Mr & Mrs J Dudhee

St Mary's Lodge Residential Care Home for the Elderly

Inspection report

81-83 Cheam Road
Sutton
Surrey
SM1 2BD

Date of inspection visit:
11 April 2017
13 April 2017

Date of publication:
22 May 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 and 13 April 2017 and was unannounced. It was carried out by one inspector.

At our last inspection in September 2016 we found three breaches of regulations in relation to safe care and treatment, meeting nutritional needs and good governance. Because of the level of risk to people's safety, we gave the service a rating of 'inadequate' for the question, 'Is the service safe?' We imposed conditions on the provider's registration that meant they were not permitted to admit people to the home until the condition had been lifted. The provider was also required to submit evidence to us showing they had made the necessary improvements, which we received.

The purpose of this inspection was to check the improvements the provider said they would make in meeting legal requirements. In addition, our processes indicate that we should carry out a further comprehensive inspection within six months after a service is rated 'inadequate' in any key question. We found that the provider had made all the necessary improvements to address the concerns we identified at our last inspection in relation to the three breaches of regulations and so had met the requirements of the conditions we imposed. As a result of improvements made by the provider we have initiated procedures to remove the aforementioned imposed conditions on the provider's registration.

St Mary's Lodge is a care home providing personal care for up to 40 people, some of whom may be living with dementia. When we carried out this inspection there were 26 people using the service. There was a registered manager in post. 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.

At our last inspection, we found the service was not safe because hazardous chemicals were not stored securely, windows were not appropriately restricted, showers ran at dangerously hot temperatures, some risk assessments were missing or incomplete and unsafe materials were kept in a part of the garden where people could access them unsupervised. At this inspection we found the provider had made improvements to the safety of the environment and to people's individual risk assessments. They had put systems in place to ensure hazardous chemicals were locked away securely when not in use and that hot water used for washing or bathing was maintained at safe temperatures. Upper floor windows we checked were appropriately restricted and the environment, including the garden, was free from hazardous materials and debris. People had access to alarms if they needed urgent assistance.

People had individual risk assessments and management plans, which were updated regularly or according to their needs. However, some details were still missing from some people's assessments and the provider had not fully considered risks posed by the use of a collapsible ramp for staff to move loaded food and drink trolleys up and down a step. The provider assured us that they would address these issues.

At our last inspection we found people did not always have the support they required to eat and drink. Staff did not always make appropriate referrals in a timely manner when people were at risk of malnutrition. At this inspection, we found the provider had made improvements meaning people had access to the equipment and staff support they needed to eat and drink. Staff monitored people's weight and made timely referrals to healthcare providers if they observed any significant changes or if people required support with any other aspect of their health.

We saw evidence that the registered manager had discussed the previous inspection findings at a staff meeting and used the discussion to ensure all staff were aware of their responsibilities in relation to the provision of safe care and treatment, good record keeping and other areas of concern we identified. This had helped them to make improvements since our last inspection in terms of governance and quality improvement. We found the provider's audits and checks were now more effective and also more proactive as they had put in place new tools to assess and monitor several aspects of service provision and identify areas for improvement.

We also found at our last inspection that the provider did not always ensure people's privacy was respected, particularly around the storage of confidential personal information. At this inspection we found this information was securely stored. Staff supported people in ways that respected their privacy and promoted their dignity and independence.

The provider had made improvements to care plans since our last inspection, by removing inaccurate or out of date information and ensuring that care plans were reviewed as regularly as needed. Care plans were based on people's needs, preferences and their own views about their care and what was important to them.

There were enough staff to care for people safely and the provider had recruitment procedures in place to help ensure only suitable staff were employed. However, their recruitment procedures did not include always obtaining a full work history from new employees. The provider obtained this information during our inspection.

There were systems in place to protect people from abuse and medicines were managed safely.

Staff received appropriate training and support to carry out their roles effectively. The provider sought advice on best practice from appropriate sources and applied the guidance to their work.

Staff obtained people's consent, where possible, before carrying out care tasks. There were systems in place to ensure that where people did not have the capacity to consent the provider acted in line with legal requirements to make decisions on people's behalf. This included any decisions to deprive people of their liberty where they were unable to consent to being admitted to the home. We observed staff giving people the information and time they needed to make choices about their care. Staff shared information via care plans about how to support people to make choices, particularly those with more complex communication needs. They involved relatives and others who were important to people when making more complex decisions, such as those around end of life care. The service facilitated peer discussions on this topic for people's relatives.

People had access to a variety of activities at the home. The service had recently employed an activities coordinator, who was in the process of developing a programme of person-centred activities to suit individual needs and tastes.

The provider continually sought feedback from people, their relatives and staff and used this to improve the quality of the service. The provider also had appropriate procedures in place to deal with complaints.

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. Some details were missing from risk assessments and the provider's recruitment procedures did not always ensure they obtained all the necessary information to ensure new staff were suitable to work at the home.

However, other aspects of the service including medicines management, the environment and staffing levels were safe.

Is the service effective?

Good

The service was effective. Staff had access to appropriate training, support and guidance to carry out their roles.

Before providing care to people, the provider ensured they obtained people's consent, where possible, and followed legal requirements where people did not have the capacity to consent.

People received the support they needed to meet their nutritional and hydration needs and to access healthcare services when required.

Is the service caring?

Good

The service was caring. Staff took time to get to know people well and build good relationships with them.

People received the support they needed to make choices about their care, including decisions about the care they should receive at the end of their lives.

Staff supported people in ways that respected and promoted their privacy, dignity and independence.

Is the service responsive?

Good

The service was responsive. People's care plans took into account their support needs, health, interests, views and backgrounds and these were used to provide people with personalised care and support.

The provider had appropriate systems in place to deal with people's concerns and complaints.

Is the service well-led?

Good

The service was well-led. The provider had made several improvements since our last inspection and had plans in place to develop these further.

There were systems in place to assess and monitor the quality of the service, including a range of audits, checks and gathering feedback from people, their relatives and staff.

There was a clear leadership structure and staff were assigned day-to-day responsibilities to help ensure continual monitoring of service quality.

St Mary's Lodge Residential Care Home for the Elderly

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 checked 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 11 and 13 April 2017 and was unannounced. It was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, evidence the provider sent us about action they had taken since our last inspection and statutory notifications. These are notifications the provider is required by law to send to us about certain significant events that take place within the service.

During the inspection we spoke with two people who used the service, one relative of a person who used the service and two members of staff. We looked at four people's care plans and inspected the provider's audits and checks that were carried out since our last inspection. We observed staff caring for people and we used the Short Observations Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2016 we found a breach of the regulation in relation to safe care and treatment. This was an ongoing breach that we had identified at each of our previous two inspections in October 2015 and March 2016. We found that the provider did not have appropriate measures in place to ensure that hot water outlets were running at safe temperatures and that risk assessments were not complete and up to date. Additionally, we found that the provider did not ensure harmful chemicals were stored safely and securely, that risks posed by the environment such as trip hazards and loose garden tools were not managed appropriately and that some upper floor windows were not appropriately restricted to reduce the risk of people falling from height. Some alarm pull cords in bathrooms were not kept where people could reach them and there was a risk posed by staff carrying trays of hot food and drinks up and down a steep step, which had not been appropriately assessed.

At this inspection, people told us they felt safe at the home. One person said, "I'm safe here. I can't go out alone but I'm safe if I am with someone. I feel safe when I have my shower because I get good support." Another person told us, "I feel safe. I have nothing to worry about."

Although the provider had not put in place a risk assessment and management plan for staff carrying trays of food and drinks up and down steps, this was because they had obtained a collapsible ramp that allowed staff to use trolleys instead of trays. This meant the risk of staff accidentally dropping hot food and drinks on themselves or others was significantly reduced. However, there were still risks associated with pushing heavy trolleys up or down a collapsible ramp and the registered manager had not formally assessed these risks, although they told us staff were always required to work in pairs for this task. The registered manager told us they would carry out the risk assessment and put in place a management plan for any additional risks identified by this.

Each person had an initial risk screening and individual assessment of their risks and the provider had made improvements to these since our last inspection. Suitable management plans were in place to reduce the risks. These were reviewed and updated regularly at a frequency appropriate to the level of risk. Examples of individual risks included the use of bed rails and other equipment, the risks of people developing pressure ulcers, falls and aggression or other behaviour that challenged the service. One person who had a history of becoming physically aggressive also had characteristics that could increase the risk of staff becoming injured when supporting them. This information was included in the person's risk assessment so staff were aware and knew how to respond safely as the person had a risk management plan containing these details. However, we also found that some details were missing from risk management plans. For example, one person's management plan stated that they used pressure relieving equipment to reduce the risk of them developing pressure ulcers but did not specify what equipment or how they should use this. This meant there was a risk that staff did not have the information they needed to protect the person from the risk of developing pressure ulcers, particularly as the provider was in the process of recruiting new staff who were not necessarily familiar with the person and their needs. We alerted a senior member of staff, who told us they would make sure this information was added.

We checked recruitment records for four members of staff who had started working at the service since our last inspection. The provider had obtained proof of identification, criminal record checks, references and evidence that employees were fit to work. This helped to ensure they only recruited staff who were suitable to care for people. However, we noted that one employee's records contained no information about their work history during a period of 16 years. Care providers are legally required to obtain a full work history for each employee together with a satisfactory written explanation of any gaps. We spoke to the registered manager, who immediately contacted the employee and obtained this information. The manager told us they would update their recruitment policy to reflect this requirement for all new staff.

We found the environment was clean, tidy and free from visible hazards. Fire extinguishers were mounted on walls to avoid people tripping on them. We inspected the garden and saw the provider had arranged for garden tools, bricks and other potentially hazardous items to be stored in secure sheds. Chemicals were stored securely where people could not access them unsupervised and the provider had made sure all upper floor windows were appropriately restricted.

We tested the water temperature from hot taps and showers in every communal bathroom and in four bedrooms. These were all within the safe range for hot water and records showed staff tested them daily to ensure they were safe to use. All of the bathrooms were fitted with alarm pull cords so people could call staff in an emergency. The cords hung low enough for people to be able to reach them if they fell. Staff carried out regular checks of alarms and call bells to ensure they were in good working order.

The provider had systems to review accidents and incidents, identify and trends and put in place actions to prevent reoccurrence. We saw an example where records showed that a person had a number of falls within a period of six months and staff had responded by supporting the person to access appropriate healthcare services, reviewing and updating their risk assessment and arranging for a doctor to review the person's medicines to try and identify a cause for the falls.

There were appropriate procedures in place to protect people from abuse. Staff were aware of different types of abuse and knew how to report any signs or allegations of abuse. There was information displayed in communal areas of the home about how to contact the local authority safeguarding team if anyone had any concerns.

There were enough staff to keep people safe and the provider's systems for assessing and meeting the home's staffing needs had the flexibility to increase staffing levels if more people were admitted to the home. We observed that staff were present in all communal rooms people were using throughout our inspection and were able to provide support promptly when people needed or requested it.

We saw evidence that medicines were managed safely. Staff carried out weekly checks of medicines stock to ensure people had received their medicines as prescribed and all medicines in the home were accounted for. They also carried out daily checks of medicine storage areas to ensure they were kept at an appropriate temperature. We looked at four people's medicines administration records, which indicated people received their medicines as prescribed. People's care plans contained personalised information about what staff should do if they declined to take their medicines, where applicable. For two people, where this had become a long-term problem, staff had consulted doctors and pharmacists in line with the home's medicines policy to discuss whether it was appropriate to administer the medicines covertly (without the person's knowledge). Where this was agreed, people had clear guidelines as to how staff should do this. This helped to ensure people received their medicines safely and in line with appropriate guidance.

Good

Is the service effective?

Our findings

At our last inspection in September 2016 we found a breach of the regulation in relation to meeting people's nutritional needs. People did not always receive the support they needed to eat and drink enough to remain healthy. Care plans did not clearly state what support people needed to eat. When people lost or gained a significant amount of weight, staff did not always take prompt or appropriate action to protect them from the risks of malnutrition or poor health.

At this inspection, people spoke positively about the food and drinks they received at the home. One person told us, "The food is all right. I have no complaints and I get enough. I'm getting a cup of tea now. We're well fed and I'm a good eater." We heard another person telling staff they had chosen a particular meal because, "I don't like the bones on the chicken but this is nice. It's enough. I'm no big eater."

People's care plans had been updated since our last inspection and now contained suitable information about any support or encouragement people needed to eat and drink and any factors that might affect this. For example, one person's care plan stated that although they could usually eat independently, staff should offer assistance if the person was unwell. We observed staff supporting people in line with the instructions in their care plans. For example, one person's care plan stated that they needed full support with eating their meal and we noted that a member of staff sat with them throughout the mealtime to provide assistance. Care plans also contained information about any food allergies, intolerances, likes and dislikes and any other needs, for example if people required fortifying agents to be added to their food. This was to help staff ensure that they offered people food that was suitable for their needs and preferences. We spoke with the chef, who was able to tell us details about different people's needs and preferences around food.

We observed staff supporting people with their main meal of the day. Some people were using adapted plates and cutlery to enable them to eat with minimal support and to help ensure they were able to eat enough food. People's food was prepared in accordance with their care plans. For example, we saw staff cut up one person's food as directed by their care plan. This helped to ensure people received food that was suitable for them.

We also observed that staff offered hot and cold drinks to people regularly throughout the day and that a large bowl of fresh fruit was available. We saw staff offering fruit to people who were unable to reach the bowl independently.

There was a member of staff assigned daily to ensure that each person received enough nutritious food and had enough drinks and that mealtimes were an enjoyable experience. This member of staff was also responsible for following up any significant changes in people's weight. Staff told us the system was working well. We looked at monthly checks of each person's weight and saw that only one person had lost a significant amount of weight since our last inspection. There was evidence that staff had referred the person promptly to appropriate healthcare providers and that a doctor was due to visit them on the day of our inspection to follow this up. We also saw evidence that the registered manager spoke to staff after our last inspection about improving the records they made around people's weight, health and appointments with

healthcare professionals. Monitoring people's weight and following up any concerns helped to protect them from the risks of malnutrition and associated health problems.

The registered manager told us staff training took place on an annual cycle beginning in April. Because our inspection took place in April, the training plan for this year was not yet in place as the training needs of staff were in the process of being assessed. However, we saw evidence that the training plan was in the process of being finalised and that staff had received a variety of suitable training in the year since April 2016. This included training that was specific to their roles and designed to support staff to meet the individual care needs of people using the service. Staff also received one-to-one supervision approximately once every two months to discuss their work and any training needs they had. Staff told us the supervision and training they received were of good quality and helpful to them. This helped to ensure people received care from staff who were appropriately supported to carry out their roles effectively.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The 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. Where people had capacity, we saw evidence that staff had discussed their care plans with them and obtained their consent for carrying out the planned care. The provider had carried out assessments of people's capacity where needed for decisions about their care and had followed the relevant legal requirements for making the decisions in consultation with people's relatives and advocates, doctors and other appropriate professionals.

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. The provider had a 'DoLS tracker' to ensure that applications to deprive people of their liberty or to renew an existing DoLS authorisations were made in a timely manner according to the requirements of the DoLS Code of Practice. Authorisations we looked at were all within their expiry date and did not have conditions attached to them.

Care plans contained information about people's health needs and we saw evidence that staff liaised with healthcare providers to ensure people's individual healthcare needs were met. Where healthcare providers made recommendations about people's care, staff added this to their care plans so all staff had easy access to the information. For example, for one person a speech and language therapist had recommended that staff cut their food into small pieces to make it easier for the person to swallow and this was added to the care plan.

At our last inspection we made a recommendation that the provider seek appropriate guidance on making the home environment more suitable for people living with dementia. At this inspection we saw evidence that the provider had sought advice from the Alzheimer's Society, the local healthcare commissioner and other local care home providers. There were plans in place to make some improvements. For example, the provider planned to paint doors and skirting boards in different colours to contrast with the white walls and make them more easily identifiable. This was planned for completion by the end of 2017.

Good

Is the service caring?

Our findings

At our last inspection in September 2016, some people told us staff did not have time to sit and talk to them. We also found that people's confidential personal information was not stored securely, which compromised their privacy.

At this inspection people told us, "The staff are nice" and, "I like the staff. They are all really nice." We checked and found cupboards containing confidential personal information were kept locked. We also observed staff spending time with people throughout the inspection, engaging them in conversations or activities and responding quickly when people asked for support.

People's care plans contained information about how and when to provide them with emotional support, reassurance and empathy. For example, one person's care plan stated that they sometimes cried for no apparent reason but this was likely to be because they were missing a family member who had passed away. Another person's care plan described a redirection technique staff should use when the person showed signs of becoming distressed. This showed staff had taken the time to get to know and understand people and shared the information with colleagues through care plans so they were able to provide a consistently caring approach that met people's emotional needs.

We observed staff offering people choices at different times of the day and supporting them according to what they chose. For example, we saw staff asking one person how their lunch was and checking that the meal they received was what they wanted. We also saw staff offering another person a choice of activities. Each person had a 'choice care plan' with information about how staff should communicate information about people's care options to help ensure they received the support they needed to choose. Staff we spoke with were aware of these and able to give us examples of how they offered choices to different people depending on their communication needs.

Staff were mindful of people's privacy and dignity while providing care to them. For example, when one person removed some of their clothing in a communal area and declined support to get dressed or leave the area, staff erected a privacy screen around the person to preserve their dignity while they continued with the activity they were doing. When another person dropped a full plate of food on the floor, staff responded calmly so as not to draw attention to the person and embarrass them. We heard the member of staff reassuring the person and saying, "Don't worry, I'll get you another one." We also saw staff asking discreetly whether people wanted assistance to use the toilet so that other people were not able to overhear. Staff were able to give us examples of how they promoted privacy and dignity, such as offering private space for people to meet with visitors.

Staff made an effort to promote people's independence and planned care in such a way as to facilitate this. For example, one person needed physical support to eat using cutlery but their care plan directed staff to encourage them to eat finger foods as they were able to do this independently. We observed staff encouraging people to eat as independently as possible during lunchtime, although they also provided assistance where people needed it.

People's care plans contained information about how they wished to be supported at the end of their lives. End of life care plans included who they wished to be present, funeral arrangements and any additional wishes they had about what care staff should provide. We also saw evidence that a person's relative had led a session at a meeting with other relatives to discuss end of life care planning after volunteering to do so. Senior staff told us this had worked well because relatives had fed back that it was easier to discuss this difficult topic with peers who were in a similar situation to themselves, rather than hearing about it from care staff. Encouraging people and their relatives to talk about this topic helped to ensure people's wishes were known and that they received the care they wanted at this time. Staff told us they had received "very useful" training around end of life care and this made them feel more confident that they could support people well at the end of their lives.

Good

Is the service responsive?

Our findings

At our last inspection in September 2016, we found care plans did not always contain accurate and up to date information and there was some contradictory information, meaning there was a risk that staff did not always have the correct information they needed to give people the care and support they required.

At this inspection, we found this issue had mainly been addressed although we did find one example of contradictory information where a person's nutrition assessment stated they did not need any support with eating while their care plan directed staff to cut up the person's food otherwise they would not eat. We advised senior staff of this discrepancy and they told us they would ensure the necessary updates were made. Other care plans we looked at were up to date and did not contain contradictory information.

Each person had an assessment of their needs and these were used to create care plans tailored to their individual needs. These included the level of support people needed with different tasks, any risks involved, how staff should support people with any equipment or aids they used, people's health needs and details of any other services they used. There was also information about people's preferences, hobbies and interests and usual day and night time routines.

For people living with dementia, the care plans contained information about how this affected the person's life, their behaviour and their care needs. There was also information about how staff should respond, for example if people were presenting as agitated, confused or distressed. This information was personalised to help ensure each person received the care and support that was appropriate to their needs. The care plans also took into account people's own views. For example, one person sometimes presented with aggressive behaviour towards staff and their care plan explained that they sometimes perceived staff as threatening them. This helped staff to understand people's needs better and to provide person-centred care that focused on them as individuals.

At the time of our inspection the provider had recently recruited a new activities coordinator. We observed them and other staff leading group and individual activities such as table top games and looking at photographs to identify objects from the past and famous people. Although the activities were not always tailored to people's individual needs, interests and abilities, senior staff explained this was because the new activities coordinator was in the process of getting to know people and was planning to introduce a tailored group and individual activities programme once they had established what each person's abilities and tastes were. The provider was also planning to install raised flowerbeds in the garden so people could pursue their interest in gardening.

People received support to meet their religious and cultural needs. One person told us they went to church while others confirmed that religious leaders visited the home to provide services for those who wished to participate. We saw evidence that the provider had arranged for a church choir to visit the home and lead a carol service at Christmas.

The service had a complaints policy in place and people we spoke with knew how to complain if they

wanted to. We looked at records showing how the provider dealt with complaints. They recorded the action they had taken, such as calling staff meetings to discuss good practice and improvements that were needed, then advised the person who had complained about the action they took and checked whether they were satisfied with the response.

Good

Is the service well-led?

Our findings

At our last inspection in September 2016 we found a breach of the regulation in relation to good governance. The provider's audits and checks had failed to identify the areas of concern we found at the inspection and the provider had failed to make sufficient improvements to resolve issues found at previous inspections, or to put in place suitable systems to do so.

At this inspection we found the provider had taken appropriate action to address the concerns we identified previously. Staff carried out daily checks to ensure the home environment, including the garden, was safe and we saw guidelines staff had received to ensure the checks were carried out thoroughly so any problems would be quickly identified. The registered manager also carried out spot checks two or three times a week to ensure the daily checks remained effective.

We saw evidence that the registered manager had discussed the previous inspection findings at a staff meeting and used the discussion to ensure all staff were aware of their responsibilities in relation to the provision of safe care and treatment, good record keeping and other areas of concern we identified. The registered manager told us this had been helpful as staff were now much more aware of hazards to people's safety and took prompt action if they identified risks, for example alerting cleaning staff if they saw them leaving a cupboard unlocked that contained hazardous chemicals. Staff we spoke with felt that the service had improved significantly since our last inspection and were happy with changes the provider had made.

The provider used audits and checks to assess the quality of other aspects of the service and took appropriate action to address any shortfalls. For example, audits of care records had identified that the quality of record keeping needed to be improved. The provider had issued guidelines to staff on completing daily reports and senior staff told us they had improved since staff had received the guidelines. The provider had audited all people's care plans over the two months before our inspection to ensure they were appropriately completed and contained all of the required documentation. An audit of medicines management carried out by a pharmacist the month before our visit indicated the pharmacist had found nothing of concern and noted that improvements indicated by the last audit had been carried out.

The registered manager made appropriate use of delegation to ensure tasks were completed. There was a deputy manager in post and each person had a key worker, whose role included ensuring that person's care plan was up to date and that their bedrooms were kept as they preferred them to be. Shift leaders assigned 'champion' roles for each shift to members of staff who were then responsible for ensuring that certain aspects of people's care, such as medicines management or nutrition, were of good quality. We saw evidence that staff had informed people's relatives about this at a meeting and had also informed them who their relatives' keyworkers were so they knew whom to contact in the first instance if they wanted to discuss any aspect of their family member's care.

We saw evidence that the registered manager held regular meetings with their staff team and also with people and their relatives to discuss improvements that needed to be made, ask for their opinions and keep them updated on any changes within the service. The manager shared positive feedback they had received

from healthcare professionals, which staff told us was helpful in raising morale. Senior staff told us that because a session on end of life care a person's relative had led was successful they were inviting other relatives to suggest topics for other peer-led sessions they wished to hold. Records showed that relatives' meetings were well attended, with 29 relatives attending one meeting in December 2016. The relative we spoke with told us the meetings at the home were "very helpful." A senior member of staff told us, "The more we involve [relatives], the more they want to come." They told us it was also helpful from their perspective because relatives often had good ideas about improvements the provider could make to the service.

The provider also carried out regular surveys to gather feedback about the service from people and their relatives. Questionnaires asked people and their relatives to rate aspects of the service on a scale from 'very poor' to 'very good' and we noted that a survey carried out at the end of 2016 and start of 2017 had obtained more positive feedback than previous surveys, with no 'poor' or 'very poor' responses. An earlier survey had contained some 'poor' responses and negative feedback, mainly about food choices, and comments on the latest survey indicated that people and relatives felt there had been an improvement in this area. This showed how the provider used feedback to improve the service.

In addition to the improvements they had made since our last inspection, we saw evidence that the provider was planning to carry out further work to improve the safety, appearance and other features of the home environment. This included a covered path to make the garden more accessible for people who used wheelchairs and also to allow food trolleys to access different parts of the home via external doors so they did not have to be taken up and down steps. Each item on the improvement plan had a responsible person assigned to make sure it was completed and there were target completion dates so the provider could keep track of progress.