Althea Healthcare Properties Limited

The Queen Charlotte

Inspection report

432 Chickerell Road
Chickerell
Weymouth
Dorset
DT3 4DQ

Tel: 01305773128
Website: www.kingsleyhealthcare.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 7 and 8 July 2016 and was unannounced.

At our inspection in September 2015 we found issues with people receiving safe care and treatment and with staff deployment. Staff had not been trained to manage challenging behaviours and lacked an understanding of dementia. Staff did not have enough time for people resulting in a lack of empathy and dignity. Communication methods were not being used to support people who had a sensory or cognitive impairment and there was a lack of stimulation. We found limited detail and involvement of people in their care plans, no consideration of the compatibility of people living together and information not being shared with staff in a timely manner about people's care needs. We found that audits were not effective as they had not included the delivery of care to people and staffing levels. We found at this inspection that improvements had been made although further improvements were required.

The service is registered to provide accommodation and residential or nursing care for up to 51 people. During the inspection there were 40 people living at the service many whom were living with a dementia.

The service comprised of a ground, first and second floor providing accommodation. Bedrooms had an en-suite toilet and sink. The ground floor had two lounge areas which gave access into a secure garden area, and a dining room. Both the first and second floor also had lounge and dining areas and kitchenettes. There was a lift and staircases to the first and second floor. The service had specialist bathrooms, a kitchen, sluice and laundry facilities.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was in the process of applying for their registration.

Staff understood the risks people faced. However risk assessments had been completed but care plans did not consistently include enough detail about the actions needed to minimise risk. The recording of incidents was not consistently taking place. Inconsistencies in record keeping and reviewing processes meant that at times risks to people and effective ways to manage risk were not able to be evaluated effectively. Some care plans did not reflect fully what we observed. This meant that if people had been supported by staff that didn't have experience of caring for them they were at risk of receiving inappropriate care. Staff had a good knowledge of people. They told us that handovers happened each day and were detailed and included actions that needed to be carried over from the previous shift. Reviews included setting goals for people.

Medicine was stored and administered safely. Staff had a recognised tool to assess if people were in pain

but we found this was not consistently being used. This meant that some people may not have received pain relief when they needed it.

There were enough staff to support in a timely way and at the pace of the person. Staff were being recruited safely and had employment and criminal checks in place. Processes were in place to manage unsafe practice.

Staff had received training and were aware of the signs of abuse and what actions they would need to take if they suspected abuse was happening. They received an induction and ongoing training that enabled them to effectively carry out their roles. Records showed us that the majority of staff had completed the provider's mandatory training courses however a number had been slow in progressing through the e-learning programme.

Staff felt supported by the senior team in their day to day work. Formal staff supervision had not been happening regularly but there was a plan in place which was being discussed at the next senior meeting.

Staff were aware of any risks associated with peoples eating and drinking requirements, their likes, dislikes and allergies. Referrals had been made to dieticians and swallowing and language therapists when required.

Staff understood the importance of supporting people as individuals and respected their privacy and dignity. They had undertaken behavioural management training and dementia awareness courses which had given them confidence to carry out their roles effectively.

We found the service were working within the principles of the mental capacity act. Where people had been assessed as not having the capacity to make a specific decision a best interest decision had been taken which included people's families.

People had access to healthcare which included GP's and district nurses, physiotherapists, mental health professionals and dieticians.

Staff supported people with patience and kindness and had a good understanding of people's interests, likes and dislikes. The relationship between staff and people was affectionate but professional. Visual aids had been used to support people to recognise their rooms. These included photographs of the person, their families and activities or trades they enjoyed.

Staff had a good knowledge of peoples interests and engaged them in conversations about their past jobs and hobbies. Activities had been organised to reflect current social and sporting events. Links had been made with the local community and was continuing to be developed.

The complaints records showed us that complaints were investigated, actions taken and outcomes reported back to complainant.

Staff felt part of the changes taking place in the home and spoke enthusiastically about the manager and being part of a team. Meetings were being held weekly with senior staff and included updates on actions in the services improvement plan.

Processes were in place to monitor service delivery. This included audits of all aspects of the service and a quality assurance survey to gather feedback from staff, families and other stakeholders. The information

captured provided sufficient data to lead to positive change.

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 always safe.

Risk assessments had been completed but care plans did not consistently include enough detail about the actions needed to minimise risk.

Inconsistencies in record keeping and reviewing processes meant that effective ways to manage risk were not always able to be evaluated effectively.

There were enough staff to support people. Staff were recruited safely and processes were in place to manage unsafe practice.

Staff had the knowledge to keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received induction and ongoing training that enabled them to effectively carry out their roles but some were slow in progressing through the e-learning training programme. Training had included behavioural management training and dementia awareness courses.

Staff were supported but supervision had not been taking place regularly.

Staff were aware of peoples eating and drinking requirements and referrals were made to specialists when appropriate.

We found the service were working within the principles of the mental capacity act.

People had access to healthcare in a timely way.

Is the service caring?

Good

The service was caring.

Staff supported people with patience and kindness and had a good understanding of people's interests, likes and dislikes.

Communication tools were being used to support people who had difficulties understanding or communicating verbally.

People and their families were involved in decisions about their care.

People had their dignity and privacy respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect practice. Reviews took place monthly and included setting goals for people.

Staff had a good knowledge of people including their history and interests.

A range of activities took place both individually and in groups and reflected current social and sporting events. Links had been made with the local community.

Complaints process was in place and demonstrated the service listened and acted on feedback positively.

Is the service well-led?

Requires Improvement

The service was not always well led.

Recent high staff turnover had created communication issues for families and professionals. There was not a registered manager in place.

Staff, families and professionals spoke positively and enthusiastically about the new manager.

Audits and quality assurance processes were in place to monitor service delivery. The information captured provided sufficient data to lead to positive change.

The Queen Charlotte

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 the 7 and 8 July 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist clinical advisor. The specialist advisor had experience in nursing and the care of frail older people.

Before the inspection we looked at notifications we had received about the service and we spoke with social care and health commissioners and a GP to get information on their experience of the service. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information from the provider during the inspection.

During our inspection we spoke with five people who used the service and six people who were visiting. We spoke with the Operations Manager, Manager, three nurses, eight care staff, one housekeeper and one member of the catering team. Also during our inspection we spoke with a district nurse and a community mental health nurse that had experience of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 10 people's care files and discussed their accuracy with care workers. We checked three staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.

We walked around the building making general observations of staff practice.

Requires Improvement

Is the service safe?

Our findings

Some people at times experienced agitation which led to them putting themselves, other people and staff at risk of physical harm. Risk assessments had been completed but care plans did not consistently include enough detail about the actions needed to minimise risk. One person had a history of chronic pain. They had been prescribed paracetamol to manage pain when required. The medicine care plan stated that staff needed to observe for pain as the person may not be able to tell them. Indicators of pain were recorded as agitation and restlessness. We read the person's care plan and they were agitated several times most days however their care plan for managing their agitation did not make reference to pain management. We checked their medicine administration record and were not able to find any assessment of pain linked to the person's agitation. We spoke with the nurse supporting the person. They told us they had administered paracetamol twice that day as the person had indicated they had pain. There was a risk that the person may not be offered pain relief if staff used the care plan for managing agitation in isolation. We discussed this with the manager who told us the person had the capacity to decide whether they needed pain management and they would be offered it in line with the PRN care plan although this had not been recorded. They told us they would review the case file immediately to ensure that the two care plans both reinforced the need to ensure pain management is considered and offered.

We observed staff supporting people in a calm and professional way when they were agitated. One person was becoming agitated and the care worker distracted them by engaging the person in a conversation about a topic they knew they enjoyed talking about. We spoke with care workers who explained how they supported people who could become agitated when receiving personal care. Actions that helped included explaining what they were doing and not starting until the person consented, constantly reassuring, changing staff and leaving the person for a few minutes and returning if they began to get agitated. We spoke with a relative who felt the staff were calm and caring when dealing with a relation who at times became agitated. They said "Staff will take (relatives) hand and talk to them. They manage it quite well". We spoke to visiting health professionals who told us they had confidence in the abilities of the staff to support people with complex needs.

Assessments were being carried out monthly to monitor people's weight and any associated risks of malnutrition. Reviews had been completed monthly and actions taken to minimise any identified risk. These included increasing calories at mealtimes and making referrals to swallowing specialists. Staff were aware of the actions they needed to take to support people safely. This included adding prescribed thickener to drinks for people who had swallowing difficulties and using the correct type of beaker for people to drink from. However, a risk assessment of one person's weight had showed their risk of further weight loss and malnutrition had increased. Actions had been put in place and had included discussing with a dietician. The dietician advised they would speak to the person's GP and request a fortified drink supplement be prescribed. The following month the person continued to lose weight and the fortified drink supplement had not been prescribed. The monthly review of the person's care had not identified this. The manager reviewed the file one month later and identified the request for the supplement drink was two months outstanding and immediately contacted the GP who prescribed the supplement. A new handover system had been put into place to minimise the risk of this happening again.

Some people were at risk of their skin breaking down and had care plans which detailed how to minimise risk. They included pressure relieving mattresses and when in bed changing position regularly. Air mattresses had been set correctly and records showed us people were being regularly supported to change position.

Incidents and accidents were recorded and analysed monthly to identify any trends. For example, one person experienced a number of falls. Action had been taken to reduce the risk to this person such as referral to other professionals and use of a sensor mat. However, we observed an incident where a person had become agitated towards a member of staff which had not been recorded as an incident. We raised this with the manager who arranged for action to be taken.

There was guidance for staff on when to administer peoples 'as required' medicines such as pain relief. Some people were unable to communicate when they were in pain and a tool was used to help identify people experiencing pain and requiring 'as required' pain relief. This tool had not been consistently used. The manager told us that the pain assessment tool had not been used for June as a different member of staff had updated the files. The pain assessments were in place during the inspection and a nurse told us that this had been beneficial, for example, one person was receiving pain relief every morning to see if this helped them when being transferred from bed.

Medicine was stored and administered safely however the recording of creams was not consistently taking place. Some creams were applied by care workers when they assisted people with personal care. These creams were kept in a person's room. A body chart had been completed showing where creams needed to be applied. Care workers were not consistently signing to show the creams had been applied. We spoke with the manager who told us they would look at the process and include checks as part of their medicine audit. Some people took medicines that were covered by the Misuse of Drugs Act. This meant they had to be stored and administered with more security than other medicines. We checked three people's records and they were accurate. People had their medicines regularly reviewed. We spoke with one family who told us "They always give him his medicine on time". They explained that prior to admission their relative experienced a recurring health problem. They told us this hadn't happened in over a year and felt it was due to medicine being administered correctly.

Staff, families and visiting professionals told us they felt there was enough staff. We observed people being supported in a timely way and at the pace of the person. Recent changes had been made to staff deployment. Staff had been allocated to one floor on the rota. They told us that it enabled them to get to know people better and that families liked it as there was more consistency. Staff were being recruited safely and had employment and criminal checks in place. Processes were in place to manage unsafe practice.

Relatives and visiting professionals told us they felt the care was safe. One relative said "Staff know where she is and what she needs". Another told us "Never had concerns about safety. Carers are nice and caring". Staff had completed safeguarding training and had knowledge of the types of abuse people were at risk from, how to recognise signs of abuse and the actions they needed to take if they suspected abuse. Processes were in place to protect staff from bullying.

Requires Improvement

Is the service effective?

Our findings

At our inspection in September 2015 we found issues with staff not having been trained to manage challenging behaviours and lacking an understanding of dementia. There was a breach of regulation. We found at this inspection that improvements had been made but more improvement was required.

Staff received an induction and training that enabled them to effectively carry out their roles. This included an introduction to the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. We spoke to one care worker who had been in post for over six months and they had not completed their full induction. The majority of staff had completed the training courses identified by the provider as mandatory. However the manager told us a number had been slow in progressing through the e-learning programme. The manager had completed a training needs analysis which had identified any outstanding training and staff had been told it needed to be completed by the end of July 2016.

The community mental health team had provided behaviour management training to the staff that was specific to people living in the service. We observed staff confidently following strategies they had learnt from the training and had formed part of a person's care plan. We spoke to one care worker who said "If (person) unmanageable by two staff, particularly with personal care, and would not respond to reassurance it is best to leave them for a while and try offering the same assistance later". We spoke with another care worker who had completed a dementia course. They told us "I learnt a lot about dementia. You learn how to relate to people".

Staff felt supported by the senior team in their day to day work. Formal staff supervision had not been happening regularly. Records showed us that staff had received supervision in either March or April 2016 but that in May and June only six had been completed. We discussed this with the manager who told us that a meeting had been planned for the following week with senior staff to discuss timescales and to allocate staff responsibilities for supervisions and appraisals.

Staff were aware of risks associated with peoples eating and drinking requirements, their likes, dislikes and allergies. However, information had not always been communicated to the kitchen staff. We spoke to the chef who was not aware that two people followed a diabetic diet and so this had not been considered when planning menus. However this had not impacted on their diabetes management. To support people who were at risk of weight loss some foods such as potatoes, sauces and soups were fortified by the kitchen with extra ingredients like butter and full fat milk. Fortified food was served to all the people living at the service and not just people identified as being at risk of malnutrition. We discussed with the manager the potential risk to a person's health and well- being when being given excessive calories through a fortified diet when risk assessments were not indicating a risk of malnutrition. They told us they would review this practice with the chef.

People were supported with their meals as described in their care plans. Where there was a risk of a person not eating or drinking enough food and fluid charts were being completed throughout the day and night.

We read one person's chart mid-morning and they had only taken small amounts of fluid and been declining drinks. The care assistant reported this to the nurse who we observed assessing the person, offering choices and returning with the person's favourite milkshake. They encouraged and supported them to drink the full beaker. The charts included a target amount of fluid required each day and were reviewed by the manager the next morning. Where risks had increased actions included making changes to care plans, referrals to GP's and dieticians.

There were choices of places people could have their meals which included their own room, main dining areas or quieter parts of the home. People were supported by staff at a comfortable pace which enabled them to enjoy their meal experience. Specialist beakers, cutlery and plate guards were being used to support people to be independent with eating and drinking. People and their families told us the food was good. One relative described it as "Top notch". We read that one person didn't always settle for meals and tended to come and go from the table. Their care plan had included offering finger foods so that they could eat whilst on the go. We observed people being offered alternatives to the menu throughout the day. One person was not eating their cooked lunch. The care worker offered lots of choices which were declined. They then said "How about a marmalade sandwich" and the person gave the broadest smile as a response. This meant that people were being supported in an individual and flexible way by staff who knew them.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service were working within the principles of the Act. We observed staff explaining the actions they were planning to take with people and giving them time to think and consent. We read care plans that gave a clear description of a person's ability to make choices about a range of day to day decisions. Where people had been assessed as not having the capacity to make a specific decision a best interest decision had been taken. Best interest decisions had involved the person's family and at times their GP. A DoLs authorisation was in place for one person and had a condition that the person went out one or two hours a week. Staff were aware of the condition and confirmed they were being met.

People had access to healthcare which included GP's and district nurses, physiotherapists, mental health professionals and dieticians. Health professionals were confident in the decisions made and told us guidance was followed and records were kept up to date.

Good

Is the service caring?

Our findings

At our inspection in September 2015 we found that staff did not have enough time for people resulting in a lack of empathy and dignity. Communication methods were not being used to support people who had a sensory or cognitive impairment and there was a lack of stimulation. There was a breach of regulation. We found at this inspection that the service had made improvements.

We observed staff showing people patience and kindness. One care worker said "We all have a lot of love in us. We all care". Another told us "I love working here with these residents, they are all very special people, all different and I have a great respect for them all". When people were sitting awkwardly we observed staff helping them get comfortable.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. We observed a care worker talking with a person about a job they used to have and another talking with a person about the football. One family told us a birthday party had been organised by the home for their relative. They said "Staff pulled out all the stops and the family really appreciated that". We observed staff showing an interest in people as individuals and asked their opinions about events in the news and other topical issues. Staff were quick to respond to people's requests and the relationship between staff and people was affectionate but professional.

Staff deployment around the home had been reviewed. An outcome had been that staff had been put into three teams and designated a floor of the home as their main place of work. Staff told us this had helped develop relationships with people and their families. One told us "We have the same staff on each floor. Family really like it for consistency. We've been doing this now for about three months". Another told us "We get to know the residents and their families and build a relationship".

Visual aids had been used to support people to recognise their rooms. These included photographs of the person, their families and activities or trades they enjoyed. One person had a board of switches on their wall which provided an opportunity to reminisce and use skills.

Staff had a good understanding of the importance of supporting people as individuals and respected their privacy and dignity. One member of staff told us "This is the resident's home, it is not our place of work, we just come here to support people who live here just as much as if we were community carers going into their homes. We treat this as their home because it is, so we have to ask their permission to go into their rooms and every carer does". Another member of staff said "I love working here with these residents, they are all very special people, all different and I have great respect for them all. This is a wonderful place to work with a great team".

We saw staff knocked on people's doors and waited for a response before entering a bedroom. When they entered a room they asked permission from the person before undertaking any tasks such as cleaning or providing any care or support function.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in September 2015 we found limited detail and involvement of people in their care plans, no consideration of the compatibility of people living together and information not being shared with staff in a timely manner about people's care needs. There was a breach of regulation. We found at this inspection that the service had made improvements but further improvement was required.

People's needs had been assessed and care plans developed to meet those needs. However we found some examples of care plans not containing sufficient detail although staff were able to explain how the persons care needs were met. Full care plans were stored and accessed electronically. A paper summary version had been placed in people's rooms to provide a quick reference overview of the support a person needed. We found that the summary did not always reflect the updated information stored electronically. Some care plans did not reflect fully what we observed. We saw that one person had a physical condition that affected a limb and this had not been reflected in the moving and handling care plan. We read that another person had a mental health condition and a care plan was not in place to explain to staff how the person needed to be supported with this or how to notice signs of a deterioration in their wellbeing. This meant that if people had been supported by staff that didn't have experience of caring for them they were at risk of receiving inappropriate care. We discussed this with the manager who was in the process of reviewing each person's care plans with families where possible. We reviewed a care plan that had been reviewed and found it contained sufficient detail. The manager told us that all care file reviews would be completed by the end of August.

Staff had a good knowledge of people. They told us that handovers happened each day and were detailed and included actions that needed to be carried over from the previous shift.

People received care that was responsive to their changing needs. Reviews included setting goals for people. One person had been poorly and had needed to spend many weeks in bed. Prior to the person being poorly they had been able to walk on their own. As the person returned to better health the review included making a referral to the community rehabilitation team (CRT). A revised care plan had been written following the guidance of the CRT and the person was regaining their mobility.

Assessments had been completed prior to people moving into the service and included information gathered from the person, their families and other professionals. This information had been used to write the initial care plans. The manager told us the assessment included whether the service could meet the person's needs. A mental health nurse told us that the service had been unable to offer one person a home as the level of care they needed couldn't be provided. The manager told us that consideration is given to people's compatibility to live together and included where their room would be in the home and the staff team that would be supporting them.

Care files included information about people's interests. We spoke to the activities co-ordinator who told us "When I started I went into people's care files and looked at interests. Just the odd resident who doesn't have information". Staff were talking with people and their families and gathering information about

people's history and the events that were important to them. The information was being collected into a booklet created by the Alzheimer's Society called 'This is Me'. The booklet is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.

We observed people enjoying activities with staff such as knitting and talking about pictures in books of topics they enjoyed. One person liked to bang things and make a noise and they had been given a small drum to bang. Staff had a good knowledge of peoples interests and engaged them in conversations about their past jobs and hobbies. We were told of one person who enjoyed people watching and arrangements had been made to go into the local town for a coffee. A hairdresser visited weekly for people. Links had been made with the local church and schools and the local community had been invited to join in with a recent summer fayre.

Activities had been organised to reflect current social and sporting events. These had included celebrations for the Queen's birthday and a mini olympic games day. During our inspection we saw people enjoying a Wimbledon tennis event and the kitchen had organised fizzy drinks, strawberries and cream and a strawberry mousse for people with safe swallowing plans.

Information about the complaints procedure was displayed on the wall in the foyer. The complaints records showed us that complaints were investigated, actions taken and outcomes reported back to complainant. People were given information on how to appeal if they were not happy with how the complaint had been managed.

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager in post. The previous registered manager left in December 2014. The new manager had submitted their application for registration to CQC. Families and professionals told us they had found communication with the service difficult due to a high turnover of staff and there was a degree of uncertainty due to this experience. One relative said "A big change over of staff here you never know who you're going to see". Another said "There have been three different managers in a year. They all say they are going to do this that and the other and then go".

Staff and professionals with experience of the service spoke positively about the new manager who had been in post for three months. A GP told us "There has been a big staff turnover. The new manager talks to me directly which is working well and provides reliable information". A mental health nurse told us "Since (manager) took over there's a real positive feel". Staff told us the manager was supportive and approachable. One senior care worker said "They are brilliant and really listen, nothing is too much trouble and you feel really part of the team here". Another care worker told us "I feel like my work is appreciated by the manager". We observed interactions between staff and the manager that were relaxed and professional.

Staff felt part of the changes taking place in the home and spoke enthusiastically about the new working arrangements which involved working in smaller teams. A care worker told us "I feel absolutely able to talk with the manager. Feel improved, staff getting on more as a team. They care about the residents". Meetings were being held weekly with senior staff and included updates on actions in the services improvement plan.

The Manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Processes were in place to monitor service delivery. The manager walked around the home each day observing practice and the environment. Audits included medicine, care plans, staff training, dignity and dining experience. The information captured provided sufficient data to lead to positive change. An example included improving peoples dining experience by making changes to the environment such as tablecloths and flowers on the table. Also introducing more varied meals and places for people to eat. The manager told us they were committed to ongoing improvements and said "It's the start of where we have to go to put things right".

People and staff were involved in the quality assurance process. Staff, people and their families had completed a survey in March 2016 asking their views on the quality of the service. We were told by the manager that a meeting with people and their families had been arranged the following week to share feedback. Due to the high number of staff changes the staff survey was going to be repeated. A survey form had also been sent to professionals who had experience of the service and they were awaiting the results.