W & S Red Rose Healthcare Limited

Morley Manor Residential Home

Inspection report

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Leeds
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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

Morley Manor Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide care and support for up to 31 people, some of whom are living with dementia. Nursing care is not provided. The home is situated on the outskirts of Morley, within reach of the town centre and local amenities. At this inspection there were 24 people living at the home, one of whom was in hospital.

This comprehensive inspection took place on 14 December 2017 and was unannounced. At the last inspection in August 2017 we rated the service as 'Requires Improvement'. Although the provider had made significant improvements and was no longer in breach of the Regulations, we found further improvement was required to make sure new work practices were embedded and sustainable.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Morley Manor Residential Home on our website at www.cqc.org.uk

At this inspection we found further improvements had been made and these had been sustained.

There was a registered manager in place. 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.

People told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. Risks to people had been assessed and plans put in place to keep risks to a minimum. Improvements had been made to the environment to make it safe and this work was planned to continue.

The systems in place to make sure that people were supported to take medicines safely had been improved and were effective.

There were a sufficient number of staff on duty to make sure people's needs were met. Recruitment procedures made sure that staff had the required skills and were of suitable character and background. Staff were supported by a comprehensive training programme and supervisions to help them carry out their roles effectively. Staff were led by an open and accessible management team.

The registered manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of

movement is restricted and they lack capacity to make their own decisions. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with sufficient amounts of food and drink. Where people required support with eating or drinking, this was appropriately provided, taking into account people's likes and dislikes.

People told us that staff were caring and that their privacy and dignity were respected. Care plans showed that individual preferences were taken into account. Care plans were up to date and gave clear directions to staff about the support people required to have their needs met. People's needs were regularly reviewed and appropriate changes were made to the support people received. People were supported to maintain their health and had access to health services if needed.

People were encouraged to follow their interests and take part in a range of activities.

People had opportunities to make comments about the service and how it could be improved. A complaints procedure was in place and people told us they knew how to raise a concern if needed.

The manager had good oversight of the service and there was a clear ethos of care. The registered manager had made improvements at the service since they started in post and these had been sustained. There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified. The provider was actively involved in service development.

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.

The management of medicines had improved and people received their medicines safely.

Staff were aware of safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff followed the requirements of the Mental Capacity Act 2005. Relevant legislative requirements were followed where people's freedom of movement was restricted.

People were supported to maintain good health and were supported to access relevant services such as a doctor or other professionals as needed.

People were provided with sufficient amounts of freshly prepared food and drink.

Is the service caring?

Good

The service was caring.

People were looked after by caring staff.

People were treated with dignity and respect whilst being supported with personal care.

People and their relatives, if necessary, were involved in making decisions about their care and treatment.

Is the service responsive?

Good

The service was responsive.

People received care which was responsive to their needs. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People could take part in a range of activities.

People knew how to make a complaint or compliment about the service.

Is the service well-led?

Good

The service was well-led.

The management and staff team had continued to make improvements which had been sustained.

There was a positive, caring culture at the service.

There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

There were opportunities for people to feed back their views about the service.

Morley Manor Residential Home

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 14 December 2017 and was unannounced. The inspection was carried out by one adult social care inspector, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of supporting someone living with dementia.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR), although this had not been updated since our previous inspection. The PIR 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 also sought feedback from Leeds County Council Quality Monitoring Team, and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During this inspection we looked around the premises, spent time with people in their rooms and in communal areas. We looked at four people's care planning documentation and other records associated with running a care service. This included recruitment records, the staff rota, notifications and records of meetings.

We spoke with six people who received a service and one visiting relative. We met with the registered provider, registered manager and deputy manager. We also spoke with five care staff, the activity coordinator and the maintenance person.

Good

Is the service safe?

Our findings

At our last inspection we rated this domain 'Requires Improvement'. Although the provider was not in breach of Regulations, we found further improvement was needed to make sure medicines management was robust. At this inspection we found the necessary improvements had been made.

People told us it was a safe service. Comments included, "Yes, I'm safe" and "It's safe here".

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Each person had a Medication Administration Record (MAR) which detailed the medicines to be administered and when they had been given. MARs were correctly completed with no gaps. MARs also contained prescribing information prepared by the pharmacist, information relating to any allergies the person may have and a photograph to aid identification. Each person had a patient information chart which included a picture of each prescribed tablet to assist staff with identification.
We observed a medicines round. The staff member explained to people what medicine they were taking and why. People were offered a drink of water and were given the support and time they needed when taking their medicines. The MAR was signed by the staff member after they were sure that medicines had been taken.

There were clear protocols in place for the administration of 'as required' or PRN medicines. Some people required skin creams and there was clear information about when cream was to be used and where it should be applied. For a medicine that staff administered as a patch, a system was in place for recording the site of application. This is necessary because the application site needs to be rotated to prevent skin damage.

At our last inspection we found that the temperature of the storage room was not being checked to make sure medicines were kept at the right temperature. At this inspection, the temperature of the room and medicines fridge was being checked on a daily basis. Records showed that the temperature was within the required range to make sure the quality of medicines was not compromised.

There were up to date safeguarding policies and procedures in place which detailed the action to be taken where abuse or harm was suspected. Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being.

When people were in their rooms we saw that call bells were kept within reach so that a member of staff could be alerted if needed. We identified no concerns with the response time of staff to answer call bells.

Records showed that any incidents or accidents were recorded and appropriate action taken in response. Each incident was also logged on an overview spreadsheet which was checked at the end of the month to identify any trends or patterns. The registered manager told us they would also complete a six month overview, in order to identify longer term trends. Any serious incidents or concerns had been reported to other authorities, such as CQC or the local safeguarding team, as necessary.

The care planning process included the completion of risk assessments, which detailed the risks to each person and the action to be taken to reduce them. Risk assessments were completed for areas such as moving and handling, dietary intake and skin integrity. The provider used recognised risk assessment tools, such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) to complete individual risk assessments. Risk assessments were up to date and included a timescale for review, to make sure they reflected changing needs.

Each person had a Personal Emergency Evacuation Plan (PEEP) in case of an emergency. These were very detailed and gave specific information about how to support individuals if, for example, the building needed to be evacuated. Information included how a person's mobility may impact on any evacuation. There was also information about how best to communicate in an emergency, such as the use of signs.

Regular checks were carried out on the environment and equipment to make sure it was safe. These included checks on fire doors, bed rails, hoists and wheelchairs. Call bells and window restrictors were also checked each week. There were up to date test certificates in place for electrical wiring, gas safety and lifts. We spoke with the staff member responsible for maintenance, who told us, "The place is improving".

Safe fire procedures had been maintained. A fire risk assessment was carried out in July 2017. Actions identified in the assessment had been carried out to make sure the environment was safe. A new fire system was to be installed in the near future.

There were regular tests of fire call points and emergency lighting to make sure they operated effectively. Each member of staff had received one to one fire training. There were occasional fire drills which had been carried out in line with people's PEEPs and they had used a simulated fire in a part of the building. This meant people and staff would be more familiar with the evacuation routine should an emergency occur.

There was a robust system in place to make sure new staff had the right qualities to care for older people. There had been no new staff recruited since our last inspection but we saw that previous applicants had completed an application form which was discussed at interview. References were sought prior to employment and checks were carried out on each applicant's suitability for the position. A criminal background check was provided by the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records.

There were sufficient numbers of staff to meet people's needs and keep them safe. The care staff on duty were supported by ancillary staff who included cooks, domestics and maintenance personnel. The registered manager told us they still relied on occasional agency staff to cover shifts. However, they used the same agency and tried to get agency staff who knew the service. Regular agency staff were asked to come in to shadow permanent staff on a weekend so they could get to know people and their routines. There was a comprehensive dependency tool which was used to check staffing levels were sufficient. This was updated weekly to reflect any changes in needs or occupancy. None of the people or relatives that we spoke with raised concerns about the number of staff in the service.

Staff followed infection control guidance. The people and relatives we spoke with told us the service was

kept clean and tidy. We observed domestic staff cleaning throughout the day and there were no unpleasant odours. We noted staff used personal protective equipment (PPE), such as gloves and aprons, as necessary. We found no issues with the cleanliness of the service.

Good

Is the service effective?

Our findings

At our last inspection we rated this domain 'Requires Improvement'. Although the provider was not in breach of Regulations, there remained improvements to be made to make sure new practices were embedded and sustainable. At this inspection we found improvements had continued and were sustained.

The staff we spoke with told us they were supported in their roles. Comments included, "I'm very happy. There have been a lot of changes for the better. I get all the training I need", "I find it alright here. The staff team are helpful and I have been supported" and "I love the job. We all know what we are doing and we have improved so much".

Training records showed that staff had undertaken a range of different courses over the last year. These included dementia awareness, safeguarding, mental capacity and falls awareness. We saw that staff were working towards the Care Certificate, which is a nationally recognised standard for care workers. The registered manager used a training matrix to give an overview of the training each member of staff had undertaken as well as training planned for the future. This also highlighted when training was due for renewal so that it could be booked in a timely manner.

New staff received an induction when they started working at the service. This gave them an opportunity to receive essential training and learn about the people who used the service, their needs and preferences. One staff member who had recently been on induction told us, "I was observed for competence in all aspects of care before being able to work on my own". New starters had a mentor, who was an experienced member of staff. This was someone they could go to for support or guidance to better understand their role. New staff also had two or three days shadowing other staff on shift so they were able to familiarise themselves with routines.

Staff received a regular supervision meeting with a manager to discuss work issues and development. The meeting included a discussion about performance, training and a review of goals. Yearly appraisal meetings also took place to discuss staff progress and development. An action plan was produced from the meeting which included individual staff goals. For example, one staff member wanted to attend training on managing challenging behaviour. We saw this had been planned for the new year.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. At the time of our inspection there were five people who had an authorised DoLS in place and 13 people waiting for responses from the local authority.

The staff team had an awareness of provisions of the MCA and DoLS and had received training in the topic. Where there was uncertainty about a person's capacity to make important decisions a mental capacity assessment had been completed. This showed why the person lacked capacity and explained why a decision would need to be made on their behalf. Some people had decisions made on their behalf by a Lasting Power of Attorney, who was a legally authorised representative. For those people who did not have an authorised representative, a best interest decision had been made. This was a decision made by others closely involved with the person, such as relatives, social workers or health professionals.

An example of this process was seen for one person who had refused an important regular injection. The mental capacity assessment demonstrated why the person lacked capacity and the best interest meeting showed who had attended and their decision.

People were provided with a sufficient range of food and drink. We observed the meal time experience. People seemed happy with the food they were offered and the meals looked appealing. Healthy options were available if people wanted. Staff were attentive to people's needs and offered support where needed. People were offered a choice of drinks and staff made sure to check with people if they wanted anything during the meal. Overall, it was a sociable and relaxed experience.

The chef maintained a list of each person's nutritional requirements so that people received the food they needed. The list was updated if there were any changes or new admissions to the service. Information included food allergies, preferences and any special requirements, such as soft food or a diabetic diet. Alternatives were available if people did not want what was on offer.

Some people were at risk of malnutrition or dehydration. Where this was the case, care plans detailed the support people needed to maintain their health. Staff monitored some people's food and fluid intake to make sure they were eating and drinking sufficient amounts. Food charts recorded the food a person was taking each day and included portion sizes. All charts were fully completed, which showed staff were effectively monitoring people's nutrition in order to take action, if required.

The service supported people to maintain their health. People's care records showed details of appointments and visits by health and social care professionals. Staff had worked with various other professionals and made sure people accessed other services in cases of emergency, or when their needs had changed. For example, doctors, community nurses, opticians and chiropodists. Care plans reflected the advice and guidance provided by external health and social care professionals.

Records showed that any charts used for the monitoring of people's health were completed properly and reviewed as necessary. These included charts for the monitoring of weight, skin integrity and food and fluid intake. Some people were at risk of pressure ulceration. Assessments had been carried out to identify which people were at risk and preventative pressure relieving measures were in place for those people who required them. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin.

Improvements to the environment had continued. Some parts of the building had been made better for people living with dementia. Toilet seats were colour contrasting and there was signage around the service,

with pictures to assist with orientation. The provider had visited other services to get ideas for making the environment better for people living with dementia. This was a work in progress, although one idea was being implemented when we visited. People's room doors were being painted to look like street doors which made it feel more homely. There were also plans to create a sensory room.

Good

Is the service caring?

Our findings

At our last inspection we rated this domain as 'Good'.

People told us it was a caring service. Comments included, "Yes they (staff) are caring. They're always ready to give you any assistance", "I'm feeling happy with quality of life" and "They are very caring staff. My daughter is very caring, like the staff here".

Care staff told us they had time to socialise with people and we observed several occasions where people were engaged in conversation with the staff on duty. There was a friendly, positive atmosphere throughout our visit. We saw that people's requests for assistance were answered promptly and politely. Throughout the visit, the interactions we observed between staff and people who used the service were warm, supportive and encouraging. Staff approached people in a sensitive way and engaged people in conversation, which was meaningful and relevant to them.

Care plans contained social profiles, which included details about the person's life history and things that were important to them, such as particular events or family information. This allowed staff to familiarise themselves with people's backgrounds, which supported meaningful conversation.

When people required support, for example, assistance to get to their room, staff explained what they were doing and took time to reassure and go at the person's pace. We observed that when someone became distressed or confused a staff member sat with them to offer reassurance and comfort.

We observed staff treat people with respect and dignity. They made sure that any personal care was carried out behind closed doors in order to maintain people's privacy. Staff knocked on peoples' doors before entering and spoke with people in a dignified manner, explaining what they needed to do. Care staff had been trained in equality and diversity as well as privacy and dignity which promoted their awareness in these areas.

People were encouraged to make decisions about what they wanted to do during the day. We saw that people were free to go where they wanted in each unit. Care staff checked with people before giving support and we observed people being asked questions relevant to the task they were undertaking. For example, 'Do you want to go to the lounge?' and 'Would you like a drink?'.

There was useful information in people's care plans about how to communicate and support decision making. This included evidence of good practice in the use of interpreters or family where needed, as well as observation of non-verbal cues to capture how people were feeling. This meant staff had a better understanding of how to involve people in making their own decisions.

Communication care plans were in place for each person. We saw specific information for care staff to follow in relation to how they engaged with people. This supported them to involve people in day to day decisions. For instance, one person's communication care plan set out how staff should support the person by gently

reminding them to wear their reading glasses, as they didn't always remember they had them. We saw that an occupational therapist had been involved in the person's care and had developed a therapy care plan to guide staff as how best to support the person. For example, to use personal care time to have a chat as well as to explain step by step what they were doing.

We talked with the registered manager about equality and diversity and how people's cultural needs were supported. They told us about one person who's first language was not English. They were supported with an interpreter at meetings and written information was provided in their own language. They were also supported to stay in touch with the community by being supported to attend a Chinese luncheon club. The religious needs of people were considered, and to support this, a Methodist church visited every month.

The registered manager told us people were supported to access an advocate if this was needed. An advocate speaks on behalf of a person where they are unable or unconfident to fully express their own views. The service referred people to an Independent Mental Capacity Advocate (IMCA) when an important decision needed to be made on their behalf and they had no other representative.

Good

Is the service responsive?

Our findings

At our last inspection, we rated this domain as 'Good'.

Before admission to the service, people had an initial assessment, which considered their needs and if the service was able to meet them. From this assessment, care plans were developed which gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions.

People received person-centred care which was responsive to their needs. Person centred care is about treating people as individuals and providing care and support which takes account of their likes, dislikes and preferences. We reviewed people's records and saw they were very detailed and specific to the individual. The information recorded reflected the values associated with the person and their needs.

For example, it was recorded for one person that they liked a quilt on their bed, irrespective of the weather or temperature. We saw that this person did have a quilt on their bed as they preferred. One person's nutrition plan detailed the routine they liked to follow at mealtime. Guidance to staff included to ask the person what they would like from the menu, make sure they were sat upright in their chair, to place a lap table in front of them making sure they could reach the food and to cut food up for them but not to 'mush it up' as the person hated messy food.

Care plans had been developed following an initial assessment of each person's needs. The care plans we looked at were up to date and reviewed on a monthly basis to make sure they were current. Areas covered included health, mobility, personal care and diet. There was a clear picture of peoples' needs and how they were to be met. People and their relatives were involved in assessments and reviews and the service took appropriate action where changes in needs were identified.

Clear efforts had been made to capture peoples' personal stories prior to, and after admission to the service. The information included their strengths, family and relationships, life history, views, wishes and preferences. This gave staff a better understanding of each person and how to support them as an individual.

There was an activities co-ordinator present in the home on five days of the week. An activities information board by the main entrance showed a range of activities on offer through the week. These included quizzes, games and a film afternoon. In the morning we saw a group of people involved in making Christmas cookies with the activity coordinator. From the smiles and laughter, we could tell it was a fun and sociable experience for those taking part.

A staff member talked about how activities were person-centred and explained, "The activity coordinator gave [Name of person] a soft ball so they could play football. [Name] is keen on football". The staff member went on to say that the person enjoyed music, so the coordinator was sourcing music from the internet, which was in the person's original language.

The provider told us that the activity coordinator would take people out every Tuesday to promote community involvement. This was confirmed by one person who said, "I go out once a week", but added, "I would like to go out more". Visitors were made welcome at any time of the day and a number of people went out with friends and family when they could.

People told us they would complain to a member of staff or management. We noted there were information leaflets displayed on the resident's noticeboard encouraging people who used the service, and staff, to raise any issues or concerns. Minutes of the relatives meeting in June 2017 showed that the complaints process had been discussed as an agenda item.

A detailed and up to date complaints policy was in place. The registered manager maintained a record of complaints which showed that no complaints had been received since our last inspection. Previous complaints were clearly recorded with a description of the complaint and the action taken to resolve it.

There were end of life care plans in place for people, which meant information was available to inform staff of the person's preferences at this important time and to ensure their final wishes were respected. For one person who had recently died, we saw that staff had discussed their end of life wishes with them and gave the person the opportunity to express their preferences regarding their care, comfort and end of life arrangements. The person had requested for familiar staff to be with them should they reach their end of life and if possible to sit with them until the end.

The registered manager told us that the person's wishes had been carried out and care staff had sat with the person as had been requested. A district nurse had been involved in providing end of life care. The registered manager said that the service also had support from a local hospice when appropriate.

Good

Is the service well-led?

Our findings

At our last inspection, we rated this domain as 'Requires Improvement'. Although the provider was not in breach of Regulations, there remained improvements to be made to make sure new practices were embedded and sustainable. At this inspection, we found the improvements had been sustained.

There was a registered manager in post. They talked with us about the work they had been doing at the service since they started. They explained, "We are getting there. I have been able to go on management training. I think staff morale is a lot better and staff are more positive". The registered manager felt they had a good relationship with the provider and told us, "He has been supportive. We have weekly meetings. He listens. I have the go ahead to do anything needed".

We spoke with the provider who told us, "It's like a new start. We are making the environment more dementia friendly. The target is to complete the works by March 2018. I have weekly meetings with (manager name)". The provider demonstrated a commitment and drive to make sure improvements at the service were sustained.

People made positive comments about the management of the service. Comments included, "I am happy with management and staff. I ask about any changes", "Yes, they (managers) are lovely" and "Management work well together and are very good".

The staff we spoke with were positive about the improvements made over the last few months. Feedback included, "The atmosphere is a lot better. (Manager name) has done a good job to bring it around" and "Improvements have carried on. Staff are behind all the changes. We have improved so much".

There were robust systems in place to monitor and maintain the quality of the service. The registered manager met weekly with the provider to discuss operational issues such as safeguarding referrals, staff changes, training and discussion of feedback from relatives meetings. The registered manager maintained an action plan to make sure identified areas for improvement were addressed. This was reviewed with the provider and updated regularly.

A range of quality audits were completed by the management team. These included audits on medicines, incidents and the environment. Where any issues were identified, action was taken to make improvements. For example, a health and safety audit in November 2017 found that the names of first aiders were not displayed in the building. We noted that this information was now on display. The provider carried out occasional 'spot checks' of care practice which were recorded. There was continuous assessment of the environment and an improvement plan was in place, which included redecorating. There were also plans for a small shop and bar as well as a sensory room. A senior care staff checklist had been introduced which was completed on a daily basis. This included checks of medicines, incidents, dietary records and health and safety.

Throughout the inspection, all the records we looked at were well maintained and stored securely, where

required, to maintain confidentiality

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The registered manager talked about the values of the service. They explained, "We are here for the residents. There has been a lot of person-centred care training". They told us that they wanted to provide person-centred care in line with people's preferences and to support people's independence. The registered manager explained these values were discussed with staff in team meetings and supervisions.

Staff told us they were involved in the development of the service and had opportunities to put forward their views. There were team meetings every one or two months and these were used to discuss the progress of the service and share ideas. The last team meeting included a discussion about team building.

People who used the service and relatives were given opportunities to feed back their views and make suggestions about the service. There were occasional resident meetings where relatives were welcome to attend. Some satisfaction questionnaires had been sent out to gauge people's views. We saw completed copies of these kept with people's care records. We noted there were suggestion boxes in the service where people could place any comments. There was evidence in meeting records that feedback was considered by the registered manager and provider to look at how to make improvements.