St Cuthberts Care

Bailiffgate

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

Bailiffgate is located close to the centre of the town of Alnwick. It provides care for up to eleven people who have learning disabilities. There were nine people using the service when we carried out our inspection.

The inspection took place on the 12 and 19 July 2016 and was unannounced. The service was last inspected on 14 and 15 December 2014. There was one breach of regulations at that inspection related to the numbers of suitably skilled staff deployed in the service. It was also found that documentation related to decisions taken in the best interests of people needed to be improved. We found that there had been an improvement in relation to both of these issues during this inspection.

A new manager had been appointed and was in the process of being registered with the care Quality Commission (CQC). There were plans to recruit a deputy 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. We received feedback about a number of positive changes made by the new manager.

Suitable numbers of staff were deployed and there had been an increase in staffing since the last inspection. This included the appointment of an activities coordinator. Safe recruitment procedures were followed which helped to protect people from abuse.

Safeguarding policies and procedures were in place and staff had received training in the safeguarding of vulnerable adults. A session had been held with people to raise their awareness of safeguarding issues and how to tell someone if they had concerns.

We checked the management of medicines and found there were suitable procedures in place for the ordering, receipt, storage and administration of medicines. Routine stock checks and audits of medicines were carried out and the competency of staff to administer medicines safely was checked on a regular basis.

Checks on the safety of the premises were carried out including gas and electrical safety and window restrictors and water temperatures. Debris which could have posed a hazard was found in the rear garden and was awaiting disposal. This had been removed by the second day of the inspection.

Individual risks to people were assessed such as risks associated with road safety, behavioural disturbance and falls. Where risks had been identified, care plans were in place. These were up to date and regularly reviewed. A record of accidents and incidents was maintained and monitored for any patterns or trends.

Suitable infection control procedures were in place. The home was clean and well maintained and

bedrooms were nicely personalised and homely.

Staff received regular training which was relevant to their role. Staff received regular supervision, and annual appraisals were carried out. This meant that the development and support needs of staff were met.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). 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). Capacity assessments had been carried out and applications to deprive people of their liberty had been made to the local authority in line with legal requirements.

People were supported with eating and drinking. Special diets were catered for and people were offered choices of meals and were supported to prepare their own food where appropriate. Advice had been sought from professionals where necessary including the speech and language therapist to provide advice about swallowing difficulties.

The health needs of people were met. They were supported to attend health appointments in the community. Communication aids were in use to support people to express when they were in pain or feeling unwell.

We observed caring and respectful interactions with people throughout the inspection. People were included and involved, and treated as equals by staff. Communication was adapted to ensure that people were supported to share their views and express their feelings. Regular meetings were held with people as a group and individually. These were recorded in pictorial easy read format.

Person centred care plans were in place to meet the physical, psychological and social needs of people. These were up to date and were reviewed regularly. Effective systems were in place to ensure that staff remained up to date with any changes to care and treatment. Relatives told us they were kept informed about the care of their family member.

The amount of activities available to people had increased since the last inspection and there were comments from staff and relatives about the positive impact of this on people who used the service.

A complaints procedure was in place and was available in easy read format. Complaints were also logged including the response to these.

Staff and relatives spoke positively about the new manager and the improvements they had made.

A number of checks and audits were carried out to ensure the quality and safety of the service. Surveys were provided to people to elicit their views about the quality of the service which were available in an easy read format.

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.

Suitable numbers of staff were on duty and staffing levels had increased since the last inspection. Safe recruitment procedures were in place which helped to protect people from abuse.

Appropriate procedures were in place for the management of medicines. Regular audits were carried out and the competency of staff was assessed to ensure that they followed the correct procedures to administer medicines safely.

Safeguarding policies and procedures were in place. Staff had received training and sessions had also been held with people who used the service to raise their awareness of safeguarding issues and how to report concerns.

Confrontations that could be deemed as abusive between people had not been notified to CQC in line with legal requirements.

Risk assessments were in place related to the safety of the premises and individual risks to people were assessed and regularly reviewed.

Is the service effective?

Good

The service was effective.

Staff received regular training which was relevant to their role. They received regular supervision and annual appraisals and supervisors had completed training in effective supervision.

People were supported with eating and drinking and were encouraged and supported to make their own meals. Special dietary requirements were catered for.

The health needs of people were met and they had access to a range of health professionals and services. Communication aids were used to support people with communication difficulties to express pain or explain if they felt unwell.

The service operated within the principles of the mental Capacity Act 2005 and best interests decisions we read were appropriately documented.

Is the service caring?

Good

The service was caring.

We observed caring and respectful interactions with people throughout the inspection.

People were supported to be involved in decisions about the service and communication was adapted to enable them to do so.

There was an inclusive culture in the service, and people who used the service had attended some training attended by staff and had been involved in interviewing new staff.

The privacy and dignity of people was maintained.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place and these were reviewed and updated regularly.

People were supported to take part in a range of activities. Staff and family members told us that the increase in activities had impacted positively on the people who used the service.

We saw that the personal choices and preferences of people were respected and supported.

Is the service well-led?

Good

The service was well led.

Staff and relatives spoke highly of the new manager. They told us that they had made significant improvements to the service including in the organisation of the service and increased opportunities for people.

A number of checks and audits were carried out to ensure the quality and safety of the service.

Bailiffgate

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 12 and 19 July 2016 and was unannounced. The inspection was carried out by one inspector.

We spoke with six people who lived at the service during our inspection. We spoke with local authority contracts and safeguarding officers. We used the information they provided when planning our inspection.

We spoke with the manager, senior carer and two care workers during our inspection. We also spoke with the director of care, an operations manager and the safeguarding lead from the organisation.

We read three people's care records and three staff recruitment records. We looked at a variety of records which related to the management of the service such as audits and surveys. We also checked records relating to the safety and maintenance of the premises and equipment.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We had not requested a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make. We also looked at notifications submitted by the provider in line with legal requirements.

Good

Is the service safe?

Our findings

At the last inspection we found that there were insufficient suitably skilled staff on duty. At this inspection we found that staffing levels had increased and that three to four staff were on duty during the day. This included an activities coordinator who worked five days per week. One person who had a high level of need had left the service and staffing remained under review and was increased or decreased depending upon the level of support people needed. One staff member told us, "It has improved greatly with the input of more staff. We are not as stressed and there are loads of activities going on now. I think people are happier for having more to do. We just couldn't do much before." We also spoke with a relative who told us, "It is much better than it was last year. It has really picked up." One member of staff slept in the premises at night and one staff member told us, "It is very rare that anyone gets up and there is the occasional alarm. There has never been anything I couldn't manage through the night and we have support from on call managers if we need anything." Monitors, such as those used to alert staff of someone having seizure at night, were in place. This meant that sleep in staff were alerted and able to check people were safe.

We checked the recruitment records of staff and found that safe recruitment procedures had been followed. Two references were obtained and there were no unexplained gaps in employment. Staff records showed that all applicants had been screened by the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable people. This helped to protect people from abuse.

Safeguarding policies and procedures were in place. Staff had received training in safeguarding vulnerable adults and one staff member told us, "We have done training and I wouldn't hesitate to report anything of concern. I have never seen anything in all the years I have worked here." Another staff member told us, "We do the training and the manager has also held a session with people who use the service. It really helped to boost our understanding too." The session that had been held with people asked the question, "What would you do if someone wasn't very nice to you?" There were pictorial prompts about how to report concerns and a telephone number was provided for people to contact someone outside the organisation. A safeguarding log was maintained electronically on the computer system. Senior managers within the organisation monitored safeguarding issues and a safeguarding lead was in post who provided support to services. They had devised a flow chart for staff to follow outlining their responsibilities and explaining how to report concerns.

We checked the management of medicines and found that there were suitable procedures in place for the ordering, receipt, storage, administration and disposal of medicines. Individual stock balances of medicines belonging to people were maintained and there were weekly medicine audits. We checked the stock balance of medicine belonging to one person and found the correct amount in stock. Medicines were clearly labelled with the date of opening and expiry dates. Temperatures of storage areas were checked daily. This is important as some medicines deteriorate if stored at the incorrect temperature. There were no controlled drugs (medicines liable to misuse) and no medicines were given covertly, such as being hidden in food or drinks. The competency of staff to administer medicines was checked regularly. This helped to ensure that staff followed safe procedures when administering medicines. Appropriate procedures were in place for the return and disposal of spoiled medicines. Weekly medication audits took place which included checks on

signatures in medicine administration records (MAR's), appropriate use of codes, and that any refusals of medicines had been followed up. Medicines were also counted. We found one discrepancy in one MAR and we were told that this had been addressed by the manager and discussed with staff. Topical medicines charts were in place for medicines applied to the skin such as creams and lotions. Body maps (drawings of a person's body) were in place. We saw that one body map had been colour coded to denote where two types of cream and a medicated shampoo should be applied. This meant that instructions to staff were clear.

Individual risks to people were assessed which meant that steps could be taken to ensure they remained safe where risks were identified. We found that one person had been at high risk of falls. Advice had been sought from an occupational therapist which had significantly reduced this risk. Risk assessments were in place relating to falls, behaviour, road safety, choking and managing finances. These were regularly reviewed. Personal emergency evacuation plans 'PEEPs' were in place. PEEPs outline the level of support needed by a person in the event of an evacuation from the service.

Regular checks on the safety of the premises were carried out. We saw a record of a 'Premises walk through inspection'. This included a check on communal rooms, hallways entrance and exits, laundry, handrails, and cleaning schedules. An action point had been recorded to request lockable cupboards for bathrooms to store potentially hazardous items. We found that these had been provided. This meant that the safety of people who used the service was considered by the provider. Certificates of electrical and gas safety were in place. A legionella risk assessment had been carried out and control measures were in place to prevent the risks from legionella bacteria from occurring. Weekly checks on equipment were carried out such as wheelchairs, and window restrictors. Water temperatures were regulated and there were regular water temperature checks. An annual health and safety audit was carried out by the provider. This meant that the provider sought to ensure the safety of people, staff and visitors to the service. We checked the rear garden and found debris including bricks and building materials in one part of the garden. We discussed this with the manager who said the items were awaiting removal and that people did not have unsupervised access to the garden. These items had been removed by the end of the inspection. The manager stated that they would include the garden areas on the safety check of the premises to ensure the outdoor area remained safe at all times.

Suitable infection control procedures were in place. The service was clean and there was a dedicated member of domestic staff, although staff and people who used the service carried out some cleaning duties or supported people with their housekeeping. Staff had all signed a 'cooksafe' document about food hygiene and food stored in the fridge was labelled and dated. Food temperature records were available. Colour coded chopping boards were in use to chop different food items separately.

Personal protective equipment such as gloves and aprons were available. We looked in the laundry, which was clean and tidy, and there were clear instructions about the use of different coloured cloths and mops for cleaning different areas in the home, such as kitchens and bathrooms. Hazardous cleaning substances were locked away. An infection control trainer had delivered a training session to people who used the service and had shown them hand washing techniques which they had enjoyed.

A record of accidents and incidents was maintained. This was held electronically on the computer systems and monitored by senior managers in the organisation. The organisation held a 'risk register' of areas of concern to be discussed at senior level and monitored. This meant that senior managers could monitor the safety of individual services and provide support and guidance to the home manager.

Good

Is the service effective?

Our findings

Staff received regular training and one staff member of staff told us, "We have some training at head office and some on line (computer). We do loads of training." We checked staff files and found they had received a variety of training including: safeguarding, dementia awareness, diabetes awareness, epilepsy awareness, mental capacity act and deprivation of liberty safeguards, health and safety, nutrition, and food safety. This meant that staff had received training relevant to their role. New staff underwent a period of induction into the service. Regular supervision was carried out and supervisors had completed 'effective supervision' training. Supervision records were held on the computer and the manager was alerted to any due or overdue sessions, as these changed colour to amber or red. Supervision records we saw were detailed. Annual appraisals had been carried out. This meant that the support and development needs of staff had been considered by the provider.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). 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). Capacity assessments had been carried out and the manager had submitted applications to deprive people of their liberty to the local authority, in line with legal requirements, and had notified CQC when applications had been granted. Decisions taken in the best interests of people who lacked capacity were documented. Decisions were made based on long term knowledge of the person and their likes and dislikes. There was a record of people involved in decision making. An independent mental capacity advocate (IMCA) had been present at the review of the care needs of one person. An IMCA is an advocate who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them.

People were supported with eating and drinking. We joined people at lunch time and found that menus were in place and that people were offered choices at mealtimes. One person told us, "I'm having an egg sandwich with tomato sauce on it." People were encouraged to make their own meals and two people were making sandwiches. Staff supported people where necessary and provided verbal prompts and instructions. A staff member told us, "We have a menu but we are very flexible so people can change their mind and we adapt the choices available." Breakfast choices included cereals, toast, fruit, yogurt, bread rolls, cheeses, meats and spreads. Tea, coffee, and juice were available and cooked breakfasts were available at the weekends or through the week if anyone particularly wanted something cooked. Staff told us there were ample supplies of food. One staff member told us, "There is never any shortage of food here. We get bulkier shopping delivered but we go out every day with people to the shops to buy fresh food. People can really have whatever they want." Special diets such, as diabetic and low cholesterol meals, were catered for.

Specialist advice was sought when necessary including from a speech and language therapist who had been consulted about one person who was at risk of choking. The speech and language therapist had been invited to a team meeting to speak with staff. This was designed to help to meet the training and development needs of staff and to raise their awareness of problems associated with swallowing to help to ensure people's needs were met.

Health needs were met and people were supported to access appointments in the community, such as visits to their GP. We saw that people had attended a number of health appointments including hospital visits, opticians and chiropody.

Care plans were in place to support the assessment of pain in people who may be unable to verbalise this. These contained good detail and included instructions to staff to monitor facial expressions and gestures including wincing, crying and holding the affected body part. This was important as some people did not have the capacity to express pain verbally or request pain relief. Additional communication aids were in place to enable staff to support people to tell them how they were feeling using emoticons (pictures of facial expressions) and a body diagram. For example, if a person looked pale, or was suspected of being unwell, staff would use the communication aid to help the person to point to the part of the body that may be affected. Staff reported that this had been particularly helpful for one person.

The premises were clean and well maintained. People showed us their bedrooms which were personalised and homely. They told us that they were very happy with their accommodation and that they had been able to choose their own bedding and décor. One person told us they had just bought new covers for their bed and took us to show us their room. They had matching curtains, bedding and wallpaper all in their favourite colour. There were plans to change one shower room into a wet room due to the dated design of the room and to improve access to the shower which had a slight step.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person indicated towards staff members and told us. "I like it here, and I like them." Another person told us, "They're all good ones in here." We observed kind and compassionate care throughout the inspection. A relative told us they were very happy with the care provided and said, "My relative couldn't be better taken care of. The service has come on leaps and bounds and all the staff are great. They know (name of person) so well. I can't fault the care in any way."

Staff showed a genuine affection for the people they cared for. We asked staff what they enjoyed most about their job and two staff told us it was the people they cared for. All interactions we observed with people were respectful, courteous and warm. One member of staff told us, "All the people who work here are lovely; really caring people. I learned from them how to treat people." A good deal of humour was displayed and people enjoyed close relationships with staff. A staff member joked with one person about a job they had forgotten to do, the person laughed loudly and said, "I forgot all about that, did you have to do it?" We observed good natured banter between people and staff throughout the day. The privacy and dignity of people was maintained. People were supported with personal hygiene needs discreetly, and staff did not enter the rooms of people without knocking or asking their permission first. Confidentiality was maintained, and records about people were stored securely.

One person became anxious and a staff member held them and said, "You're alright, you've got me". The person responded, "I've missed you all week." Another staff member was helping at lunch time and said, "Would you like some pudding now?" The person responded affectionately, "Yes please darling." Staff ate lunch with people which was good practice and demonstrated that the culture in the home was inclusive and reinforced equality. This was evident in the way that people were included in training delivered to staff. People had also been involved in staff interviews and had chosen their own questions to ask applicants. These included, "Will you go horse riding?", "Can you swim?", "Can you drive?" and "Can you cook?"

People were encouraged to share their feelings through use of the visual communication aids, using pictures of facial expressions. A visual diary was on display in the kitchen, with photographs of activities occurring that day and of the staff and people who would be taking part. Information for people was available in a variety of easy read formats.

Service user questionnaires had been carried out, and we saw that the information from these had been used to make changes in the service. People had expressed in a questionnaire that they did not always feel safe due to a particular issue in the home that has since been addressed. They used the pictorial images to show that this sometimes made them unhappy and scared. In the next questionnaire they had responded that they were very happy living in the service. 'Residents' meetings and individual meetings with key workers were held on a regular basis and agendas and minutes were available in visual format, including photographs of people who attended. People were supported during these meetings to make decisions about the service and were provided with information in a way that they could understand.

People were supported to remain as independent as possible. This had become easier due to the increase

in the number of staff on duty. One staff member told us, "People can do more for themselves now, we encourage that. It was difficult before and we probably did things for people instead of encouraging them to be more independent."

Good

Is the service responsive?

Our findings

We checked care records and found them to be neat, well organised and easy to navigate. Care plans were person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. People were consulted about their care plans where possible and regular meetings took place between key workers and people who used the service. One member of staff told us, "I am a key worker for a few people. It means we keep records up to date and remember people's birthdays and birthdays of families and friends. We have just swapped around which is a good idea as it brings fresh eyes to people's needs." Records of key worker meetings were held in people's care files. Discussions recorded included safeguarding, choice, human rights and complaints.

Care plans were in place related to physical and psychological needs. Social needs were also recorded and included, for example, that one person needed support to call a friend on the telephone regularly. There were also plans in place to promote independence and life skills, for example cooking and housework. Individual care plans were in place to promote positive behaviour, and these were personalised. Positive behavioural support seeks to identify individual triggers to behaviour and to meet the needs of people in an attempt to prevent behaviour from occurring. There was clear advice to staff about how to respond to behavioural disturbance and distress to ensure staff were consistent in their approach. Care plans were up to date and had been evaluated monthly. Where amendments to care records had taken place, such as changes to care plans, information was placed in a 'reading file' for staff. This meant that care plans were regularly reviewed and reflected the care being delivered. Staff were aware of the most recent plans in place. A relative told us that they were happy with the response from staff and that they were always contacted if there were any problems. They told us, "If anything is wrong they tell me straight away. It is reassuring that I can visit any time I like. I can just knock on the door as if my relative was still in their own home."

A range of activities were available. People, relatives and staff commented upon the positive impact of the recruitment of additional staff including the activities coordinator. One relative told us, "Staff do plenty of activities with people, in fact my relative has a more active social life than me! They go out a lot and they have entertainers visiting the home. They have a summer barbecue planned one weekend." One person told us, "I go shopping and to the leisure centre. I like to go out a lot." A staff member said, "People used to sit in the kitchen quite a lot but there are a lot of activities now." Another relative told us, "My family member is definitely a lot happier due to the increase in activities."

People were out at a coffee morning on the first day of the inspection. They also visited the leisure centre and some people were supported to go for personal shopping. A trip to the swimming pool was planned in the evening. We spoke with the activities coordinator who told us, "We have introduced a number of activities. There is a four week cycle but they aren't set in stone and I monitor how much people have enjoyed events and activities. People are building up confidence and self-esteem through giving them choice." The daily activity timetable was displayed and contained a list of social activities, personal shopping, life skills and relaxation. We observed people being supported with household skills and one person told us, "I have stripped my own bed today." Another person was asked if they wanted to go to the leisure centre and said they didn't want to that day as they were a bit tired. A car was available to transport

people, and staff were also insured to use their own vehicles meaning that people could get to most activities without difficulty. The activity coordinator was supporting one person to find employment.

Complaints procedures were in place including in an easy read 'I would like to make a complaint' form. A relative told us that they knew how to complain and would speak with the manager. A record of complaints was held by the service. One informal complaint had been received which was logged and the outcome was recorded. The complainant was happy with the response to their concerns.

Good

Is the service well-led?

Our findings

A new manager was in post and was in the process of being registered with CQC. The service was in the process of recruiting a deputy manager at the time of the inspection.

Staff and relatives were complimentary about the new manager. One staff member told us, "The manager is lovely. She's been really good for the service. Her attitude is good and she is supportive. She cares about the staff team and she makes you want to do things for her." Another staff member told us, "The manager has made a huge difference. She is very accommodating and fair and will help you, but is also firm and would tell you straight away if anything was wrong." A relative told us, "Communication has picked up a bit and the new manager has some good ideas and is very enthusiastic since taking up post. The appointment of an activities coordinator has definitely made a difference." Another relative told us, "The manager seems very nice and is very thorough. She is making sure that people are getting what is rightfully theirs and whatever help they need."

We checked statutory notifications sent to us by the provider. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We discussed these with the manager who was aware of the events and incidents that needed to be notified.

We spoke with the manager who told us they were keen to foster a culture where people were placed at the centre of everything staff do. They said, "I use the opportunity when discussing residents to emphasise important messages about dignity, respect, and individuality. I reinforce the need for positive behavioural support at staff meetings and one to one with staff during supervision. I try to role model best practice." The manager told us that they had aspirations to increase the community presence of the service. We found that there were good links with services and resources in the community, including educational, recreational and those related to health promotion, and that the manager promoted an increase in opportunities to people who used the service.

A number of quality checks and audits were carried out by the manager including audits of medicines, care plans and the premises. Records were neatly filed and easy to locate and staff told us that the service was more organised. Senior managers visited the service regularly and the management team consisted of the operational support manager, safeguarding lead and risk and compliance manager. A central computerised system which held information about the home meant that the senior management team had an overview of what was happening in the service at any given time, including safeguarding issues, complaints or concerns about individual people, inspection or regulatory requirements and staffing issues. A weekly management report was completed which included this information. A report went to the director of care and each service was discussed at directorate meetings. This meant that information about services was discussed and monitored at board level.

Regular meetings were held with people and staff. Questionnaires were provided to survey relatives and

professional visitors about the quality of the service. Adapted surveys were in use for people to share their views with support from staff. This meant that people were consulted about the quality of the service in a way which maximised their opportunity to participate.