Acegold Limited

Oakfield Care Home

Inspection report

Weston Park
Weston Village
Bath
Somerset
BA1 4AS

Tel: 01225560579
Website: www.fshc.co.uk

Date of inspection visit:
24 April 2017

Date of publication:
06 June 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 24 April 2017 and was unannounced. When the service was last inspected in January 2016 we found four breaches of the regulations of the Health and Social Care Act 2008. The breaches related to staffing, safe care and treatment, good governance and person-centred care. These breaches were followed up as part of our inspection.

Oakfield Care Home is registered to provide accommodation and nursing care for up to 28 people. At the time of our inspection there were 19 people living at the service.

A registered manager was not in post at the time of inspection. 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. A manager has recently been appointed and they told us that they intend to process their registered manager's application.

People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Staff were not consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager. Since their appointment the manager has introduced a regular programme of supervision. The supervision matrix identified that the majority of staff had received a supervision in April. New staff undertook an induction and mandatory training programme before starting to care for people on their own.

At our previous inspection the provider was not consistently responsive to people's needs. The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement. Although some care plans required further development in relation to catheter care we found sufficient improvements had been made to care plans.

At our previous inspection the provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. Although we received mixed comments about staffing levels we found sufficient improvements had been made. Staffing levels were in the main maintained in accordance with the assessed dependency needs of the people who used the service.

At our previous inspection risk assessments relating to the health, safety and welfare of people were not sufficiently detailed to mitigate potential risks to the person. At this inspection we found sufficient improvements had been made. Where risks had been identified, care plans detailed the steps staff should take in order to keep people safe.

At our previous inspection we found there were ineffective governance systems in place to monitor health and safety and the welfare of people. At this inspection we found sufficient improvements had been made. A full time maintenance person has been appointed. Regular maintenance audits relating to fire safety records, legionella, water temperatures, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) and window restrictors are now undertaken.

Arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned.

Medicines were managed safely. We observed part of a medicines round and the nurse administering the medicines knew people, their medicines and why they had been prescribed them.

People's nutrition and hydration needs were effectively managed. Care plans contained nutritional assessments and where risks had been identified specialist advice and support had been sought.

People and their relatives felt that the staff were caring and we received a number of positive comments.

We observed positive interactions between staff and people using the service. Staff knew people well and there was friendly atmosphere around the building. We observed staff laughing and joking with people. Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

There is a full time activities coordinator in post who has been proactive and imaginative in creating sessions in consultation with people.

To ensure continuous improvement the manager has introduced a more effective auditing programme. This has resulted in a number of improvements being made since the previous inspection. The provider's action plan telling us how they intended to meet the requirements of the regulations they previously breached has in the main been implemented. The manager agreed to address issues surrounding consent and catheter care as a matter of priority.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. The manager has introduced a regular programme of resident meetings. Annual customer surveys were conducted with people. The service was open and transparent regarding concerns raised and actions taken.

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.

Staffing levels were maintained in accordance with the assessed dependency needs of the people.

Medicines were managed safely.

Where risks had been identified, care plans detailed the steps staff should take in order to keep people safe.

Safe recruitment processes were in place that safeguarded people living in the home. A range of checks had been carried out on staff to determine their suitability for employment.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not consistently upheld in line with the Mental Capacity Act 2005.

People's nutrition and hydration needs were effectively managed.

Staff monitored people's healthcare needs and made referrals to other healthcare professionals where appropriate.

Is the service caring?

Good

The service was caring.

In the main people and their relatives felt that the staff were caring and we received a number of positive comments.

Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people.

Staff protected people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

The majority of care plans were detailed and person centred.

Some further work was required on the catheter plans and supporting documentation. The manager agreed to take this forward as a matter of priority.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

The provider had systems in place to receive and monitor any complaints that were made.

Is the service well-led?

Good

The service was well-led.

The appointment of the new manager has been well received by staff, people and relatives.

To ensure continuous improvement the manager has introduced a more effective auditing programme. This has resulted in a number of improvements being made since the previous inspection.

People were encouraged to provide feedback on their experience of the service and actions were taken, where appropriate.

Oakfield Care 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 24 April 2017 and was unannounced. The inspection was undertaken by two inspectors 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.

When the service was last inspected in January 2016 we found four breaches of the regulations of the Health and Social Care Act 2008. During this inspection we checked that the improvements required by the provider after our last inspection had been made. It was rated as 'Requires Improvement.'

Before the inspection, the provider completed 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 reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service. We also received feedback from the local authority about the service.

We spoke with 10 people, three visitors and six members of staff. We spoke with the manager and the regional manager. We also spoke briefly with the chief executive who was visiting the service for part of the day.

We reviewed the care plans and associated records of six people and a sample of the Medicines Administration Records (MAR). We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Good

Is the service safe?

Our findings

At our previous inspection the provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. Although we received mixed comments about staffing levels we found sufficient improvements had been made.

Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. The tool determines the level of staffing required whilst taking into account the dependency needs of people. The dependency tool calculated that 4.1 staff should cover the AM shift, 3.4 staff should cover the PM shift and 2.1 staff should cover the overnight shift. Staffing rotas viewed from the 3 April to 23 April 2017 demonstrated that staffing levels were in the main maintained in accordance with the assessed dependency needs of the people who used the service. Despite this there were mixed comments from staff and people and relatives about the levels of staff. Staff comments included; "We are recruiting and we can use agency staff if we're short, but at the same time staff are leaving"; "I think we need more staff. Lots of people would prefer more 1:1 with us, but when we're rushing to the next person we just don't have the time"; "Sometimes it's ok, sometimes it's not."

Relatives also expressed their concerns about the staffing levels. One relative told us they spent a lot of time at the service owing to their perception of staff shortages, particularly when a member of staff calls in sick. One relative told us; "I worry about [person's name] when I'm not here." One person told us; "I do not think it is always safe here, there are too many agency staff who do not know the patients." Other people told us they felt safe living at the service. Comments included; "I am relieved to be here, I could not cope at home, here I am safe and being well looked after"; "I feel lucky to be here, I have a special bed and it feels safe, I have a call bell and someone will come if I need them"; and "I know I am safe because staff are always passing by and they would see if I was in trouble."

The manager told us that the service is undertaking a recruitment drive and planned absences are covered by agency staff, where required. We observed that there appeared to be adequate numbers of staff on duty, although from the layout of the home, which is on three floors, they were not always visible, especially as most people stayed in their room. Staff were available for personal care, meal assistance and medication duties, when needed.

At our previous inspection risk assessments relating to the health, safety and welfare of people were not effectively managed to mitigate potential risks to the person. At this inspection we found sufficient improvements had been made.

Care plans contained risk assessments for areas such as moving and handling, falls and choking. Where risks had been identified, care plans detailed the steps staff should take in order to keep people safe. For example, hoist and sling details were listed when people were unable to transfer independently. In addition, these details were also available for staff in people's rooms so that they had easy access to the information. When people were able to mobilise but needed some assistance from staff, the plans detailed how staff could help people to maintain their independence whilst keeping safe. For example, in one plan it had been

documented that staff should ensure the person always wore well-fitting shoes, that they should walk with a Zimmer frame and that one member of staff should supervise.

At our previous inspection we found there were ineffective governance systems in place to monitor health and safety and the welfare of people. The provider sent us an action plan telling us how they intended to meet the requirements of the regulation. At this inspection we found sufficient improvements had been made.

A full time maintenance person has been appointed. Regular maintenance audits relating to fire safety records, legionella, water temperatures, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) and window restrictors are now undertaken. Where actions were required they are taken forward within a reasonable timescale.

Arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the nature of the incident, immediate actions taken and whether any further actions were required. Where necessary care plans were reviewed following investigations. For example, we looked at an incident report for a person who had been found on the floor. The report was detailed and the care plan had been updated to reflect the details of the fall. Risk assessments were amended to mitigate future risks.

Medicines were managed safely. We observed part of a medicines round and the nurse administering the medicines knew people, their medicines and why they had been prescribed them. They stayed with people to ensure they had swallowed their medicines before signing for them and asked if they required any additional medicines such as pain relief. Medicine administration records (MAR) charts had been completed in full and there were no gaps noted, which indicated people received their medicines as prescribed. People's preferences (in relation to how they liked to take their medicines) had generally been noted, although these were not documented on the front of all of the charts. There were PRN (as required) medicine protocols in place which informed staff when and why people might require additional medicines.

Recorded showed that topical medicines such as creams and lotions were applied as prescribed. The nursing staff applied steroid creams and the care staff applied other creams. All of the charts we looked at had been completed in full.

Medicines were stored safely and the stock levels were accurate. Twice daily stock checks were undertaken although the provider's medication policy recommended weekly checks.

Items that required refrigeration were stored safely in a medicines fridge. The temperature was monitored daily, although the minimum and maximum temperatures were not. Items stored in the fridge had been labelled when opened and the expiry dates had been added to prevent people receiving any medicines that were out of date. Medicines were disposed of safely.

We saw the latest Pharmacist advice visit which had taken place earlier in the month. Following this visit, there was a medication action plan in place and we saw that actions had been taken to address the issues raised; for example medication competency checks had been started.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults.

The staff we spoke with had a good awareness and understood their responsibilities with regard to safeguarding people from abuse. They were able to explain the actions they would take if they suspected a person was being abused. Staff also understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

Requires Improvement

Is the service effective?

Our findings

People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Staff we spoke with had a basic understanding of DoLS. The training matrix identified that 60% of the staff had received DoLS training. The manager told us that there is a training plan in place to ensure compliance rates improve.

Consent to care was not always sought in line with legislation. Some people had sensor mats in place to alert staff if they moved from an area in their bedroom or if they fell. Although the sensor mats were being used as an aid to keep people safe, there was nothing documented to indicate that the people or their advocates had consented to having their freedom of movement restricted. With this type of equipment, there is an impact on the person's privacy and also a risk that it can be used as a form of restraint. It is therefore important that their use is considered carefully. The service was not fully compliant with the provider's Mental Capacity Act policy which stated; "Team members must keep a comprehensive and accurate record of decisions taken about capacity and best interest that show the process leading to any decision."

We recommend that the service review their procedures to ensure they fully comply with their Mental Capacity Act policy and the principles of the MCA.

We observed that staff asked people for their consent throughout the day in relation to day to day choices. For example, we saw that staff knocked on people's doors before entering their rooms, asked them if they would like a drink and asked if they could help them with anything.

Staff were not consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager. Staff said they had not received regular supervision sessions. The service had not complied with the provider's supervision policy which states that staff supervision should be held every two months. Since their appointment the manager has introduced a regular programme of supervision. The supervision matrix identified that the majority of staff had received a supervision in April. The matrix identified that some staff members supervision were overdue. The manager was aware of this position and is taking the matter forward.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, infection prevention, health and safety and first aid awareness. The training records demonstrated that staff mandatory training was in the main up to date. The manager had a training plan in

place to ensure that all mandatory training compliance rates improved.

People told us that they thought they were being cared for by competent, knowledgeable staff. Comments included; "staff are well trained, they know what they are doing, even the agency staff"; "All the staff are good at their job, they know what to do and when to do it"; "I think staff are well trained, they know the routine, no problems"; and "As far as I am concerned, staff have had the appropriate training to look after me." We received mixed comments from relatives; "Some carers are inadequate, older carers are better and try to train the younger ones"; "I do not think they are well trained but they think so. They are slapdash in the basics"; and "Staff vary, there are some who are good, but others are not."

People's nutrition and hydration needs were effectively managed. People were supported to have enough to eat and drink. Care plans contained nutritional assessments and where risks had been identified specialist advice and support had been sought. For example, in one person's plan there was clear detailed guidance on how staff should support the person to eat and drink safely without choking. They had been reviewed by the speech and language therapist (SALT) and a textured diet and thickened fluids had been recommended. It had been documented within the plan that staff should "position upright for meals" and "needs encouragement to eat and increase fluid intake". We observed the person being assisted with their lunch. They were sat in an upright position and the staff member who was assisting them was encouraging them by saying "Oh, this looks nice" and "Does it taste as good as it looks?" and "Let me know if it's good because I've ordered this for my lunch."

Some people were having their food and fluid intake monitored. Charts that we looked at had all been completed in full. We received mixed comments about the food. Comments included; "Food is perfectly alright, it is always served hot"; "I am not a fussy eater, I enjoy all that they serve"; "We get plenty to eat and drink, the food is well cooked and I like the choices"; and "Food is unimaginative and of poor quality and basics are poor. Food is not always hot when served."

People had access to on-going health care services. For example, records showed that people were reviewed by the GP, SALT and the Mental Health team.

Good

Is the service caring?

Our findings

In the main people and their relatives felt that the staff were caring and we received a number of positive comments. They included; "Staff are very good, they are always available to help; they are considerate and patient".; "Staff know and understand [person's name], they are kind"; "I am well cared for and well looked after by staff who are kind and caring"; and "All staff treat me well, we have a lovely chat when they are helping me, they do their best". There were notable exceptions that expressed differing views about the level of care; "I feel well cared for, but feel there are not enough staff, especially at holiday times"; "Staff vary, there are some who are good, but others are not" and "Occasionally there are language difficulties."

We observed positive interactions between staff and people using the service. Staff knew people well and there was friendly atmosphere around the building. We observed staff laughing and joking with people. When one person wanted a member of staff to go outside with them so they could have a cigarette a member of staff came quickly.

Staff spoke positively about their role. Comments included "All of the staff are very willing. We really do try and look after people well" and "We're a lovely little home. We work well together, we communicate well and we know all the residents really well. We're a good team."

Staff knew how to maintain people's dignity and privacy. One said "It's important to close the door and curtains for example, but it's also important to ask people. I always follow people's requests." People confirmed that during personal care doors are closed and curtains drawn before care begins and that their modesty is preserved. People appeared to be well cared for; they looked well kempt, hair was groomed and fingernails were clean. Staff referred to people by their preferred name, using appropriate volume and tone of voice.

Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. They were aware of people's personal histories and interests. One member of staff told us about some of the people they cared for; "[Person's name] likes to have their hair shampooed in the bath and likes to get dressed in their room. She likes to feed the cats and likes her curtains drawn as it makes her feel secure. She was married. Their grandchildren visit regularly. [Person's name] likes telly magazines and chit chat. She worked in a chocolate factory. She likes dried fruit and chocolate buttons. [Person's name] likes her hair brushed. She doesn't like her feet creamed but we persuade her. She likes orange and water and puts toilet paper into sections. She likes routine and likes me to say goodbye to her before I go. She used to work at a school."

Good

Is the service responsive?

Our findings

At our previous inspection the provider was not consistently responsive to people's needs. The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement. The provider sent us an action plan telling us how they intended to meet the requirements of the regulation. Although some of their work required further development we found sufficient improvements had been made.

The majority of care plans were detailed and person centred. For example, people's preferred time to get up and go to bed and the kinds of food that people preferred to eat were documented. One member of staff said "I always read the plans, but I talk to people too and get to know them, and find out what they want me to do for them". In addition, the plans had been regularly reviewed. People and their relatives felt listened to and were involved in the care planning process. One relative told us; "She's very happy here. Since the new manager has been here we have been invited to meetings. There is one care plan meeting every six months. They inform us about incidents. They know not to leave a message and they should speak to my sister directly. I visit four times a week. She needed additional help with personal care and this has been addressed. I feel listened to." Due to the noise levels coming from an adjoining room at their request their relative had been moved to another room.

When people had been assessed as being at risk of skin breakdown, the care plans detailed the steps staff should take to minimise this risk. For example, some people had air mattresses in place and needed to have their position changed regularly to prevent pressure sores. All of the air mattresses we looked at were set correctly and position change charts showed that people had their positions changed in accordance with the care plan.

When people's needs changed, the care plans reflected this. For example, staff had noted that one person had developed red skin around their eye. This had been clearly documented and a photograph of the area had been taken in order that staff could observe and monitor for signs of improvement or deterioration.

We looked at care plans for people who had catheters in situ. The care plans gave clear guidance for staff on how to manage these. Staff were familiar with how to care for catheters and the signs and symptoms of infections or blockages. However, record keeping in relation to how staff monitored urine output and how concerns were escalated were unclear. For example, in one person's care plan it had been documented "Requires encouragement to increase fluid intake to have a clear output." The person had experienced previous urinary tract infections. We looked at the fluid charts for this person and no urine output had been documented for 19/04/2017. In addition on 21/04/2017 and 22/04/2017 the recorded output was only 200mls. There was nothing documented to indicate that the poor urine output had been noted or escalated to the nurse in charge. Another person also had a urinary catheter in situ and had also experienced a previous urinary tract infection. The charts for this person showed that on 20/04/2017 and 22/04/2017 that their urine output was 300mls. Again, there was nothing documented to indicate that the poor urine output had been noted or escalated. A poor urine output can indicate dehydration and can lead to a urinary tract

infection. The manager agreed to review the catheter plans and supporting documents to ensure that they documented the nurse's actions where concerns were identified.

The provider had systems in place to receive and monitor any complaints that were made. The last formal complaint received was in October 2016. The raised concern was taken forward and actioned to the complainant's satisfaction. One relative told us that the concern they had raised regarding an agency member of staff had been addressed to their satisfaction. A number of recent compliments had been received by the service. One person wrote to the service and stated; "Just wanted to say a personal and heartfelt thank you for all you did for [person's name]. We're a small family and not many of us came in. It was comforting to know she was so well looked after. I was really impressed by the way she was always looking clean, fresh and comfortable."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

There is a full time activities coordinator in post who has been proactive and imaginative in creating sessions in consultation with people. Activity sessions are held during the afternoons in the dining room and activities vary from crafts and music to outside entertainers. People who remain in their own rooms, are offered one-to-one time during the mornings. Children from the local school visit and there are good links to the local churches. Services are held monthly, a lay reader and a Catholic Priest also visit the service. The activities coordinator has also been creating a wish list with individual residents and is planning on fulfilling these wishes. One person had expressed a wish to see a donkey; this was achieved after contacting the local donkey sanctuary who arranged for the person who had lived on a farm to visit a family who kept donkeys and chickens. This was filmed and shown on local TV. One person, who wished to be able to use a computer, is to have lessons arranged by the activities coordinator.

Good

Is the service well-led?

Our findings

To ensure continuous improvement the manager has introduced a more effective auditing programme. This has resulted in a number of improvements being made since the previous inspection. The provider's action plan telling us how they intended to meet the requirements of the regulations they previously breached has in the main been implemented. Some improvements are required on areas of their work such as the need for consent regarding the use of sensor mats and improved recording of their catheter care. The manager provided assurances that these matters would be addressed as a matter of priority.

The appointment of the new manager has been well received by staff, people and relatives. Comments included; "The new manager is really good"; "the new manager is settling in well"; "Morale was low before, but it's gradually lifting and improving"; "He often pops by and says hello"; and "He comes in to see me and asks if everything is OK, he is easy to talk to"; "The new manager knows me well. If I'm not happy, I go straight to the office". One person expressed concerns regarding staff absences not being adequately addressed. They told us; "There are members of staff who repeatedly go off sick leaving their colleagues to work short-handed and residents suffer. The manager does not appear to be addressing this." The manager told us they are currently undertaking a recruitment drive to ensure the service staffing levels are maintained.

The manager communicated with staff about the service to involve them in decisions and improvements that could be made. We found recent staff meeting minute's demonstrated evidence of good management and leadership of staff within the service. Agenda items included recruitment, reports and handover, tea rounds and call bells. The meetings also provided an opportunity for staff to discuss any concerns or raise questions. We noted a discussion regarding a need for call bell response times to improve. The manger advised that call bell response times will be reviewed to establish the reasoning for some delays.

The manager also held daily meetings with the heads of departments. The meetings covered a number of operational issues such as attendance, arising concerns with people in the service, maintenance, menus and activities. This ensured that each team were aware of any issues that needed to be dealt with on each day. One member of staff described these meetings as being "quite informative."

The service continues with their regular 'resident of the day' system which focused on a particular person on a rotational basis. The family of the person receive an invite to attend the service to speak in person about their family member. The care plan was audited, their room had a deep clean and the resident had time to speak with key departmental heads such as the manager, the chef, housekeeping and maintenance staff to ensure the service was sufficiently meeting their needs. This demonstrated the way the service was reviewing care and adapting to change.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. The manager has introduced a regular programme of resident meetings. The first meeting held since their appointment was 16 March 2017. Issues discussed included food, staffing, activities, complaints and use of the dining room. The meeting provided an opportunity to tell the manager exactly

what they thought, good and bad. People provided mixed comments regarding the call bell response times. Some people felt they were acceptable, others did not. It was evident that the manager was listening to people's concerns on this issue and they are currently being reviewed.

Annual customer surveys were conducted with people. Plans were implemented which demonstrated how the service responded to the issues raised. This included the appointment of a full time maintenance man and tea and coffee making facilities being made available for visitors in the dining room. The service was open and transparent regarding concerns raised and actions taken.