Mauricare Limited

Ashview House Residential Care Home

Inspection report

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Date of inspection visit:
25 January 2016

Date of publication:
02 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 25 January 2016. This was an unannounced inspection.

Our last inspection took place on 1 December 2015, where we identified multiple Regulatory breaches. We found the service was not safe, effective, caring, responsive or well-led. This service was placed into special measures as a result of an earlier inspection in April 2015. After our December inspection, we found there was not enough improvement to take the service out of special measures and we continued to take enforcement action against the provider. This included preventing the provider from accepting new admissions to the service. Following this inspection, we found that although some improvements had been made, these were not sufficient enough to remove the service out of special measures. CQC is now considering the appropriate regulatory response to resolve the on-going problems we found.

The service is registered to provide accommodation and personal care for up to 22 people. People who use the service have physical health and/or mental health needs, such as dementia. At the time of our inspection three people were using the service. The numbers of people using the service were low because of the action taken by the local authority after our last inspection, to safeguard people from risks to their health, safety and well-being.

The service had a registered manager. However, they were no longer working at the home. 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 and associated Regulations about how the service is run. A new manager had been appointed by the provider and they had applied to register with us. At the time of our inspection, their application was being considered by us.

During this inspection we found that some of the required improvements had not been made and we identified a number of continued and one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Risks to people's health and wellbeing were not consistently assessed, managed and reviewed. This meant systems were not always in place to promote people's health, safety and wellbeing.

The provider did not have effective systems in place to consistently assess, monitor and improve quality and manage risks to people's health, safety and wellbeing. This meant that concerns with people's care, including safety concerns were not always being identified and rectified by the provider.

People's health needs were not consistently monitored and prompt advice from health and social care professionals was not always requested when people's needs changed.

When people did not have the ability to make decisions about their care, the legal requirements of the

Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not always followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Effective systems were not in place to ensure everyone who used the service could safely access the community if they chose to do so.

Improvements had been made to the way medicines were managed. This meant people were protected from the risks associated with medicines. Staff understood how to protect people from the risk of abuse.

There were sufficient numbers of staff to meet people's needs. Staff had started to receive the training they required to provide them with the knowledge and skills to meet people's needs effectively.

People could eat and drink suitable amounts of food and drink that met their individual preferences.

Staff treated people with kindness and compassion and people's privacy was promoted. People were encouraged to make choices about their care and independence was promoted.

The new manager had sought feedback from people who used and visited the service. They planned to use this feedback to identify what improvements were needed to improve people's care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

Staff felt supported by the new manager and staff spoke positively about some of the improvements they had made to people's care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Risks to people's health, safety and wellbeing were not always assessed, monitored or managed effectively.

Sufficient numbers of staff were available to keep people safe and people were protected from abuse and avoidable harm. Medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective. The legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) authorisation were not consistently met.

People's health and wellbeing needs were not consistently monitored and prompt action and advice was not taken or sought in response to changes or concerns with people's health and wellbeing.

Staff were receiving training to provide them with the knowledge and skills needed to meet people's needs. Improvements were needed to ensure staff applied their training effectively.

People could eat and drink suitable amounts of food and drink that met their preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring. Effective systems were not in place to ensure people's dignity was consistently promoted.

People were treated with kindness and compassion. People's right to privacy was supported and promoted.

People were encouraged to be independent and staff supported people to make decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Further

improvements were needed to ensure people's care plans contained information that was specific to their individual needs.

People were being supported to participate in leisure and social based activities, but improvements were needed to ensure everyone had the opportunity to access the community if they wished to do so.

People knew how to complain and complaints were investigated in line with the provider's complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Although we had noted some improvements in this area, effective systems were still not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing.

A new manager had been appointed. They had started to seek feedback from people about their care in order to identify where improvements were needed.

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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 was 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 25 January 2016 and was unannounced. Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the local authority and public. We used this information to formulate our inspection plan.

We spoke with all three people who used the service and a person who was visiting the service. We also spoke with three members of care staff, an activity coordinator, the manager and the provider. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing care in communal areas and we observed how the staff interacted with people who used the service.

We looked at the three people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, staff rotas and training records.

Requires Improvement

Is the service safe?

Our findings

At our last two inspections, we found that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

We found that risks to people's safety were still not always assessed and planned for. At our last two inspections, we found that the risks associated with one person's behaviours that challenged had not been assessed and planned for to promote the safety of other people who used the service and the staff. This had led to staff managing the person's aggression in an inconsistent manner, which placed them and people who used the service at risk of harm to their safety and wellbeing. At this inspection, we found the risks associated with this person's behaviour that challenged had still not been assessed and planned for. However, at the end of our inspection, the manager had addressed this and a risk assessment and management plan was put in place. This meant there were ineffective systems in place to ensure risks to people's health, safety and wellbeing were assessed, monitored and managed in a timely manner.

A recent skin risk assessment had shown this person had been identified as at high risk of skin damage. However, staff confirmed that no risk management plan was in place to show how this risk should be managed. Staff told us the person's skin was in good condition, but there was a risk this could deteriorate as the person often declined assistance and support from the staff. This meant an effective management plan had not been devised to help staff to manage this person's risk of skin damage. After our inspection, the manager sent us a copy of a risk management plan they had put in place as a result of our inspection. This showed the manager was responsive to our feedback, but an effective system was not in place to ensure risks to people's health, safety and wellbeing were consistently and promptly identified and managed.

A falls risk assessment had also been completed for this person. However, we found the assessment had been completed incorrectly and had not identified or reflected that this person was at risk of falling. Staff we spoke with confirmed they felt the person was at risk of falling because of their unsteady gait. This meant the assessment tool used to identify the person's risk of falling had been ineffective and had not identified or planned how to manage this person's risk of falling. The manager contacted us after the inspection to inform us the falls risk assessment had been corrected, but no management plan was shared with us to show how this risk was being managed.

Another person was using a medical device to help manage a medical condition. Risks known to be associated with this device included infection and bleeding. No information was contained in the person's care plan to guide staff on how to manage the risks associated with the device. For example, no information was recorded to inform staff of any signs that would show the device was not working effectively. Staff told us they did not have to check the device as visiting health professionals checked this on a daily basis. However, it is important that staff understand how to identify problems with the device so they can seek timely professional advice if needed. This meant the risks associated with providing care for someone with this medical device had not been assessed and planned for by the manager and provider. After our

inspection, the manager sent us a copy of a risk management plan they had put in place as a result of our inspection. We found that improvements could be made to this plan to ensure the information staff needed to manage the risks associated with the medical device were managed effectively. For example, the signs and symptoms of infection should be listed so staff know how to recognise infection should it occur.

The above evidence shows that risks were still not assessed, monitored or managed in a manner that effectively and consistently protected people from risks to their health, safety and wellbeing. This was a continued breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found there were not always enough staff available to keep people safe and meet people's individual needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had been made. People told us the staff were always available to provide them with care and support. One person said, "The girls (staff) sit with me a lot now. They seem to have more time". The manager and provider were using a tool to identify the numbers of staff needed to keep people safe and meet people's individual needs. Staff rotas showed and people and staff confirmed that the provider's minimum safe staffing levels were being consistently met.

At our last two inspections, we found that people were not consistently protected from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the staffs' understanding of what constituted abuse had improved. People told us they felt safe around the staff. One person said, "There's too many folk around here now, they'd soon notice if someone wasn't doing their job right". Staff told us that recruitment checks were in place to ensure they were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. Staff also told us how they would recognise and report abuse in accordance with the agreed local safeguarding procedures. Staff told us and care records showed no incidents of suspected abuse had occurred since our last inspection. This meant we were unable to confirm that staff were acting upon potential safeguarding concerns.

At our last two inspections, we found that medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had been made. People told us and we saw they were encouraged and supported to take their medicines as prescribed. Our observations and medicines records showed that effective systems were in place that ensured medicines were ordered, stored, administered and recorded to protect people from the risks associated with them.

Inadequate

Is the service effective?

Our findings

At our last inspection, we could not be assured that people were being deprived of their liberty in a lawful manner. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we identified that further improvements were required to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were consistently met.

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). At our last inspection, staff were unaware of and unable to demonstrate who was being restricted under the DoLS. At this inspection, staff told us and care records confirmed that one person was being restricted under the DoLS. However, we found that a condition that the person's DoLS was subject to, was not being consistently met. This condition required staff to record in sufficient detail how the person's care needs were being addressed. The person's care records did not always show that the person's care needs were being addressed as specified in the condition. 15 of the 58 entries between 7 January 2016 (the day after their DoLS the condition was put in place) and 25 January 2015 did not contain sufficient detail to show personal care had been offered to the person by the staff. This meant the condition the person's DoLS was subject to was not being consistently met. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that when people were unable to make important decisions about their health and wellbeing, the provider could not always show they were acting in people's best interests. At this inspection, we found effective systems were still not in place to ensure staff acted in people's best interest when they could not make decisions for themselves. This included the need to seek advice from health and social care professionals to ensure they were providing people's care in the best possible way. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

One person who used the service had been assessed by the staff and local authority as not having the capacity to make decisions about their care and support. This person frequently declined assistance from staff to have their personal care needs met, which posed a risk to their health and wellbeing. Care records showed this person could refuse personal care for significant periods of time. For example, care records showed the person had refused assistance with personal care for a period of eight consecutive days. There was no clear plan in place guiding staff on how to best manage this person's refusal to receive assistance and participate in personal care tasks. Staff confirmed no advice had been sought from health and social care professionals to help manage this person's care needs effectively. Care records showed and staff confirmed that a best interest meeting had not taken place to agree how this person's behaviours should be managed to ensure their health and wellbeing needs were being met in the best way for them. This showed

the requirements of the MCA were not being followed to ensure the staff were providing care and support to the person in the best way for their individual needs. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that people's health and wellbeing were not consistently monitored to promote their health and wellbeing. At this inspection, we found some improvements had been made. For example, one person's care records showed staff were recording and monitoring their fluid intake in accordance with professional advice. However, we found more improvements were needed to ensure people's health and wellbeing was monitored consistently and effectively. For example, staff were not centrally monitoring and acting upon one person's refusal to receive assistance and support from staff to meet their personal care needs. This person's care records often recorded 'No concerns' despite the person frequently declining personal care support. This meant action had not been taken to ensure this person received effective care that met their needs. Following our inspection, the manager contacted us to inform us they had requested an appointment from the person's doctor with regards to their behaviours that challenged. This showed the manager had been responsive to our feedback, but effective systems were not in place to ensure prompt action was taken in response to people's care needs not being consistently met.

At our last inspection, we found that professional advice was not always sought in a prompt manner to ensure that changes in people's health and wellbeing were appropriately assessed. We saw some improvements had been made. For example, a doctor had been called in response to a recent deterioration in one person's health. However, we found more improvements were needed to ensure professional advice was consistently sought promptly when required. For example, one person's care records showed they had unintentionally lost over six percent of their body weight in a four month period. Care records showed and staff confirmed no action had been taken to seek advice from health care professionals with regards to this unintentional weight loss. Care records showed and staff confirmed that no other action had been taken by the manager or provider to show they were managing the risk of further weight loss. When we fed this back to the manager and provider, they arranged for the person to be weighed again. The results showed a small weight gain. However, the person was still below their usual weight. Following our inspection, the manager contacted us to inform us they had now referred this person to a doctor with regards to their weight loss. This showed the manager was responsive to our feedback, but effective systems were not in place to ensure professional advice was sought in a prompt manner when required.

The above evidence shows that effective health monitoring did not always occur, and prompt action was not always taken to promote people's health, safety and wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found there were not enough staff available at mealtimes to ensure people received the support they needed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made.

No one required physical assistance from staff to eat and drink, but staff prompted and encouraged people to eat and drink as required. People told us and we saw they could choose the foods they ate. For example, one person told us, "I fancied a take away, so the staff got me a menu and I had one". We saw that staff gave people drinks and snacks throughout the day and people confirmed they always had enough food and drink to satisfy them.

At our last inspection, we found that staff did not always have the knowledge and skills required to meet

people's individual needs in a safe and effective manner. This was also a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements were being made and staff were starting to receive appropriate training. Since our last inspection some staff had completed moving and positioning and MCA training. Our observations showed that some of this training had been effective as we saw staff support one person to move using a hoist in a safe manner. However, further improvements were needed to ensure staff consistently followed the requirements of the MCA. The manager told us and staff confirmed that some staff were also now working proactively towards achieving a diploma in health and social care. This showed the staff were now being actively encouraged to attend training to give them the knowledge and skills needed to meet people's needs. However, further improvements were required to ensure staff effectively applied the skills acquired from training.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, people told us that staff were not always kind and caring. People's right to privacy was not consistently respected and people were not always enabled to make choices about their care. At this inspection, we found some improvements had been made by the staff, but further improvements were required by the provider to ensure people were consistently in a caring and compassionate manner. For example, the provider had not ensured effective systems were in place to encourage and support one person to engage in personal care tasks, such as washing and dressing. This meant there was a risk that this person's dignity was not consistently promoted.

People told us they were treated with kindness and compassion. One person said, "They are very good to me". Another person said, "They are very kind". A relative we spoke with also confirmed the staff interacted with people in a caring manner.

We observed caring interactions between people and staff. People told us and staff confirmed they had more time to spend sitting and chatting to people. One staff member said, "It's really nice to have that time to chat now". We saw staff spent time talking and participating in activities with people. For example, we saw one staff member sit and read a book with one person who used the service. The person responded positively to this by smiling, laughing and responding to the staffs comments and actions.

People told us and we saw they were enabled to make choices about their care. One person said, "I choose where I want to eat, I've been eating in here (the lounge) a lot recently". We saw that a small dining table had been moved into the lounge area to enable people to eat in their preferred location. Another person said, "I go to bed when I like, I just have to ask the girls and they help me". This showed the staff respected and responded to the choices people made.

We saw that people were enabled to be as independent as they could be. Mobility aids were kept within people's reach, so they could mobilise independently around the home if it was safe to do so.

People told us and we saw that privacy was promoted. We saw people were supported to move to their bedrooms when they wanted to spend time alone in their rooms. Staff knocked on people's doors and waited for a response when they completed safety checks.

People told us and a relative we spoke with confirmed relatives and friends could visit the home at any time. People also told us their right to speak with their visitors in private was also respected by the staff.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that improvements were required to ensure care was consistently provided in accordance with people's preferences and individual needs. At this inspection, we found some further improvements were still required.

People told us they were supported to participate in activities that were meaningful to them. One person showed us a painting they were working on and said, "I like painting, I like anything that uses my hands". Another person showed us a book they had been looking at with a member of staff. Care records showed people were enabled to participate in activities such as; baking and BINGO and people confirmed they enjoyed these activities. The activities coordinator told us they were planning to take two people who used the service out to a local café and shop. One of these people told us they were looking forward to this. This showed there were plans in place to support two people who used the service to access the community. We asked the activities coordinator if the third person who used the service would also be going. They replied, "I asked [a senior carer] if I could take them out on a trip to the museum as I think they would really like that, but I was told I couldn't". We asked the activities coordinator why they couldn't take this person out. They replied, "I think it's because they can get a bit agitated sometimes". This person was unable to tell us that they wanted to visit the museum, but the information gained from the activities coordinator indicated a visit to the museum would be in keeping with their preferences and interests. This person's care records did not show any valid reasons why they should not access the community with support from the staff. Improvements were therefore needed to ensure systems are in place to enable all people to safely access the community if they wish to do so.

We found that care records contained information regarding people's likes, dislikes and care preferences. For example, one person told us what their preferred time of waking was. We found the information the person gave us matched the information recorded in their care plan about their morning routine. However, improvements were needed to ensure all care records were specific and individual to each person's needs. For example, all care records contained a generic risk assessment for bathing, rather than individual risk assessments tailored for each person's specific risks and risk management plans.

People and their relatives knew how to complain and they told us they were confident their concerns would be acted upon. People told us they would share complaints with a senior member of staff who they thought was the manager of the home. This meant some improvements were needed to ensure people were aware and reminded of the change in the home's management. This would ensure they could direct any complaints to the manager. The complaints policy was displayed in the reception area of the home. We found complaints were investigated in line with the complaints policy.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

We found that risks to people's health, safety and wellbeing were not being consistently assessed, monitored or reviewed. For example, action was only taken to address the need for a risk management plan for a person's behaviours that challenged after this inspection. This was despite us raising this as a concern at our last two inspections. This showed that effective systems were not in place to promptly respond to risks to people's health, safety and wellbeing.

Although some improvements had been made to equip staff with the skills they needed to meet people's individual needs. Further improvements were required to ensure the staffs' development needs and competencies were effectively managed. For example, senior staff had been given new responsibilities at the home, like completing falls and skin damage risk assessments. The staff had not received training to enable them to complete this effectively as we found one person's falls and skin damage risks assessments had been completed incorrectly. The manager contacted us after our inspection, to inform us they were now providing this staff member with the guidance needed to complete these forms correctly.

Some systems were now in place to assess and monitor the quality of care. These included checks of how care was delivered and the cleanliness of the home. We saw that some of the systems in place had been effective in making improvements. For example, one quality check showed new carpets were required in some parts of the home to address the risk of trips and falls. New carpets had been fitted to address this quality issue. However, further improvements were required to ensure these checks covered all areas of care. For example, no checks of the content of people's care records had been completed. This meant the manager and provider had not identified some of the problems we identified during our inspection. This included not identifying the lack of consistent recording by staff to show the condition of a person's DoLS authorisation was being consistently met. The manager told us they were going to start checking the content of people's care records immediately to address this concern.

Effective systems were not in place to ensure people's health needs were effectively monitored as planned. For example, no one took responsibility to check how often one person was refusing assistance to meet their personal care needs. This meant patterns and possible triggers for this behaviour could not be identified and professional advice had not been sought. The manager contacted us after our inspection to share a management plan for this person's behaviour that challenged. This showed the need to record any refusals of personal care in the person's care records. However, there was no reference to the monitoring of this specific behaviour that challenged. This showed the need for monitoring of this behaviour had still not been recognised by the manager.

The manager and provider shared their improvement action plan with us that outlined how and when they

were going to make the improvements required from our last inspection. We asked the manager to review the timescales of this plan to ensure improvements were made in a timelier manner than planned. For example, the plan to ensure care plans and risk assessments were up to date, accurate and easily accessible was set for 28 February 2016. More prompt action was required to ensure the safety of the three people who used the service. The manager told us they would review the timescales on the action plan to ensure improvements were made in a more timely manner.

The above evidence shows that effective systems were still not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found the provider had failed to notify us of reportable incidents that had occurred at the home. This included a safeguarding concern and a serious injury. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. No reportable incidents had occurred since our last inspection. Therefore we were unable to identify if the required improvements in this area had been made and sustained.

The provider had recruited a new manager to run the home. The manager had applied to be registered with us and at the time of our inspection, their application was being considered by us. Staff told us they felt supported by the new manager. One staff member said, "I can nip and see them anytime, they always listen to me". Another staff member said, "They are really supportive".

We asked people if anything had changed since our last inspection. People struggled to answer this, but one person told us staff had more time to spend with them. Staff told us the provider and new manager had been proactive in making some improvements following our last inspection. One staff member said, "They spoke with us all and didn't blame anyone". Another staff member said, "They've seen what was going on for themselves now and they've made changes to the paperwork and staffing". Staff told us they had confidence in the new manager to make the required improvements. One staff member said, "It was heart breaking after the last inspection, but they have recognised what needs to be done and they've come in like a tonne of bricks to get it better" and, "I'm happy that things are finally getting better".

The new manager had sent out satisfaction questionnaires to gain feedback from the three people who used the service and their relatives. They were waiting for the feedback to be returned, so they could analyse this to identify where improvements were needed. Regular meetings were facilitated by the activities coordinator to gain feedback from people about their care. We saw information gained from these meetings was acted upon to make improvements to people's care. For example, people told us and we saw they had expressed a wish to try cauliflower cheese, so this was provided for people by the cook. This showed the staff were responsive to people's feedback about their care.