Eldercare (Halifax) Limited

Denison House Nursing Home

Inspection report

Denison House Nursing Home
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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

This inspection took place on 17 February 2017 and was unannounced. This meant that staff and the registered provider did not know we were visiting.

At the last inspection on 17 August 2016 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in Regulation 9 Person centred care, Regulation 11 Consent, Regulation 12 Safe Care and treatment, Regulation 17 Good Governance and Regulation 18 Staffing. At this inspection we saw that improvements had been made and there were no breaches of regulations.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Denison House is registered as a nursing home but has not provided nursing care since September 2014. The service is registered to accommodate 30 people. There were 13 people living at the service when we inspected. One person was in hospital so only 12 people were present during the inspection.

There was a registered manager employed at the service. They had only recently been registered but had worked at the service since November 2016. 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.

Risks to people's health and safety had been identified. Care plans contained risk assessments relating to people's health and there were risk management plans to guide staff.

Safe recruitment procedures were in place to ensure suitable staff were employed to work with people at the service. There were sufficient staff to meet people's needs. The registered provider used a tool to determine the numbers of staff required to meet people's needs. We recognised that the numbers of people who used the service were low accounting for suitable staffing levels but the registered manager assured us that this would be reviewed when numbers increased.

Accidents and incidents were recorded, analysed and trends identified.

Medicines were managed safely.

The service had some signage in place to encourage people to find their way around. Signage covered communal areas. There were plans in place to develop this further.

Staff knew the people they cared for and were trained in areas that related to their role. They were supported through supervision.

Staff worked within the principles of the Mental Capacity Act 2005. Consent was sought from people about what assistance they needed with daily activities. Deprivation of liberty safeguard (DoLS) authorisations had been submitted by the registered manager in order to ensure that people were not being detained without authorisation. Where day to day decisions were taken for people, staff had completed a mental capacity assessment and best interest decision tool to evidence the decision.

People's nutritional needs were met. Although drinks were always available unless staff assisted some people they were unable to access them. We have made a recommendation about best practice in hydration.

The service was caring. Staff approached and spoke with people kindly and with respect.

Care plans were person centred and were regularly reviewed.

There was an activities organiser employed at the service and staff assisted in organising activities for people which reduced the risk of social isolation.

There was a complaints policy and procedure and people knew how to make complaints.

The quality assurance system in place used audits in each area of the service so that there was a consistent approach to improvement.

Staff were happy in their work and were positive about the support they received from management. They worked together with health and social care professionals in order to ensure good outcomes for people.

The provider had allocated a quality manager to support the registered manager. They and the staff were provided with sufficient direction and leadership to ensure that people received a consistently good standard of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

Staff recruitment was robust and the numbers of staff were sufficient to meet people's needs.

Staff understood what it meant to safeguard people. They were aware of different types of abuse and how to report any concerns. Medicines were managed safely.

Risks to people's health and safety had been identified and risk management plans put in place to ensure people's safety.

Is the service effective?

Good

This service was effective.

Staff were trained in subjects relevant to their roles and supported through supervision.

Staff were working within the principles of the Mental Capacity Act 2005.

Peoples nutritional needs were met. Additional support with hydration would benefit people who used the service.

Is the service caring?

Good

This service was caring.

Everyone told us that they found the staff to be kind and caring. Relatives confirmed that staff treated people in a caring way.

Staff were aware of good practice when interacting with someone living with dementia.

People were treated with dignity and respect by staff who were polite.

Is the service responsive?

Good

This service was responsive.

Care plans reflected individual needs. The care people received reflected what was documented in the care plans. Relatives had been involved in planning people's care where appropriate.

People knew how to make a complaint if they needed to.

Activities were on offer if people wished to join in. There were also resources available for one to one activities.

Is the service well-led?

Good

This service was well led.

The culture was open and positive.

There was a registered manager employed at the service. They were aware of their responsibilities in relation to notifying CQC of any incidents at the service. People who used the service, staff and relatives had confidence in the registered manager.

There was an effective quality assurance system in place which identified areas for improvement. Feedback was sought from people.

Denison House Nursing 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 checked 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 17 February 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience that had experience of community nursing. 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 registered provider had returned a Provider Information Return (PIR) in July 2016. We did not ask the them to submit this document again. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at all notifications and contacts we had received from or about the service. This information helped us to plan the inspection. We also contacted the local authority contracting team for an update. They told us that the embargo on admissions that had been in place was now lifted due to improvements made at the service and there was an agreement in place whereby the registered provider would only admit two people a month.

During the inspection we spoke with five people who used the service. In order to understand the experience of those people who could not communicate with us verbally we used the short observational tool (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed practice throughout the inspection.

The registered manager made themself available throughout the day to answer any questions we had and supply any documents we requested. In addition the quality manager was present to provide support. We

spoke with three care workers, the maintenance person and the administrator. We were also able to speak to a district nurse and physiotherapist who were visiting the service on the day of the inspection and four relatives.

We reviewed the care plans, risk assessments and medicine records of two people in detail and looked at two other care plans. We observed medicines being administered and a member of staff explained the way in which medicines were managed within the service. We observed lunch time.

We inspected records relating to the running of the service. These included five staff recruitment and training files, the training matrix, maintenance and servicing documents and the quality assurance system.

Good

Is the service safe?

Our findings

When we inspected in August 2016 we had found breaches of regulation relating to people's safety and staffing levels. At this inspection we saw that there had been improvements and the service had met the regulations.

Everyone we spoke with told us that they felt safe living at Denison House. One person told us, "Yes I feel safe. It's comfortable and I have bed sensors so I feel safe from falls" and a second person told us, "I feel safe here definitely. I can see people passing my door; that's nice and reassuring." A relative told us, "I feel [relative] is safe here. There are always girls [staff] around if [relative] needs something. I'm happier now that [relative's] down stairs." One person living with dementia said when we spoke with her, "I like it here. It's much better that when I was in [Name of place]." We observed people walking around safely. Where access was restricted key codes were on doors to maintain people's safety.

Risks to people's health and safety had been assessed and recorded with clear instructions for staff to follow. This ensured that staff knew what to do in order to keep people safe. For example window restrictors were fitted in order to prevent falls from a height, avoiding harm to people. All maintenance checks and servicing of equipment was up to date. Checks of water systems had been carried out. There had been a risk to the water supply identified in one area and an action plan had been put in place which was being followed. There was a fire risk assessment in place and fire safety checks and servicing of equipment had been completed.

Risks of infection were minimised because the service was kept clean and tidy. The domestic staff were following cleaning schedules to ensure that each area of the service was regularly cleaned. We did see that two bathroom floors had been painted with a non-slip floor covering. This was starting to peel back. The registered manager told us they were aware of this and that there were plans to repaint the floors in order to prevent it becoming a trip hazard for people who used the service. In addition we saw that a radiator top and sides had become loose showing sharp edges which could cause an injury. We spoke to the registered manager who said that this would be dealt with as a priority. A physiotherapist who was visiting a person when we inspected told us, "It is clean and smells nice. I feel more confident."

Risks relating to people's health and wellbeing were recorded in their care records and where further input from healthcare professionals was required this had been organised through the person's GP. We saw that where people were assessed as needing specialist equipment to keep them safe this had been provided. One person had a sensor mat in their bedroom to alert the carers if they got up as they were at high risk of falls. This person kept activating the sensors and we saw that staff attended promptly and stayed with the person until they were more settled following the risk management plan.

Accidents and incidents were properly investigated and reported. If people sustained serious injuries they had been a safeguarding alert to North Yorkshire County Council (NYCC) and CQC had been notified. One person had recently fallen and sustained a broken bone. There was now a plan in place for them to be monitored by staff and a sensor mat was in place as a secondary measure. An incident/accident form had

been completed. Any accidents and incidents had been audited and analysed to identify if there were trends which would assist the registered provider in preventing further accidents occurring. During December 2016 we could see that three accidents had occurred but there was no trend identified. People's care plans had been amended following the accidents.

Staff had been recruited safely. People had completed application forms, two references had been sought and a Disclosure and Barring service (DBS) check carried out. DBS checks provide information about any convictions, cautions, warnings or reprimands. These checks help employers make safer recruitment decisions and are designed to minimise the risk of unsuitable people working in health or social care settings.

There was sufficient staff on duty to meet people's needs. One person told us, "Yes, most of the time there are enough staff." A dependency tool was used to assess the number of staff required in relation to people's needs. The registered manager told us that staff numbers would be increased as numbers of people who used the service increased. The rotas identified that numbers of staff on duty over the last six weeks had been sustained at one senior and two care workers during the day and two care workers at night. In addition there was a chef, cleaner, maintenance person and administration assistant working at the service. The chef was not at work on the day we inspected and we were told that the registered provider was in the process of recruiting a second chef and one member of night staff. Until then regular agency care workers had been used and identified on the rotas. Care workers had provided breakfast and lunch.

Staff could tell us what it meant to safeguard someone and how to recognise signs of abuse. One member of staff told us, "I would report any concerns to the manager" and another was able to describe the management plan for one person that they followed in order to safeguard them. Staff had received training about how to safeguard adults. There had been four safeguarding incidents since the last inspection which had been investigated and closed with no action required.

Personal money kept by the service for people was secured in a safe and transactions were well documented. People's personal money was managed by the administrator and registered manager who were the only two members of staff with access to the safe where the money was kept. There were clear records kept and monthly audits carried out. A check of one person's money showed that the balance was correct.

Medicines were managed safely. There was a policy covering the different aspects of medicines management. The temperature of rooms and fridges where medicines were stored was monitored. Medicines were stored at the correct temperature making them effective and safe to use. Staff were encouraged to report medicine errors so lessons could be learned and practices made safer. Incidents involving medicines were recorded and appropriate action was taken. There had been one medicine error identified during an internal medicine audit and dealt with appropriately. In December 2016 the medicines audit identified that the staff signature list needed to be updated. We saw that this had been done.

Good

Is the service effective?

Our findings

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.

At the last inspection in August 2016 we had found a breach of regulation because some of the best interest decision making was not appropriate and there was no evidence of people having consented to their care and support. At this inspection we saw there had been an improvement and the service was no longer in breach.

Staff asked people what they wanted to do, where they wanted to go, what they wanted to eat throughout day. We saw from records that there had been involvement in care planning by families and consent to care and support by family members where they held Lasting Power of Attorney (LPA) or Enduring Power Of Attorney (EPA). This was because people lacked the mental capacity to give consent and a representative had been appointed to do so on their behalf.

Where day to day decisions for the person were taken staff had completed a mental capacity assessment and best interest decision tool to evidence the decision. There was clear evidence recorded of why the decision was made. We saw little evidence of multi-disciplinary and family involvement in best interest decision making except where more complex decisions were needed as in the case of the deprivation of liberty safeguards. For example a decision had been made to seek medical assistance if one person was unwell by the registered manager and senior care worker. We saw that when the person required healthcare a district nurse had been called and where they had symptoms of possible swallowing difficulties a visit by the speech and language therapist (SALT) had been organised in accordance with the best interest decision.

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. One person had a DoLS authorisation in place and ten applications for DoLS were awaiting a decision. Staff were working within the principles of MCA.

The people we spoke with said that they were well looked after and relatives told us that they thought that the staff tried their best to meet their relative's needs. One relative told us, "They know [relatives] behaviour which can be very challenging and they try very hard to manage it and to divert some of [relatives] more challenging behaviours." A second relative said, "The staff will always keep me up to date with any changes in mum's condition." A district nurse who was visiting a person on the day we inspected told us, "I am really impressed with the staff. They know people well."

Changes to ensure that people benefited from an environment that met their needs were on-going. We could see that further improvements had been made since the last inspection to meet the needs of people living with dementia. Some areas had been redecorated and in one corner of a large lounge was a sensory station with revolving light and glitter balls and a light tube. In addition there was memorabilia on corridor walls providing points of interest to stimulate discussion. There was a bench on one corridor where people sat and chatted and there were plans to develop this further by introducing a bus stop. Signage had increased and assisted people in finding their way to communal areas. More work using identifying images or words on doors would benefit people in independently finding their bedroom. There were display boards showing recent activities that people had undertaken.

We observed lunchtime in the dining room where we saw display boards with pictures of the menus. Music was playing quietly and the tables were set with tablecloths, cutlery and condiments. People were having fish and chips from the local chip shop which most were enjoying. Drinks of juice were offered to people throughout the meal time and there were drinks available in the lounge where people could help themselves if they were able. We did not see anyone get a drink in the lounge but saw that drinks were also offered to people at set times throughout the day from a trolley.

We saw that one person who was in bed and able to drink unaided, had no fluids available by their bed. Their relative told us, "I think there should be drinks available at all times." In addition, other people, who had difficulty getting a drink, did not have immediate access to fluids if they were thirsty because they could not manage to help themselves although staff did assist people at set times throughout the day to have a drink. Where staff had given people a drink or seen that people had a drink they had recorded the amount given which helped to monitor fluid intake for some people. This meant that care of people's hydration needs was not always consistent. When we discussed this with the staff and registered manager they assured us that people were given drinks throughout the day.

We recommend that the service seek advice and guidance from a reputable source, about current best practice in hydration of older people.

We saw staff proactively assisted people to eat and drink when this was required. One person appeared a little anxious and was not eating their food. A member of staff went to sit with them reassuring and encouraging them to try the food, which they did, eventually eating it all. People were weighed regularly and the malnutrition universal screening tool (MUST) used to identify any people at risk. Where there was evidence of weight loss the person's GP had been contacted for advice.

Staff were knowledgeable about people and could tell us about the care they needed. Although not everyone had up to date training at the last inspection we saw that most staff had now completed their training which supported their role. This included training in MCA/DoLS, dementia awareness, dignity, choice and diversity, fire safety and person centred care. Some staff had completed more specialised training in subjects such as tissue viability, falls management and challenging behaviour. The registered manager was currently completing 'train the trainer' training so that they could ensure that everyone was up to date and following best practice in safely moving people. One member of staff told us, "My training was out of date but has now been booked or done" and another said, "We have lots of training. We go to head office for a lot of it." We were provided with the training matrix showing what training had been completed by staff.

Staff had received an induction when they started work at the service and this was recorded. They were supported through supervision by the registered manager. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The registered manager kept a supervision

spread sheet which showed us when supervisions for people were due. One member of staff told us, "It's brilliant at the moment. I enjoy my work and feel that I know what is expected of me."

Good

Is the service caring?

Our findings

Every one that we spoke with told us that staff were kind and caring. One person who used the service told us, "I like living here. People are kind." Another person said, "The staff are lovely here they do their very best." We saw some positive interactions between staff and people who used the service throughout the day.

People living at this service had family members to advocate for them. Relatives we spoke with confirmed staff treated people in a caring way. One said "The staff are lovely with [relative]. I know [relative] can be very difficult and stubborn. They get [relative's name] to do things I never would be able to do. One day I came in and [relative] was in the dining room. I was amazed that they had managed this. They take time and care." A second relative told us, "They [staff] are so friendly and caring. We couldn't ask for more."

We spent time observing how care and support was provided to people who used the service. Staff spoke kindly and respectfully to people throughout the day. They took time to help them to chairs and with their meals if they required help. One member of staff spent time helping a person with their lunch. They spoke to the person throughout the meal, encouraging them to eat. One person was living with dementia and chose not to sit at the table for their lunch. Staff used different approaches to help the person focus on eating. They changed the food to pieces they could easily pick up with their hands and eat whilst walking. When they sat in a chair in the lounge the staff brought food to them allowing them the freedom to eat where they chose.

People were treated with compassion by staff who recognised and took action when they showed signs of distress. For example, one person had been taken ill overnight. Whilst they were awaiting an ambulance staff pushed their bed next to that of their relative so that they could be comforted by holding hands. The person's relative told us, "I am pleased with the staff. They were very kind whilst we were waiting for the ambulance to come. They pushed our beds together so that I could hold [relatives] hand to comfort [relative].

People were treated with dignity and respect by staff. We saw that staff were polite with people. They showed respect for people's privacy by knocking on doors before they entered and in the way they ensured they retained privacy when delivering any personal care. We saw that people were well dressed with clean nails and hair. We saw staff used active listening skills kneeling beside people to speak with them on the same level and listening to their response.

Staff interacted with people living with dementia in their world. We saw that one person living with dementia was walking around unrestricted areas of the home throughout the day. They enjoyed stopping and chatting with people they met as they walked. Staff knew them well and spoke kindly with them each time they stopped to chat. One member of staff explained that this person believed they were at work and so they allowed them to talk about that without contradiction. The person announced they were, "going off duty now" and the member of staff waved goodbye to them and they smiled and walked off happily. All the staff took time to speak with them, which they enjoyed. This demonstrated that the staff understood best practice in dementia care as they used current thinking in their dealings with this person.

Good

Is the service responsive?

Our findings

People who used the service had care plans which reflected their individual needs. At the last inspection In August 2016 we had identified a breach of regulations because care was not always person centred. At this inspection we saw that there was an improvement in the way in which care was provided and the service was no longer in breach.

One relative told us, "I was involved in planning the care for my [relative] and another said, "Staff have taken time since coming here to understand [name of person]'s personality and life story alongside the community psychiatric nurse (CPN) in order to help manage [name of person]'s challenging behaviours." A third relative confirmed they were involved in their family member's care. They said, "I come to visit a lot and am always kept up to date with any changes."

Pre-admission assessments had been completed to ensure people's needs could be met before they were offered a place within the service. There had been two admissions to the service since the last inspection. When we spoke to these people one of them said, "I'm on respite. My [relative] and I were having difficulties looking after ourselves that's why we have come here. It's much better now that there are people around to help until we can get better and get back home."

The information gathered during the initial assessment was then used to develop a number of individualised care plans. The registered manager informed us that they had rewritten the care plans to ensure they contained the necessary detail and guidance for staff. We saw a newly produced care plan and noted it detailed the support people required, their preferences for how care and support should be delivered as well as containing corresponding risk assessments so staff knew how to mitigate known risks.

The care plans were person centred. For example one person demonstrated behaviours that challenged staff. Their relative told us, "The CPN suggested getting a soft toy dog to help reduce [their] anxiety. The staff bought [them] the toy dog because [they] loved dogs in the past and it has helped." We saw this person touching the dog and smiling showing the positive impact on their mood.

We saw that people's care and support needs were evaluated on a monthly basis as were accidents, incidents and falls. We cross referenced these records with people's care plans and risk assessments to check they were updated as required and found that they were. This provided assurance that staff were aware of people's needs as they changed and developed. For example we saw that where one person had developed a pressure ulcer staff had contacted the district nurse to attend immediately. The district nurse visited during the inspection and confirmed why they were there. They commented, "I visit the service two days a week and am really impressed with the staff. If they are concerned they will call me and they always accompany me when I am seeing someone." The care plan and risk assessment was updated following the district nurse visit.

People who used the service were encouraged to follow their interests and take part in activities. We saw photographs were displayed around the service showing people enjoying the recent 'around the world'

activity. This was an activity devised by the registered manager where one country was chosen and people enjoyed a day relating to that country. They sampled foods, dressed up and enjoyed entertainment. There was an activities co-ordinator employed at the service who was on leave during the inspection. In their absence we saw members of staff interacting with people, looking at reminiscence materials and chatting.

A member of staff who was assigned to observe the communal lounge engaged some people in a ball throwing game. They encouraged people to join in and it was clearly enjoyed with them smiling and clapping when a ball landed in the bucket. A relative told us their father enjoyed the armchair exercises. One person was stimulated by a twiddle muff. These are hand muffs with additional objects sewn into them. They provide something to hold and manipulate and can have a calming effect for people living with dementia. Although the activities programme was not consistently adhered to in the activities organiser's absence staff did provide stimulation and social interactions.

The registered provider had a complaints policy which was provided to people in their 'service user guide' which were in people's bedrooms. Records showed that the service had received no complaints and the registered manager confirmed there had been no complaints in the time they had been at the service. They told us that any complaint would be taken seriously, investigated in line with the registered provider's policy and used to develop the service when possible.

People we spoke with told us they knew how to raise concerns and would not hesitate to complain if the need arose. One person said, "I can ring at any time day or night." People were confident that complaints would be dealt with appropriately by the registered manager.

Good

Is the service well-led?

Our findings

Denison House Nursing Home is one of eight locations registered with CQC by the registered provider Eldercare (Halifax) Limited. Although it is called Denison House Nursing Home the service has not provided nursing care since September 2014. The area manager has told us they have applied to CQC to remove the regulated activities relevant to nursing care. The service was placed in special measures following the inspection on 8 and 10 March 2016. Since then we have inspected twice in August 2016 and February 2017 and the service has been consistently making improvements.

At the last inspection in August 2016 we had found that despite significant improvements the registered provider continued to be in breach of Regulations 9, 11, 12, 17 and 18. At this inspection we found that further improvements had been made and the service was no longer in breach of any regulations. A manager had been employed by the service in November 2016 and registered with CQC in February 2017. They understood their responsibilities relating to notifying CQC of events that affected the people who used the service. Since their appointment the statement of purpose had been updated to reflect the changes to management.

We found that the culture at the service was open and positive. Our observations and the feedback we received demonstrated that improvements were now being made. Staff were positive and enthusiastic about the registered manager. People told us that the service had improved since the registered manager had been employed. A district nurse told us, "I have noticed such a difference since the manager came to work here" and a member of staff told us, "The registered manager has the right attitude. She manages in a friendly way but knows where to draw the line and knows when to intervene." Another member of staff told us, "I want to help the registered manager as she is trying so hard to make improvements."

Staff told us that following the last inspection the quality manager had held a staff meeting and fed back the findings for staff to learn from. Since the registered manager had been in post staff told us that they had attended every handover so they knew about people in the service. The registered manager had worked some shifts alongside staff including nights and had worked over Christmas. Staff had confidence in the registered manager and felt they could speak to them about any work issues. Staff felt they were more effective as a team.

The registered manager had started to hold staff meetings regularly which supported staff and gave them an opportunity to discuss work topics. The registered manager attended monthly managers meetings which were held at the company head office. The registered manager told us that managers shared good practice at these meetings and since they had been rewriting care plans the format had been shared with other managers across the company.

There was an effective quality assurance system in place which promoted continuous improvement. Development of audits was more logical and showed clearly where improvements needed to be made. The registered manager carried out regular audits across all areas of the service and fed those into an action plan. They reported progress to the quality manager every week. The quality manager also visited the

service up to four times a month. They carried out a monthly quality assurance visit which looked at the running of the service, care plans, staffing, the environment, servicing and maintenance and analysed accidents, incidents and complaints. Any completed actions identified as a result of the visit were checked at the next visit.

In addition feedback from people who used the service and their relatives was sought during the quality assurance visits and recorded. Staff were also consulted and had an opportunity for their comments to be recorded. We saw records of the last three quality visits.