to one time provided to people when they chose to spend their time in their bedrooms.

People were provided with their medicines when they needed them. There were systems in place to manage people's medicines safely. Improvements were ongoing in how the staff recorded how people were provided with medicines prescribed to be administered externally, including creams.

There were systems to ensure that there were sufficient numbers of care staff to meet people's needs. Staff recruitment processes reduced the risks of staff being employed in the service who were not suitable. Staff were provided with training to meet people's needs. Improvements had been made in the provision of one to one supervision meetings for staff.

There were infection control systems to reduce the risk of cross contamination. The environment was well maintained and suitable for the people using the service.

People had access to health professionals when needed. Staff worked with other professionals involved in people's care. Improvements had been made in how the service monitored how much people had to eat and drink.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People shared positive relationships with staff. People's privacy, independence and dignity was respected. People were listened to in relation to their choices about how they wanted to be cared for. People were asked for their views about the service and these were valued and listened to.

There was a complaints procedure in place and people's complaints were addressed.

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 consistently safe.

Risks to people were assessed, but systems to reduce the risks of a person choking needed to be improved. There were systems in place designed to safeguarding people from abuse.

The staffing levels were assessed to provide people with the care and support they needed. Recruitment of staff was done safely.

There were systems in place to manage people's medicines safely.

Infection control processes reduced the risks to people of cross contamination.

Is the service effective?

Good 

The service was effective.

Staff received training in how to meet people's needs. Improvements had been made in staff supervision meetings.

Improvements had been made in how the service monitored people had enough to eat and drink.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

The Deprivation of Liberty Safeguards (DoLS) referrals had been made appropriately. People's capacity to make their own decisions was assessed.

The environment was suitable for the people who used the service.

Is the service caring?

Good 

The service was caring.

People's privacy and dignity was respected.

Staff treated with people with kindness and they knew people well. Staff and people shared positive relationships.

People's choices were respected and listened to.

Is the service responsive?

The service was not consistently responsive.

Improvements were needed in how people's care plans to show how their needs were planned for and met. People's end of life decisions were not always documented.

There were systems in place to support people to participate in social activities. There was limited interaction recorded for those people who chose to stay in their bedrooms.

There was a system in place to manage people's complaints.

Requires Improvement



Is the service well-led?

The service was not consistently well-led.

The service had quality assurance systems to identify shortfalls. However, whilst some improvements had been made since our last inspection, there were still improvements needed.

People were asked for their views about the service and these were used to improve the service.

Requires Improvement



Shaftesbury House Residential 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 was an unannounced comprehensive inspection on 30 January 2019. The inspection was undertaken by one 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.

We reviewed the Provider Information Return (PIR) which was sent to us. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with nine people who used the service and five relatives. We observed the interaction between people who used the service and the staff throughout our inspection.

We looked at records in relation to four people's care. We spoke with the quality support manager, the regional manager, a peripatetic manager, and a registered manager from another of the provider's services. We also spoke with five members of staff, including care, catering, activities, maintenance and domestic staff. We looked at records relating to the management of the service, recruitment monitoring records, and systems for monitoring the quality of the service.

Is the service safe?

Our findings

At our previous inspection of 27 November 2017, the rating for this key question was requires improvement. There was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have robust systems to identify when people were at risk of avoidable harm, including pressure ulcers. Improvements were needed in how the staff evidenced that people had received their medicines which were prescribed to administer externally, such as creams.

At this inspection of 30 January 2019, we found that some improvements had been made and were ongoing. However, further improvements were needed. There was no longer a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people told us that they were safe living in the service. One person commented, "I feel very safe here." One person's relative said, "My [family member] is very safe in here. Ten out of ten." However, one person told us that they had personal items missing from their bedroom. The peripatetic manager agreed that they would follow this up and feedback their findings. Following our inspection visit, the registered manager contacted us. The allegation was made in December 2018, which had not been followed up and no safeguarding referral had been made. The registered manager had now acted on this, including speaking with the safeguarding team and reporting it to the police. We were notified of other incidents appropriately which had been reported as a result of people's allegations and the service had raised referrals with the local authority safeguarding team as required.

People's care plans held risk assessments, including risk associated with mobility, pressure ulcers and falls. The documents included the level of risk however, not all of these included information, or associated care plans of how the assessed risks were reduced. One person's records identified that they were at risk of choking. Information about how to reduce the risks and guidance from other professionals was inconsistently recorded and not always incorporated into the care plans. This made them difficult to follow and was a risk of the person receiving unsafe care. We showed the regional manager and the quality support manager what we had found and they agreed that the records were not clear enough to guide staff how to mitigate the risks associated with choking. The quality support manager told us that all of the staff understood the person's needs, which was confirmed in our observations. We observed that when the person was being assisted to eat their lunch by a staff member, they were sat up in their bed and they were provided with a softer diet and thickened fluids. This demonstrated that staff were aware of the support required, which reduced the risks to the person.

Improvements had been made where people were at risk of developing pressure ulcers. The care plans included information from manufacturers in pressure relief equipment, which included the suggested settings for mattresses and how staff were to check people were appropriately being supported. Where risks were identified support and guidance was sought from health professionals and pressure relief equipment was used. We reviewed records when people required support to move position and found that these were completed in line with the recommended times.

One person's care records included a diabetes care plan which identified the risks associated with their condition and the warning signs staff should be aware of if they were becoming unwell. Records of falls were kept and analysed to identify any patterns. People's care records included how the risks of falls were reduced.

Risks to people injuring themselves or others were limited because equipment, including hoists, and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. Since our last inspection the personal evacuation plans had improved. These were in place for each person and detailed the information that staff should be aware of in the support that people needed should the service need evacuating.

Improvements were ongoing in how the staff recorded when people had received their medicines to be administered externally, such as creams. The medicines administration records (MAR) for other medicines to be taken orally, also identified that people received their medicines when they needed them. Medicines audits were regularly undertaken and these were used to identify any shortfalls and address them. For some people who were prescribed medicines to be taken 'as required', protocols were in place to identify when these should be administered. However, they would benefit from having more detail to reduce the risks of inappropriate administration. For example, where people were prescribed pain relief, the protocols stated they were 'for pain' but there was no information to identify where on the body the pain was.

We received mixed comments from people about if there were enough staff who were available when they needed them. Some people told us that there were enough staff and their requests for assistance were attended to promptly and some people told us that they had to wait. One person commented, "I sometimes ring the [call bell]. They come when they can. They help me when they come." Another person told us, "Yes they come when they can. I am happy with their response." One person's relative said, "Sometimes the [call bell] is not responded to very promptly. This is a regular occurrence...staff respond when they can. Not always promptly." During our inspection we saw that people had their call bells to hand, in case they needed to call for staff for assistance. Call bells were answered promptly. Regular call bell audits were undertaken. If call bells were found to take time to respond to, this was investigated and actions taken. A tool was used which assisted the management team to calculate the numbers of staff needed to meet people's dependency needs. Agency staff had been used to cover any staff vacancies. Recruitment of staff was ongoing. Therefore, there were systems in place to support people with sufficient numbers of staff.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. We saw a document which had been developed to assist the management team to monitor the recruitment records. This listed all of the staff working in the service and when the checks had been made and feedback received. This included references and Disclosure and Barring Service (DBS) checks, which flagged up if an individual had been convicted of a crime or was not suitable for working in the service.

The service was visibly clean. Infection control audits were carried out to enable the management team to identify any shortfalls and actions needed to improve. Staff had received training in infection control and food hygiene. The service had achieved the highest rating in their food hygiene inspection by the local authority. There were disposable gloves and aprons that staff could use, such as when supporting people with their personal care needs, to reduce the risks of cross contamination. These were available throughout the service to allow access. In addition, bathrooms provided disposable paper towels and hand wash to use to reduce the risks of cross contamination.

Is the service effective?

Our findings

At our previous inspection of 27 November 2017, the rating for this key question was requires improvement. Improvements were needed in how the service monitored how much people had to eat and drink. Staff were not being provided with supervision as stated in the provider's own policies. At this inspection of 30 January 2019, we found that improvements had been made in the provision of one to one staff supervision meetings and the monitoring if people had enough to eat and drink. People were provided with an effective service.

We received concerns from a person's relative about inappropriate and unsafe moving and handling techniques which had been used when assisting people. We reported this to the peripatetic manager and asked them to investigate and feedback their findings to us. Following our inspection visit, the registered manager told us that they had acted to reduce the risks to people. This included assessing moving and handling techniques, and the provision of more training. The registered manager intended to carry out observations of moving and handling practices, the subject would form part of discussions in one to one and daily meetings and had been covered in a staff meeting. We were assured that swift action had been taken to reduce the risks to people.

Staff told us that they received the training that they needed to meet people's needs, which was confirmed in records. This included training in medicines, dementia, dignity, basic life support, fluids and nutrition, fire, health and safety, equality and diversity and moving and handling. Notices in the service identified that staff were advised to update their training when required. There were also notices of upcoming training including moving and handling, engaging people with dementia and end of life planning. New staff received an induction course which included training and shadowing more experienced colleagues. Since our last inspection improvements had been made and staff were now receiving regular one to one supervision meetings. These provided staff with a forum to discuss the ways that they worked, receive feedback, identify ways to improve their practice and any training needs they had.

People's care needs were assessed holistically. This included their physical, mental and social needs. The assessment process was completed prior to the person moving into the service. This included visiting them at their own home, other care service or in hospital to discuss their needs. This assisted a smooth transition between services.

People told us that they were provided with a choice of good quality meals. One person said, "Very, very good. The food is excellent." One person's relative said about the food, "It is excellent." During meals, breakfast and lunch, we saw that people were offered choices of what to eat and what was served on their plate. People were shown the food on offer to help them make a choice of what they wanted. Staff offered encouragement to eat and staff were available to assist those that needed help. Lunch was a social and unrushed occasion. People were offered drinks with their meal, including alcoholic drinks of their choice. As well as the main meal menu choices, there was a menu of night bites, which people could request including items such as sandwiches, beans on toast and fresh fruit.

Improvements had been made in how the service assessed how much people had to eat and drink. Targets

for how much people should have to drink were in place and the system calculated the amount, flagging up if people had not had the recommended amount. If issues arose this was monitored and discussed in handover to ensure people were supported to have enough drink and eat. Where there were concerns that people were at risk of malnutrition or dehydration, guidance and support was sought from health professionals. We spoke with a member of the catering staff who understood people's specific dietary needs and how they were met. This included people who required a softer diet and those who needed a fortified diet and drinks to boost their calories and maintain a healthy weight.

People told us they felt that their health needs were met and they were supported to see health professionals if needed. One person's relative commented, "I have requested the doctor come and see my [family member]." Records showed that where there had been concerns about a person's health, they were referred to health professionals and any advice and treatment was recorded.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. People told us that the staff sought their consent before providing any care, which was confirmed in our observations. People's care records included if they had capacity to make their own decisions. If people lacked capacity there were systems in place to assist them. There were records of best interest decisions in place, where required. Training records identified that staff had received training in the MCA and DoLS.

People were complimentary about the environment and how it met their needs and choices. One person said, "I like my room." One person's relative said, "Maintenance jobs have taken ages recently because there has not been a maintenance worker." However, at our inspection we saw that this had been addressed and there was a new maintenance staff member working in the service. People's bedrooms included items of their personal memorabilia which reflected their choices and individuality. The ground floor communal areas had been refurbished. The lounge/dining area had been extended and provided a more open space for people to relax in. There was also an existing conservatory that people could use. There had previously been a communal toilet with access from the lounge, this had been removed ensuring people's privacy. One person told us about the refurbishment and decorations of the communal areas, "It looks very nice, can you see the difference?" One person's relative commented, "The home has recently been redecorated and is now warm welcoming and fresh and clean." There were areas in the service where people could see their visitors in private. On the first floor there was a quiet room which people could use and drinks making facilities were in place for visitors to make drinks.

The facilities were designed and adapted for use by people with limited mobility and users of wheelchairs, including wide doors, which supported people to get around using mobility equipment. Toilets and bathroom doors held signage to assist people to recognise where the doors led to. People's bedrooms had a box at the outside of the door with a photograph or picture that the person could recognise as the door to their bedroom. There was a small garden which people could use in the better weather.

Is the service caring?

Our findings

At our previous inspection of 27 November 2017, the rating for this key question was good. At this inspection of 30 January 2019 people continued to receive a caring service.

People spoken with said that the staff were caring. One person said, "The staff are very good." Another person commented, "I love them, they are like my family." One person's relative commented, "The staff are very attentive. They are very kind to [family member] and are genuinely very fond of [family member]. This place is very welcoming. This feels like a happy place to live and work."

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Staff talked about and with people in a caring and respectful way. This included positioning themselves at people's eye level to engage in effective communication and it was clear they knew people well. We saw some examples of caring interactions, one person had an alcoholic drink with their lunch, a staff member said, "I hope you are not sloshed after that." This caused the person to laugh out loud. A person became distressed when speaking with us, the peripatetic manager spoke with the person and reassured them. They spoke with the person at their eye level and held their hand when they spoke with them. One staff member who had recently started working in the service told us that they had noted that the staff were very caring.

People's care plans guided staff to ensure people's privacy, independence and dignity was respected. This was confirmed in our observations, people were encouraged to do things for themselves, with staff offering support when required.

People told us that they felt their privacy was respected, including that staff spoke with them about any personal issues in the privacy of their bedrooms. We observed this happening throughout our inspection which demonstrated how people's privacy was respected.

People told us that they made choices about their daily lives and the staff acted in accordance with their wishes. People's care records identified that people's views were respected and used when planning their care and support. This included people's choices about how they wanted to be cared for.

People told us that they could have visitors when they wanted them, which reduced the risks of isolation and loneliness. Records included information about the relationships that people maintained which were important to them.

Is the service responsive?

Our findings

At our previous inspection of 27 November 2017, the rating for this key question was requires improvement. Improvements were needed in how people's care was assessed, planned for and met. At this inspection of 30 January 2019, we found that sufficient improvements had not been made to ensure that the records were consistent and evidenced that people received person centred care. The quality support manager told us that they and the registered manager were working to improve the care plans, this was not yet fully implemented. People's end of life care was not consistently recorded.

We reviewed the care plans of four people who used the service, none were written in a person centred way and none detailed how the tasks identified to support the person would have positive outcomes for people using the service. All required improvement in detail and the language used. For example, one record stated that the person was 'bed bound' another stated that the person was 'suffering with dementia'. These were not up to date terms.

One person's records included information that they sometimes used a language other than English to communicate and there was a staff member who worked in the service who could speak this language. There was no information about what happened when this staff member was not at work or any information to show that staff had been supported to communicate with the person, such as specific words including drink, food, pain, yes and no, which would support the person in their communication. In the communication section of the care plan it stated that staff were to communicate with the person to ensure they were not isolated. In the profile section of the records it stated that the person's communication was 'very poor'.

Another person's care records identified that they had a health condition, however there was limited information about how their condition affected their daily life and how the staff were to identify when the person's condition progressed.

The ways that people's end of life decisions were recorded were inconsistent across the four care plans which we reviewed. All the care plans included information about people's decisions if they wanted to be resuscitated. One person's records who was identified as receiving end of life care did not have an end of life care plan in place which identified the person's wishes, and the specific support required for palliative care. The second care plan stated that the person did not want to discuss this and the third had an uncompleted end of life care plan. The fourth care record reviewed included the person's decisions about the care they wanted to receive at the end of their life, for example, where they wanted to be cared for, specific choices relating to their care at the end of their life and any arrangements they had made for their funerals. We saw a notice in the service which stated that end of life planning training was booked for March 2019.

Daily records included the tasks of care delivered but not about the person's wellbeing. For example, "[Person] had a full body wash and has been repositioned, drink given," and, "[Person] was asleep at start of the shift, repositioned and pad changed." We saw staff spending time with people in their bedrooms, and the quality support manager told us this was usual practice. This was not included in the daily records, such

as if this had a positive impact on their wellbeing and how they had spent this time. There was limited information to show how people had received meaningful interaction on a one to one basis and when they chose to spend their time in their bedrooms. There was time set aside on Friday for the activities staff member to spend one to one time with people and this was recorded. The service operated a resident of the day system, which would be usually one day each month for each person. This included reviewing people's care plans with them, and for example having their bedroom deep cleaned, asking if they needed anything doing in their bedroom and any specific activities they wanted to do. The service had missed the opportunity to identify and evidence the meaningful activity spent with people from the care staff to show that they were not left alone in their bedrooms for long periods of time with no interaction.

People told us that they felt that they were cared for and their needs were met. One person said, "I am very happy living here." We talked with another person about the reasons for our presence and they said, "Do you approve? I am sure you will, it is very nice." One person's relative commented, "I am generally happy with this care home. It works well for my [family member] and our family."

People's comments about the activities provided varied. One person told us, "There is always something to do." One person's relative said, "I would like my [family member] to have more activities in the day so [family member] is less bored with life." Another person's relative told us, "Why are they doing all those games, normally it lasts about 30 minutes and then it is over."

Since our last inspection there was a new activities coordinator in place. They were working on developing their role and looking at how activities could be improved for people. We observed people participating on group activities. During the morning of our inspection, five people were in the communal areas, four participated in the activities. These included giant snakes and ladders, hang man and a card game. There was lots of laughter from the people participating. In the afternoon, five people played bingo which had prizes. All the people playing told us that they were enjoying their game. There was a programme of activities displayed in the service. There was a notice telling people about bingo at a local pub, however, there was no date on this.

We received mixed feedback from people and relatives about if they knew how to make a complaint and were confident that their concerns and complaints would be addressed. Some people said they knew how to raise a complaint and felt listened to whilst others said they did not know how to complain and one said that they felt they were not listened to. One person's relative commented, "Things that I have raised have all been resolved by the home very promptly." Another person's relative told us, "They always listen to my concerns. They try to react to my concerns. However there have been so many managers recently that very few of my concerns have been resolved." There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. This was displayed in the service so people were aware. Records showed that people's complaints and concerns were investigated and responded to in line with the provider's complaints procedure.

Is the service well-led?

Our findings

At our previous inspection of 27 November 2017, the rating for this key question was requires improvement. The systems for monitoring the service were not robust enough to independently identify shortfalls and to support the provider and management team to continually improve the service people received.

At this inspection of 30 January 2019, we found some improvements had been made including the recording of when people had received their medicines to be administered externally, including creams, staff were receiving one to one supervision meetings, managing risks associated with people developing pressure ulcers and monitoring of how much people had to eat and drink. However, people's care plans had not been sufficiently improved since our last inspection, people's end of life decisions were not consistently recorded and the ways that risks associated with choking were reduced were not robust. The service had not sufficiently improved since our last inspection to provide people with a safe and responsive service at all times.

Since our last inspection there had been management changes. The previous registered manager had deregistered in November 2018. The current registered manager was registered with the Care Quality Commission in December 2018. The registered manager was on leave during our inspection and there was managerial support being provided by a peripatetic manager and a registered manager from another of the provider's services.

We were told there had been a restructure and there was a new regional manager in place and the quality support manager was new. The quality support manager told us that they were visiting the service weekly to mentor and support the new registered manager. They had gone through our previous inspection report and developed an action plan together. This was a working document which identified when actions had been completed and added to where improvements were required. The quality support manager told us that they were auditing care plans and the need for improvement had been identified. There were plans in place for the improvement of care plans, including the implementation of electronic care records to be rolled out in March 2019 with staff training and to go live in April 2019.

A meeting was held daily, attended by all the heads of departments, such as catering, activities, maintenance, care and domestic. We observed the meeting during our inspection. The resident of the day system was discussed, as were any accidents and incidents that had occurred, fluid targets, and pressure ulcers. The team were also asked if they knew the whereabouts of the service's emergency plan, all knew.

There was a programme of audits which were used to monitor the service provided. This included audits in falls, care plans, medicines, infection control, call bell response times and health and safety. There were actions in place where shortfalls had been identified to improve people's experience of the service they received. Incidents and accidents were analysed to monitor if there were any patterns and actions were put in place to learn from these and reduce the risks of them happening again.

People and relatives were involved in developing the service and were provided with the opportunity to

share their views. This included quality assurance questionnaires and meetings. Actions were taken because of people's comments to drive improvement. The results of the last 2018/19 satisfaction surveys was displayed in the service, for the access of people and visitors. This included information about the actions taken as a result of people's comments to improve the service, such as providing the drink making facilities in the first floor lounge, awareness to be raised of advocacy services and care plans were to be reviewed with people on the 'resident of the day'.

People and relatives were also able to share their views in meetings. One person's relative said about meetings, "I have seen this happen in the past. I do not know if it is happening now." Another relative commented, "Yes I have heard about these meetings. My relative] attends these meetings and knows about them."

In the entrance hall to the service there was a board with photographs of staff. However, this would benefit from having the names of staff to assist people and visitors to know who staff were.