Cherry Tree Care Limited

Cherrytree Residential Home

Inspection report

123 Station Road
Countesthorpe
Leicester
Leicestershire
LE8 5TD

Tel: 01162777960

Date of inspection visit:
20 April 2016

Date of publication:
10 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 20 April 2016. At the last inspection completed on 23 February 2015, we found the provider had not met the regulations for three areas; not making the required notifications to the Care Quality Commission, assessing and monitoring the quality of service provision and consent to treatment. At this inspection we found the provider had made the required improvements and the regulations were being met.

Cherrytree Residential Home is a care home registered to accommodate up to 40 people who are aged over 65 and who may be living with dementia or have a diagnosis of mental ill health. The home is located on two floors, with lift access to both floors. The home has a variety of communal rooms and areas where people can relax. At the time of the inspection 35 people were using the service.

The service had a 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 told us that they felt safe when staff supported them and that they enjoyed living at Cherrytree Residential Home.

Risk assessments were in place which described how to support people in a safe way. The service had safeguarding and whistleblowing procedures in place. Staff were aware of their responsibilities in these areas.

The provider carried out checks before staff started to work at the service.

People received their medicines safely and at the right time by staff who were trained and assessed as competent to administer these.

Staff were supported through training and supervision to be able to meet the needs of the people they were supporting. They undertook an induction programme when they started to work at the service.

Staff sought people's consent before providing personal care. People's capacity to make decisions had been considered in their care plans. Assessments of a person's capacity to make a specific decision had not always been fully completed.

People were supported to maintain a balanced diet. People were supported to access healthcare services.

People told us that staff were caring. Staff we spoke with had a good understanding of how to promote people's dignity. Staff understood people's needs and preferences.

People were involved in decisions about their care. They told us that staff treated them with respect.

People were involved in the assessment of their needs. People and their relatives were sometimes involved in the review of their needs.

People were supported to take part in activities that they enjoyed.

People told us they knew how to make a complaint. The service had a complaints procedure in place.

The service was well organised and led by a registered manager who understood their responsibilities under the Care Quality Commission (Registration) Regulations 2009.

People were asked for their feedback on the service that they received. The provider carried out monitoring of the quality of the service.

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 safe.

People told us that they felt safe. Staff knew how to recognise and respond to abuse correctly. The provider had followed effective recruitment procedures.

Staff managed the risks related to people's care. Individual risks had been assessed and identified as part of the care planning process.

People received their medicines safely and at the right times.

Is the service effective?

Requires Improvement

The service was not always effective.

Assessments of people's capacity had not always been fully completed. People's choices were respected and staff sought consent before providing personal care.

Staff received training to develop their knowledge and skills to support people effectively.

People were supported to maintain a balanced diet. People had access to the services of healthcare professionals as required.

Is the service caring?

Good

The service was caring.

Staff were kind and treated people with respect and dignity. Staff knew people's likes and dislikes.

People's privacy was respected and relatives and relatives were encouraged to visit regularly and made to feel welcome.

Is the service responsive?

Good

The service was responsive

People's care plans were developed around their needs, were

kept up to date and reflected people's preferences and choices. People or their relatives were involved in reviewing their care plan.

People were able to participate in activities that they enjoyed.

People knew how to complain and felt confident to raise any concerns.

Is the service well-led?

Good

The service was well-led.

People knew who the manager was and felt they were approachable.

There were quality assurance procedures in place to monitor quality.

People had been asked for their opinion on the service that had been provided.

Cherrytree Residential 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 20 April 2016 and was unannounced. The inspection was carried out 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. The expert had experience of caring for someone who used this type of service.

Before our inspection, we reviewed the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about what the service does well and improvements they plan to make. We also reviewed the information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service and the local Healthwatch for feedback.

We spoke with six people who used the service, two relatives and one friend of someone who used the service who were visiting the home. We observed staff communicating with people who used the service and supporting them throughout the day. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, two senior carers, two members of care staff and the cook.

We looked at the care records of five people who used the service and other documentation about how the home was managed. This included policies and procedures and records associated with quality assurance processes. We looked at four staff recruitment files to assess the recruitment process.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe. One person told us, "I feel safe here. Oh yes." All of the relatives who we spoke with told us that they felt that the service was safe. One relative said, "I took a week's holiday for the first time in years. But I left feeling confident that [person's name] would be looked after."

Staff we spoke with had a good understanding of how to protect people from the different types of harm and abuse. They understood their responsibilities to report any safeguarding concerns to a senior staff member or the registered manager. The management were aware of their responsibilities to report any safeguarding concerns to the local authority. Staff told us they were confident that any concerns they raised would be taken seriously by the registered manager. Staff had received appropriate safeguarding training and records confirmed this.

Staff managed the risks related to people's care. Each care plan had information about the risks associated with people's care and how staff should support the person to minimise risk. For example, one person had a risk assessment in place as they were at risk of falls. This had been completed to make sure that control measures were in place and that the person used the correct equipment to aid their mobility. Risk assessments were reviewed monthly, or when someone's needs changed. This was important to make sure that information was current and was based on people's actual needs. We found that where someone had behaviour that may be classed as challenging this had been identified in their care plan. There was guidance for the staff to follow to try and support the person from presenting the challenge. We saw that there were techniques recorded that told the staff how to support the person effectively if they presented behaviour that challenged. Staff told us how they would respond to the behaviour and this was in line with the guidance in the care plan. We saw staff respond to the person and this was done using the techniques that had been recorded.

People told us that they felt there were enough staff but they were very busy. One person told us, "The staff are very good although they are always rushing." Another person said, "We need more carers they are rushed off their feet." Staff told us that they felt there were enough staff at most times although it would be nice to have more staff in the mornings. We saw that the staff appeared to be busy but when people requested help staff would assist them as soon as they could. We found that staff spent time talking to people and had time to sit down and have a conversation and provide support. The registered manager told us that the staffing levels had been agreed based on the needs and dependency levels of the people who lived in the home. The rota showed that the staffing levels that had been assessed as being appropriate were in place. Throughout the day we saw that call bells were answered promptly and that staff were present in the communal areas to offer support if this was needed.

Staff maintained records of all accidents and incidents. The registered manager had monitored these and actions that had been taken were recorded. We saw that accidents were audited each month and that changes were made to people's care to try and reduce the likelihood of reoccurrences. For example, one person had been referred to a health professional for further assessment when they had more than one fall.

People and their relatives told us that the premises were clean. One relative said, "It is spotlessly clean. The cleaners are always on the go. They have a rota and they work round the home and then start again." The premises were generally tidy. Cleaning schedules were in place. Domestic staff were employed and we saw that they were on duty throughout the day. We found that there were some areas that required more detailed cleaning. For example we saw that the carpet in the room used for hairdressing had a layer of hair on it and there was heavy dust on furniture in rooms that were not used often. We discussed this with the manager who said that they would look at the cleaning schedules to make sure that they covered all rooms. They also told us they would discuss the floor surfaces with the provider. We saw that maintenance had been completed when it had been needed.

Staff told us that fire drills and system tests were carried out regularly. We saw that regular testing of fire equipment and evacuation procedures had taken place. The registered manager advised, and records confirmed, that where people may need additional support in the event of an evacuation they had a personal emergency evacuation plan in place. However the plans were not dated and had not been reviewed. We discussed this with the registered manager who advised that she would make sure these were dated and reviewed to ensure that they were current based on the person's needs. Where someone had specialist equipment, for example a hoist, we saw that this had been regularly serviced. However we found that a wooden chair was being used as a shower chair. We discussed this with the registered manager who told us that they would get a new shower chair as this posed a risk of cross contamination. We found that other checks in relation to the premises were carried out in line with recommended guidance. We saw that radiator covers were in place for most radiators. Where these were not in place a risk assessment had been completed. This identified that the radiators needed to be at a lower temperature to reduce the risk of people burning themselves. We found that this measure was in place and the radiators were not hot to touch.

The provider had a recruitment and selection procedure in place to ensure that appropriate checks were carried out on staff before they started work. We saw that files contained a record of a Disclosure and Barring (DBS) check, and references. These checks help to make sure that staff are suitable to work at the service.

People received their medicines as prescribed by their doctor or pharmacist. We saw that medicines, including controlled drugs, were administered, stored and disposed of correctly and there were policies and procedures in place to support this. We looked at the records for medicine administration and found that these had been completed correctly. Staff had received training in medicines management and they had been assessed to ensure that they were competent to administer medicines. We saw that where people were prescribed medicines as PRN (as required), or variable doses, protocols were not always in place to advise staff when and why to administer the medicine. Staff who we spoke with could tell us when PRN medicines should be administered and what dose of medicine should be given. The registered manager told us that the protocols were being implemented and this had been discussed with the doctor.

Requires Improvement

Is the service effective?

Our findings

At our last inspection carried out on 23 February 2015 we found that people's capacity had not been assessed when it had been believed that they did not have capacity to make a specific decision. We found that there were no records to show that decisions had been made in people's best interest in line with guidance in the Mental Capacity Act (MCA) 2005. Staff had not received training in the MCA or Deprivation of Liberty Safeguards (DoLS). We also found that guidance was not in place for staff to tell them what to do if they had concerns about a person's mental capacity to make a decision about their care. These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements.

The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that where people may have been deprived of their liberty the registered manager had made applications to the 'Supervisory body' for authority.

Staff demonstrated a good understanding of MCA and DoLS. They told us that they had received training in this area to help them understand what they needed to do. One staff member said, "People can make their own decisions about care. We involve the person and their family if they want them involved." Staff told us about their approach to supporting people and asking for consent. One staff member told us, "I always ask if the person is happy for me to help. I wouldn't do it otherwise." All of the staff we spoke with understood that people had a right to refuse care. We saw documentation in people's care plans that indicated that staff understood about capacity and the need to assess and record where a person did not have capacity. We saw that these considerations were not always specific to the different decisions that needed to be made. We discussed this with the registered manager who told us that they would make sure that where capacity had been assessed it would be identified which specific decision it was being assessed for.

People told us that they felt that they were cared for by staff who were trained and who knew them well. One person told us, "You only have to ask and they will do whatever you want." Another person said, "The staff give good care." A relative told us, "The staff are very good."

Staff told us that they had completed an induction process that included training and shadowing more experienced staff. One staff member told us, "The induction covered all of the basics." Another staff member said, "I found the induction very useful." The registered manager confirmed that the Care Certificate was being used as an induction programme for new staff. The Care Certificate was introduced in April 2015 and is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker. Records we saw confirmed that staff had completed an induction process and that new staff were working towards achieving the Care Certificate. We spoke with staff who told us that they felt that they had done enough training to do their job well. One staff member told us, "It is all good quality and have done enough to meet people's needs." We looked at the training records that were used to monitor the training needs of the staff team. These showed that staff had completed training in a range of subjects including training that was specific to meet the needs of the people who lived at the home. For example, we saw that staff had completed training in diabetes. This meant that staff were effectively trained in order to carry out their roles and meet the needs of the people who used the service.

Staff told us that they had supervision meetings with the registered manager. Supervision meetings are an opportunity for staff to meet with a line manager to discuss their practice and any concerns. Records we saw confirmed that supervision meetings and appraisals had been planned for the year and all staff had received a supervision meeting in February 2016. These had been planned for every three months. Staff told us that they had team meetings and we saw minutes from the meetings. The most recent meeting had been held in January 2016. We found that the minutes of the team meetings demonstrated that issues were discussed with the staff. For example, we saw that good practice, problems and training had all been discussed with staff. This meant that the staff were being supported to meet the needs of the people who used the service.

People enjoyed the food offered and there were choices at mealtimes. One person told us, "The food is nice." Another person said, "The food is good. I am well fed." There was a menu available, however this was handwritten on a whiteboard that was placed above the serving hatch which made it difficult to see. The cook told us that people would come and ask them what the meal was if they struggled to read the board. They told us that they had used pictures to try and make the menu easier for people to read however had been told that the pictures that had been used were not appropriate. The cook agreed to discuss this further with the registered manager and see if people would benefit from having a menu that was easier to see.

People were supported by staff at meal times and encouraged to eat their meals. We saw that most people ate in the dining room or the lounges but people had choice over where they ate. We observed lunch and saw that portion sizes were adjusted based on who the meal was for. We found that when people requested an alternative this was brought for them. The cook told us that people were involved with developing the menus and had asked for certain meals to be added to the menu. Throughout the day people were offered drinks and snacks. We saw that there was a twilight menu available for people to have meals later in the evening if they wanted to. Staff told us that some people requested food from this. People had care plans which included information on dietary needs and support that was required. The cook and staff we spoke with were able to tell us about people's dietary needs and were knowledgeable about how to support people who needed additional support.

People's healthcare was monitored and where needed they were referred to the relevant healthcare professional. One person told us, "I have seen the doctor about my hands." Another person said, "I was taken to hospital after I fell over." Records showed that people were supported to attend routine appointments to maintain their wellbeing, such as the opticians and chiropodist. We saw that staff monitored any change in people's needs, sought advice from health professionals and recorded what actions they had taken.

Good

Is the service caring?

Our findings

People spoke well of the care provided and the staff. One person told us, "The staff are lovely, really nice." Another person said, "I am pretty well cared for." One person commented, "He [carer] is very good." Relatives told us that they were happy with the care and the staff. Comments included, "The carers are good," and "They give good care."

Staff knew the people they cared for, they were able to tell us about what people liked, and disliked and how they used this information to support and care for people. One staff member told us that they got to know people well through working with them. All staff said that information about people's likes and dislikes was recorded in the care plans. We saw that staff communicated with people effectively. They ensured that they were at eye level with the person they were talking to and altered the tone of their voice appropriately. This meant that communication was discreet and focused on the person. We saw that when someone asked for a staff member to help them, the staff supported the person as soon as they could.

People and their relatives told us that they had been involved in planning their own care. We saw that people were asked information about how their routines and what they liked and disliked. We found that each care plan had a section about their personal preferences. This meant that people were asked about how they wanted the staff to meet their needs and were involved in planning their own care. We saw that information about advocacy was available for people if they wanted or needed to use this service.

People were supported by staff at their own preferred pace. For example, when people were supported with their lunch the member of staff sat with them and let the person take their own time. We observed that staff spoke with people and used their preferred names. Staff supported someone who became upset. They did this in a calm way without bringing attention to the person. They allowed the person to take their own time and offered reassurance throughout.

People told us that staff were respectful to them. Staff told us how they protected people's privacy and dignity, examples of this included knocking on doors, explaining what was happening, closing doors and getting people to do as much for themselves as possible through encouragement and prompting. We saw that staff provided reassurance and explanations to people when they supported them. We found that where there was a shared room a screen was used to protect people's dignity. The registered manager told us that both people had been asked if they were happy to share and had agreed to this. They said that people were offered the opportunity to move to a single room if they wanted to.

People told us that their family visited them and they could come when they wanted to. One person told us, "I see my friends and family a lot." Another person said, "My niece comes in." Relatives told us that they could visit when they wanted to and were made to feel welcome. One relative commented, "I have a good relationship with the home." We saw that relatives and friends visited throughout the day of our visit.

People could be confident that their personal details were stored securely and protected. We saw that confidential information was kept securely. This ensured that people could only access this when they were

authorised to do so.

People were encouraged to personalise their own private space to make them feel at home. One person told us, "It is very homely. I wouldn't change it." We were invited to see three bedrooms and people had brought their own items with them to decorate their rooms. The communal areas had been decorated in a homely manner. For example, in the lounges there were pictures, ornaments and flowers placed around the home. There were areas where books and CD's were available so that people could use these. We saw that where people had completed art work this was displayed throughout the home.

Good

Is the service responsive?

Our findings

People told us that they received care in ways that were important to them. One person said, "I go to bed between 11 and 12pm. I don't like to go to bed too early." Staff confirmed that information about people's routines and preferences had been included in their care plan. We saw that the care plans detailed information about people's preferences. For example, we saw that one person liked a cappuccino coffee in the morning and then preferred to drink tea for the rest of the day. We also saw that people's preferences around personal care had been recorded for example if the person preferred a bath or shower and when they preferred this.

People and their relatives told us that they had contributed to their care plans. The registered manager told us that people's needs were assessed before they moved into the home and that this involved the person and their family. We saw that an assessment had been completed that included key information about the person, their needs, what was important to the person and their history. Care plans contained information about what each person liked and things that were important to them. Staff were able to tell us about people's care plans. The care plans had been updated monthly to help ensure the information was accurate. We saw that reviews were held and that family members had sometimes been involved in these. We discussed this with the registered manager who told us that they were developing a process to encourage more relatives to be involve in reviews. The registered manager told us that the staff who carried out reviews asked family for their input but this was not always recorded.

We found that care plans identified people's needs and how to meet these needs however they did not always cover all health implications that could be associated with a diagnosis. For example, we saw in one care plan that a person had been diagnosed with diabetes. The care plan gave staff guidance on how to support the person to manage their diabetes however did not identify that people with diabetes may develop problems with their eyes and feet and these areas need to be monitored. We found that the person was supported to access healthcare services in all areas relating to their diabetes however the areas to be monitored had not been detailed. We discussed this with the registered manager who agreed that full information about needs would be recorded so that staff had guidance about what areas could be associated with a health diagnosis and what they needed to monitor.

Information about people was shared effectively between staff. A staff handover was held between staff and the information was recorded. We saw that staff shared information about any changes to care needs, or if something had happened. This meant that staff received up to date information before the beginning of their shift.

People told us that they took part in activities that they were interested in. One person said, "There are lots of things to do." We saw that people were supported to take part in activities. An activity co-ordinator had been employed who visited the home each day to carry out activities such as arts, crafts and bingo. We saw bingo was taking place on the day of our visit. Eight people joined in with this activity. We observed staff also carried out individual activities with people. For example, nail painting. One person said, "Look at my nails, don't they look lovely." We saw that there were activities planned for each day. These included in house

activities such as bingo and art as well as external people visiting the home such as singers. We saw that a party had been planned to celebrate the Queen's birthday. People showed us their paintings and artwork which were displayed around the home. They pointed out what they had done and were proud of this. We found that pictures of activities and trips were displayed. People told us that they had been out for a walk in the local area the day before our visit. They told us that they had enjoyed this. We saw that people accessed the garden and spent time there during the day of our visit as it was a warm day. Staff told us that people enjoyed the activities. One staff member told us, "People enjoy the activities. They have two people who come in and do entertainment." Another staff member said, "People like the activities co-ordinator. They miss her when she is not here."

All of the people we spoke with told us they would raise any concerns if they had needed to. One person told us, "I have no complaints. I can talk to the manager." Another person said, "I can't complain." A relative told us, "I speak to a carer twice a week so I know what is going on. There are no major problems. I would say something if there were any problems. [Person's name] wouldn't be here if there were issues." We saw a complaints policy was in place and was available in the main entrance to the home. This had been written in a simple format to make it easier to understand however, it was slightly obscured by a plant which made it difficult to see fully. This included timescales for when a complaint would be responded to. We saw that all complaints that had been received were responded to within the timescales recorded in the policy.

Good

Is the service well-led?

Our findings

At our last inspection carried out on 23 February 2015 we found that the registered manager and provider had not informed the Care Quality Commission of serious events affecting the service or people using the service. This is part of their registration conditions. This was a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements.

It is a legal responsibility and obligation required of a registered manager and provider to inform us of serious events affecting the service or people using the service. This includes safeguarding incidents and the more serious and life threatening pressure sores. Before our visit we looked at the records we held and the notifications we had received. We found that appropriate notifications had been made. During our visit we saw records of accidents and incidents and found that all matters that needed to be notified to CQC had been notified.

We also found that quality assurance systems had not always identified where improvements and actions were required to ensure quality and safety. This meant that people were not effectively protected against the risk of receiving care and treatment that was effectively assessed and monitored. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements.

We found that audits were in place and the registered manager was completing audits in areas such as monitoring pressure relieving mattresses, staff supervision meetings and training, care plans and medicines. The audits showed details of where improvements had been needed and what action had taken place. We saw that a new process had been implemented to effectively monitor people's weight. Records were reviewed monthly to make sure that staff had taken action if the person had lost or put on weight and reached a trigger point. We also found that the manager had reviewed audits that had taken place to make sure that any area for action had been identified and that appropriate checks had taken place.

The registered manager told us that they were identifying further areas where audits would be effective in order to continue to improve the quality of the service that had been provided. They told us that they had implemented new paperwork to make the recording more effective and this was an on-going process. For example, the registered manager told us that they were considering an audit to review the food and fluid charts to ensure that these had been completed with enough detail. We saw that a new form had been developed to make it easier for staff to record what people had eaten and drank and that this contained guidance for staff. This had only recently been introduced and the registered manager told us that they were still reviewing the effectiveness of this form before developing an audit tool for it.

We saw that the provider completed audits during their visits. Records we saw showed the last audit had

been completed in September 2015. This included checks on the environment, monitoring progress against an improvement plan for the service, checks on records and talking with people who used the service. This meant that the provider had assessed and monitored the quality of the service that had been provided.

People and their relatives told us that they knew who the manager was and that they felt listened to. One person told us, "I know the manager and the manager who is second [deputy manager], I can talk to them." Another person said, "We can talk to the manager. They do listen to you." A relative told us, "I would speak to anyone of them and know it will get sorted." Staff told us that they felt they could approach the manager. One staff member told us, "If I have a question I will ask. The manager will listen and give you an answer." Another staff member said, "I feel you can approach the manager and they listen to you. I feel supported." The registered manager told us that they had been in post for a number of years. They told us that they liked to make sure that they spent time in the home to see what was happening and to develop relationships with people who used the service. We saw on the day of the inspection that the registered manager spent time walking around the home and talking to people who used the service. This meant that the registered manager was aware of the day to day culture in the home and made sure people knew who they were.

People who used the service had meetings that gave them the opportunity to share their views about the service. We saw minutes from the last meeting that had been held in February 2016 where entertainment, food, outings suggestions and any concerns had been discussed. We saw that at previous meetings people had requested different meals to be added to the menu and the requested changes had been made. People and their relatives had not been asked for feedback formally, for example through a questionnaire. The registered manager told us that this was being introduced and would be carried out in the near future.

Staff told us that they were involved in the development of the service. One staff member told us, "They spoke to us all about changes to the shift patterns. They listened to what we said and went with what the majority if the staff had said they wanted." The registered manager told us that they had added a member of staff to do the laundry and a member of staff to assist in the kitchen after the staff had asked for support in these areas. This meant that staff had the opportunity to influence changes within the service.

The management structure in the home provided clear lines of responsibility and accountability. The registered manager was supported by the deputy manager and senior support workers. They were also supported and monitored by the owner who visited the service on a regular basis. The registered manager told us that the owner visited three times a week and was available if needed at other times. They told us, "We all have quite clear responsibilities. It helps having a good team."