Runwood Homes Limited

Madelayne Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 3 August 2016 and was unannounced.

Madelayne Court provides care and accommodation to people who may need assistance with personal care and may have care needs associated with living with dementia. The service does not provide nursing care. The service is split into seven units located over three floors. At the time of our visit there were 112 people living in the service.

A registered manager was in post at the service. 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.

When we had visited in 2015, we had concerns regarding the staffing levels at the service, in particular in one unit. During this visit we found the manager had been pro-active about resolving the concerns we had outlined in our last report and there were sufficient, suitably recruited staff available to meet people's needs safely.

People were supported to remain safe. Where staff had concerns about people's safety there were measures in place to minimise any risks to their safety. People were protected from the risk of abuse. Staff supported people to take their medicines safely, as prescribed.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. People were enabled to make their own decisions about the service they received.

Staff had the skills to help people communicate their preferences. Staff followed processes in place to ensure decisions were made in people's best interest, involving family and outside professionals as appropriate.

People's nutritional needs were well met. A choice of food and drink was offered, and drinks and snacks were available throughout the day. People's food and liquid intake was recorded and monitored and any concerns addressed promptly. Staff recognised the importance of food to people's enjoyment of life. Staff worked well with health and social care professionals to support people to maintain good health and wellbeing.

People and their families were treated with warmth, dignity and respect by staff who knew them well. People knew how to complain and the manager responded to people's concerns. Care plans and risk assessments had been revised since our last visit to provide more personalised guidance about people's specific needs. Staff supported people to lead fulfilling lives and motivated them to engage in a range of

meaningful activities and pastimes.

The systems in place to monitor the care provided were used to improve the quality of life and safety of people at the service. The staff team worked well together. The manager was supportive and approachable. They delegated effectively and had a good oversight of the whole 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?

Good

The service was safe.

There were measures in place to minimise the risks to people's safety.

People were supported by sufficient, suitably recruited staff who knew how to keep people safe.

Medicines were given safely and as prescribed.

Is the service effective?

Good

The service was effective

Staff were supported to develop skills to meet people's needs. There was a focus on enabling staff to work more effectively with people with Dementia.

People were enabled to make their own choices where they had capacity. Decisions made on people's behalf were done in their best interest.

People were supported to maintain good nutrition and hydration. Kitchen staff worked well with care staff to provide a balanced diet which people enjoyed.

Staff worked with other professionals to promote people's good health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff spoke about people with fondness and treated them with kindness and compassion.

Relatives and friends were encouraged to be part of people's lives.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

Support was personalised around individual needs.

The registered manager promoted a focus on supporting all people at the service to have meaningful lives and pastimes.

People knew who to speak to if they had any concerns. They were assured of a personalised response and that any issues would be dealt with effectively.

Is the service well-led?

Good

The service was well led.

The registered manager was committed to improving the service in response to feedback.

There was good morale amongst staff who worked well as a team.

There were effective systems in place to check the quality of the service and address poor practice.

Madelayne Court

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.

The inspection took place on 3 August 2016 and was unannounced.

The inspection team consisted of three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One of the inspectors had specialist skills in manual handling and focused on this area during the inspection.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. This included safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We met with the registered manager and the two deputy managers. We spoke with eight members of care staff, 12 people who used the service and nine family members. We also spoke with two health and social care professional to find out their views on the service.

We reviewed a range of documents and records including the care records for people who used the service. We also looked at six staff files and documents relating to the employment of staff, complaints, accidents

and incidents and the management of the service.

Good

Is the service safe?

Our findings

At our previous visit we had found the analysis of falls was not sufficiently detailed to gain an understanding of any specific areas and times of concern throughout the service. At this visit we found the registered manager had addressed our concerns thoroughly.

Due to the size of the service and the number of people walking around independently, we received a large number of notifications of falls prior to the inspection. We looked at the log of falls and saw these detailed the location, time and actions taken, for example, if an ambulance was called. The monthly analysis highlighted people who may have had a number of falls recently and actions that may be needed to reduce the risk. For example, one person was offered biscuits at night to avoid them getting up to go and look for a snack. They had also had a sensor mat and a crash mat in place in order to reduce the risk of injury. There was evidence of other actions such as referral to a falls service or to a nurse who specialised in the area of Parkinson's disease. Regular checks cross referenced the incident and accident forms against corresponding care files to ensure any corrective action had been taken.

People had been assessed to determine the level of support which they needed with their mobility. Where staff supported people with transferring, for example, when they were having a bath, support plans outlined the details of the hoist and sling. We highlighted to a senior member of staff that plans did not always include the loops combination to be used for each move; this could result in the hoisting being uncomfortable and the wrong position being achieved. The senior member of staff assured us the relevant support plans would be updated. We were shown on the day of the inspection a number of other plans which had detailed advice regarding the loops, for example, one plan said, "[Person] needs the largest sling, using the first hoop of the sling and attaching it to the first hook of the hoist arm."

Our observations showed us staff knew how to support people with their mobility needs and received practical training in this area. One staff member gave an example of the support they provided, "We observe people carefully, [Person] is at high risk of falls so we watch them when they try to get up. We make sure one of us is with [Person] when they walk."

At our last visit we had concerns regarding the level of staffing, particularly in one unit. At this inspection we noted the staffing levels had improved so there were additional staff providing care, organising activities and carrying out domestic duties. There was also an additional deputy manager in place. One of the staff described the changes in the unit where we had previously had concerns. They said, "There is enough staff now, we had two previously but the third helps."

People told us staff were busy but there were enough of them to meet people's needs. A member of staff described the staffing arrangements, whereby there was a set number of staff on each unit and 'floaters' on each floor who went to where they were needed. The member of staff told us they felt they had enough time to meet people's needs, they said, "You can't just rush it; you've got to talk to them (people) as well."

Our observations confirmed there were enough staff to meet people's needs. Staff were observed

responding within 60 seconds to a buzzer pressed by a person. The manager told us a new system to monitor staffing deployment was going to be introduced shortly after the inspection. This would assist the manager in checking who was on duty at any time and enable them to swiftly address any gaps across the service.

At our last visit, family members told us people did not always have a bath, due to lack of staffing and records supported this concern. At this visit we were not told of any concerns with bathing and checked bath records and confirmed these were provided in line with people's care plans. A relative of a person at the service told us, "I feel [Person] is safe here; they are always clean and seems to have thrived since coming here".

We observed that people were comfortable in their interactions with staff and approached them readily when requiring assistance or support. Where people were assessed as being vulnerable to abuse there was guidance in place for staff to follow. Staff were able to describe different forms of abuse and knew what to do if they felt a person was not safe. Staff said they felt confident raising concerns about a person's safety. A member of staff described how they would monitor people, for example for unexplained bruising and tell their senior if they had any concerns so these could be investigated. A family complimented the service on their openness and responsiveness. They told us, "They've reacted very quickly to anything we've raised, for example when we noticed [Person] had a bruise on their arm; they came back with a full explanation."

Staff would be told at handover meetings if there were any issues they needed to be aware of in relation to people's safety. We observed a handover meeting and saw staff discussing changes in people's demeanour and wellbeing which were a cause for concern and how to monitor and support people.

Staff worked effectively with external professionals to keep people safe. For instance, following an alert regarding a person's safety we saw they telephoned their social worker to check whether they were taking the appropriate measures. Prior to our inspection, the registered manager had let us know that they had raised concerns with the local authority when they had become worried that a person was potentially at risk of financial exploitation.

Risk was well managed within the service. Where people were deemed to be at risk, staff had completed detailed and personalised risk assessments. For example, all people who were at risk of developing pressure areas had been recently provided with improved hospital beds with air mattresses. Plans were flexible, in relation to changes in people's needs. For example, one person's support plan was flexible, depending on whether they were using a walking aid. Risk assessments were reviewed monthly.

We looked at recruitment files for three staff to review the registered provider's procedure for recruiting staff. Robust recruitment procedures were followed to help check staff were fit to work at the service before they started their employment there. This included obtaining Disclosure and Barring Service (DBS) checks and seeking references. These processes helped to protect people from the risk of harm or abuse. We were told the service had not employed agency staff for over two years, which enabled a more consistent level of care to be provided.

People received their medicines safely and as prescribed from appropriately trained staff. A person told us, "They bring me the pills three times a day and they make sure I take them regularly." We observed three medication rounds and noted staff were positive and gentle with people, for example, they chatted during the process and did not rush them. Staff told us they had only started administering medicines after receiving training, and they received regular medication competency checks. A member of staff told us, "We have annual medication training with the pharmacist and the deputy observes me administering

medication."

Records of people's medicines were completed in line with the organisations' policy and we noted that these were accurate and legible. There was a protocol for medicines in place for each person, and these were tailored to their personal needs. When people had been prescribed medicines on an as required basis, for example for pain relief, there were protocols in place for staff to follow so that they understood when a person may require this medicine. Medication risk assessments reviewed monthly or sooner if something changed for people.

Medicines were stored in a locked trolley and storage room and the member of staff was able to clearly explain the medication signing in and out procedure. Regular medication audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately. Each unit received a weekly audit of the administration and recording of medicine by one of the deputy managers.

Good

Is the service effective?

Our findings

We observed that the staff and management were efficient and effective and worked well as a cohesive team. One member of staff told us, "The team are great and we work really well together, that gives us more one to one time with residents".

Staff had the skills to meet people's needs. A relative told us, "They're really on the ball here." Another relative said, "The older, more experienced staff are fine, some of the younger ones are less thoughtful." We noted however there were a series of ways in which less experienced staff were supported to develop their skills, so the registered manager could address any gaps in knowledge and skills. For example, one of the deputy managers had carried out an observation of staff skills and they noted, "Staff present (in lounge) but encouraged to interact much more."

Staff told us they felt well supported and we saw that they received regular supervision and appraisals. The manager had made sure there were systems in place to confirm supervision meetings and appraisals were up to date.

Since our last visit there had been a focus on developing staff skills in the area of dementia. Staff had input from the organisation's dementia team and we noted staff were being enabled to provide a more personalised service to people. There were face-to-face checks and advice was given by the team to improve staff skills when interacting with people. For example, staff were encouraged to read a newspaper with someone and use this as a way to stimulate and involve them. We looked at the notes from a relatives meeting and saw that a family member felt staff didn't always interact with people but they noticed the improvements being introduced. The notes read, "I did like it when a carer was reading the newspaper to a resident." The notes recorded the registered manager having an open discussion with relatives and explaining that developing staff skills and improving interactions with people was an ongoing process.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made to the appropriate professionals for assessment when people lacked capacity and needed constant supervision to keep them safe. Staff had received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance. The manager kept a log of the DOLs applications so they could track where assessments had

been carried out and where they were still outstanding. They told us a recent assessment had indicated a person had capacity and so was able to make decisions about their care. The manager understood the reasons for the outcome and was able to discuss this with us in an informed manner.

We noted that a non-verbal person had been assessed as not having capacity to make decisions about their daily care, yet staff knew them well and so could read from their body language how they were feeling. For example, a staff member knew from the sounds the person made when they were drinking whether they wanted more juice or didn't like something. The member of staff demonstrated they had an awareness of the human rights of the person they were supporting and had the skills to enable them to be involved in their care, as much as possible.

Where people were being restricted or staff were making decisions on their behalf, the manager had ensured their personal circumstances were taken into consideration. Forms outlining decisions were personalised and people's families had been involved, as appropriate.

Staff had a good understanding of the nutritional needs of the people at the service. For example, the head chef was able to name a person who required fortified food to minimise the risk of malnutrition. There were choices available at each meal, for example the evening meal on offer on the day of our inspection was roast and people were offered an alternative of jacket potato and cheese. The registered manager had issued guidance that staff should introduce a variety of options for people who were not able to make a choice.

We met with the head chef who spoke with enthusiasm about the improvements with meal times. They attended 'residents and relatives meetings' and told us about changes which they had implemented following feedback. For example they had changed the variety of cabbage purchased after being told the existing one did not keep well in the hot plates. As a result of feedback from people, the main meal of the day had been moved to the evening.

Staff were aware of the need to keep people hydrated. A member of staff said, "You don't want to deprive them so you need to keep filling the drinks up". Staff assisted people to eat as required. Two people, who needed help with eating, told us, "They're always very good in helping me" and "They always chop everything up for me."

The manager told us there was a protected meal policy in place. This meant the meals were served at a separate time to people in their rooms and medication was not to be administered whilst meals were being served and consumed. This ensured the maximum number of staff were available to support people with their meals. We observed three meal times and in one, the medicines were being administered during the meals and hoovering was taking place just outside the dining room. This added to the noise and disruption and also posed a distraction for the member of staff administering the medicines. We discussed this with the manager who told us this should not have happened and staff would be reminded of the policy in this regard. The other two meal times we observed were not disrupted; which resulted in a more pleasant meal time experience.

There were picture menus in place to aid communication. We observed one member of staff asking people whether they wanted blackcurrant or orange juice and noted they did not show the jugs of juice to support communication. When the same member of staff then asked people which sandwiches they would like, a colleague suggested they brought the tray across so people with communication needs could point at what they wanted. This demonstrated that staff were committed to promoting best practice within the service and felt able to challenge their colleagues to improve the support people received.

In another dining room a tray of sandwiches was shown to all the people to help them select their preferences. We observed how staff tried to make the atmosphere relaxed and friendly at meals, for example, joking with a person that they didn't need to all the sandwiches.

The manager ensured observations of mealtimes took place which were practical and comprehensive and focused on enhancing people's mealtime experience. For instance, one measure looked at "Tea/coffee and biscuits are offered after lunch at the dining table, encouraging chat and relaxation." Checks also ensured any specialist needs were being catered for. The observations demonstrated an understanding of the importance of meals to people's quality of life and that the manager was actively addressing any issues we had raised.

People were supported to maintain good health. On-going health needs were met and people were supported to access healthcare professionals and specialists according to their specific needs. We observed staff discussing at the daily handover meetings who was seeing the GP when they visited that day and which people needed to see the district nurse for support with their dressings. There was also a general discussion on any warning signs regarding people's health conditions, and decisions were made about the need for action or further monitoring. For instance, one person was refusing to sit with their legs raised, as recommended by a district nurse and staff talked about different ways to encourage them in this.

We noted staff talked about people's needs holistically and also monitored their mental health. Where people had specific health needs, for example, for Speech and Language Therapy, there were details in their care plans on how best to support them.

Good

Is the service caring?

Our findings

Throughout our visit, staff were observed interacting with people in a friendly way. A person said, "My carer is very nice to me. She kisses me on the head when she leaves the room and she's always having a laugh with my (family member)". A professional told us they felt the person they worked with, "Was being well cared for; respected and valued."

Staff spoke about people with warmth. They knew people well and could tell us about their families, interests and personal histories. A staff member's face lit up when describing their interaction with a person with complex needs. They told us, "I know [person] can't speak but I just speak to her about things and she smiles so I know she is listening."

Relatives and friends were welcome to visit and were encouraged to be part of people's life. There was an attractive coffee shop which provided an opportunity for people to sit comfortably with their visitors and there was a table with toys for children to play with. We saw in the notes for a relatives' meeting that the organisation's dementia team focused on supporting relatives as their family members health deteriorated. Families were told the dementia specialist could, "Help with buying presents for you loved ones and help with talking about what you are feeling." This demonstrated an awareness and importance given to supporting people as part of a wider family, not just as individuals.

Special events were celebrated with people. People were baked a homemade cake on their birthday to share with their loved ones and a buffet was provided at Christmas time for relatives. A relative told us, "They rally round and give you a hug when you need it."

We observed during our visit that staff focussed on the person, rather than the task required. For example, when a person was seen to be distressed, a senior member of staff suggested to their colleague, "Why don't you give her a bit of TLC, like do her nails, she likes that." We later saw the member of staff doing the person's nails.

At our previous inspection, we had observed a member of staff had turned on the TV during a meal, halfway during a film, without consulting people regarding their opinion. During our visit we observed there was a focus on offering people choice throughout the day. We saw checks took place during meals to ensure that any music on was chosen by diners.

Although large, the service was divided into units which had their own identity. Where possible, staff stayed on the same unit. A member of staff told us they enjoyed working in a particular unit, they said, "I'm in my element, I know everyone, like what they prefer at tea." Attempts had been made to modify the interior of the property to make it seem more homely. For example, we saw one of the bathrooms had been decorated in a seaside theme which provided a more homely environment.

Staff understood that being well presented was important to people's dignity and wellbeing. A relative said, "The best thing is that she's clean and cared for well." The registered manager had put measures in place to

make sure people had been supported with their nails and grooming. Staff described how they supported people's privacy for example by respecting their preferences about closing doors and curtains. Confidentiality was maintained, for example, people's records were kept in a locked room.

Good

Is the service responsive?

Our findings

When we had visited last time, we had observed people with more complex needs were not supported fully to engage in meaningful pastimes. The registered manager told us that since then there had been a focus on ensuring all people were supported to interact socially, rather than just take part in structured activities. To support this there was a sensory box on each unit which was available to staff with objects to use when they were interacting with people. For example, the manager explained how cushions had been purchased specifically for people with sensory needs to be able to feel the textures.

These developments had been discussed with relatives. The dementia specialist had explained at a relatives meeting that, "Activities are not just seeing a singer or playing Bingo but it's also laying the tables, giving out the biscuits, dusting their own room and many more." Some people and relatives said they had noticed a reduction in organised activities, but that they welcomed the minibus which was used to take people out.

A relative of a person with dementia told us, "[Person's] done really well here with all the activity going on." We saw examples of positive staff interaction with people. For example, in two separate incidents, a member of staff was observed talking to a person for 10-15 minutes, getting them to recall and tell events and stories from their past.

A schedule of activities for the week was published on notice boards in the home. Specific activities were scheduled for mornings and afternoons from Monday to Friday including three minibus trips. We saw that on the day of our inspection a group had gone on a trip out to a garden centre. There was a screen showing activities people had been involved in, which served as a reminder to people and their families of what social events had been happening at the service.

We saw gardens were well maintained. During our last visit we had noted that the garden was not safely fenced off. This time we noted there was a new fence, so the garden now provided a safe place for people to enjoy. However, the layout of the property meant that although people could look out on the gardens they could not easily access them. The garden could only be accessed through the laundry or through a side door with a key pad on it. We were told only one resident had access to the code to open this door. The potential for creating a safe place for people to visit the garden independently had not been maximised, following the enclosing of the garden.

Whilst we did not see anyone use the garden independently, we did see families walking out with their relatives and people were able to have a raised bed to tend. A rabbit hutch had been added to the garden since our last visit, and the registered manager told us. "It's gone down a treat with residents."

Care plans were personalised and where there were gaps, we spoke with staff and noted that they knew the people's needs well. The provider had introduced new care plans since our last visit to ensure they were more centred on people's specific needs and preferences. All members of staff had been involved in the changes and could access information readily in the plans. A member of staff told us care plans were updated monthly but if a significant change occurred the whole care plan was re-written.

Staff were able to describe the cultural needs of the people they supported, for example, where they might have different preferences at meal times due to their religion. A professional told us, "Staff are taking time to get to know the clients individually and adapting the care giving around particular needs that the client presents with".

Care plans were checked regularly to ensure they reflected the support provided to people and had been improved in line with recent training. For example, in a recent check the deputy manager had asked for a care plan to be revised as it was not sufficiently personalised. Another care plan had to be amended to outline that a person's needs had changed and they now required support with medication.

There was a robust system in place for dealing with complaints, this included a log sheet to indicate the date of the receipt of the complaint and when the actions were taken. The process included an initial letter to acknowledge the complaint and a phone call took place where appropriate. We saw examples of responses to a complaint and noted the responses were individualised and thorough. In one example, a full investigation, which included photos, was sent to a family as well as copies of the care plan where the issues had been identified and an approach outlined to address their concerns.

Good

Is the service well-led?

Our findings

At our last visit we had some of concerns regarding the staffing and care within a specific unit. During this visit the registered manager discussed the changes which had taken place since our last inspection. We noted there was a commitment to drive through improvements and address our previous concerns. For example, the monitoring of rotas had been changed to ensure the manager had an improved oversight of the staffing available. This demonstrated openness by the manager to receive feedback and channel it into improving the quality of life for people at the service.

The registered manager knew the people in the service well and was very visible around the service. For example, one of our inspection team was a man and the manager knew the names of two people who would not want to be interviewed by a man and one person who would enjoy the opportunity. A person told us, "The manager pops in at least once a week to ask how I am". A relative told us, "If I have any concerns I'll talk to [registered manager]; she's very approachable." Another relative said, "I can speak to the manager and the deputy managers about anything or everything."

The morale was good amongst the staff team. Two staff members told us, "I would be happy for my relative to live here" and "I love working here; it is a rewarding job to be able to help people." The registered manager recognised and nurtured potential amongst the staff team and supported members of staff to be promoted from within the service. A member of staff told us they appreciated the opportunities within the service for promotion and told us they had recently completed a 3-day leadership course. As a result of this approach, people and staff were supported by senior staff who knew them and the service well.

The manager promoted good communication between the staff team and with the management team. A member of staff told us, "We have staff meetings and twice-daily handovers. The manager always makes the minutes available to all staff." We saw the minutes displayed in the care office. There were also separate monthly meetings, where the senior carers meet to discuss any concerns and share good practice. We observed good communication within the units. A member of staff said, "We have a 'car park' on the wall, we 'park' agenda items ready for the next unit meeting, it means we don't forget things we want to talk about or discuss."

We looked at the quality checks carried out by the provider, the registered manager and the deputy managers and saw these were detailed and used to drive improvements. Quality checks also supported the registered manager to manage risk at the service. For instance, during one of the checks the deputy manager had noticed tables were being set very early for lunch in one unit, which posed a risk as people were removing items from the dining room. As a result of the checks, staff were requested to set the table later in order to minimise risk of injury.

Poor practice was addressed swiftly within the service. For instance, the deputy manager carried out regular checks within individual units of all the forms and systems used to monitor people's health and wellbeing to ensure these were completed correctly. The checks involved looking at the records of people's weights and ensuring staff had picked up whether people were at risk from weight loss or gain. Where there were

concerns regarding any gaps the deputy manager addressed these directly with the staff involved.

The registered manager was committed to continual improvement of the service and was making ongoing changes to enhance the quality of life for people at the service, and to provide additional support to relatives and staff. Improvements being introduced included support groups for relatives with dementia and regular surgeries, to make it easier to speak with the manager and other senior staff. The registered manager told us their intention was, "To have a home that people want to live in, 'live' being the operative word."