

Greenmantle Care Home Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This unannounced inspection took place on 18 and 20 April 2018.

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

Greenmantle is a 15-bed care home providing accommodation and care for older people, including people living with dementia. When we visited 12 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider of the service recently changed from an individual provider to Greenmantle Care Home Ltd. Whilst this change is technically a new registration it is however just a change in legal entity for a continuing service.

At the last inspection on 23 and 29 August 2017, we found three breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not safely managed and there were not enough staff deployed to safely meet people's needs. The registered person had not adequately monitored, assessed and improved the quality of the services provided. Following the last inspection, the provider completed an action plan to show what they would do to improve the service and meet the requirements.

At this inspection, we found that action had been taken. Staffing levels had been changed and were sufficient to meet people's needs. An additional member of staff was on duty in the afternoons and an extra staff was on duty for an hour at the beginning and end of the day.

Systems to monitor the service provided had been changed and strengthened. External consultants had provided guidance and support and an action plan was in place to address issues found. The registered manager had increased the audits and checks they carried out and had taken action when issues had arisen. Staff felt the registered manager was supportive and gave them clear guidance.

Systems in place supported people to receive their prescribed medicines when they needed them. The registered manager monitored and audited medicines to ensure they were safely managed. The completion of outstanding staff competency checks will make the process more robust.

The provider's relationship with staff and some relatives was not positive and was not conducive with an

open or supportive culture. We have recommended that the provider works with staff and relatives to address any issues and to foster positive professional relationships.

Planned improvements to the environment were still pending and the bathroom and kitchen continued to need refurbishment.

There was a stable staff team who knew people's needs. Further changes had been made to care plans but some more work was needed to ensure they were detailed and person centred.

Systems were in place to minimise risk and to ensure that people were supported as safely as possible. Accidents and incidents were recorded but not reviewed or analysed to determine if there were any trends or issues that needed to be addressed.

People were supported to receive the healthcare that they needed. They told us they felt safe at Greenmantle and were supported by kind and caring staff.

Staff supported people to make choices about their care and systems were in place to ensure they were not unlawfully deprived of their liberty. Systems were in place to ensure that decisions made in people's best interest protected their human and legal rights.

Information about complaints and activities was available for people and pictures and larger print formats were used to help those who might find it difficult to read or understand. Complaints and concerns were investigated and information on complaints was clearly displayed. People were comfortable to raise concerns with the registered manager.

Discussions and reviews about people's care were held in private. Personal care was provided in private and changes to the storage of incontinence products meant that people's dignity was no longer comprised.

Systems were in place to safeguard people from abuse and staff were aware of how to identify and report any concerns about people's safety and welfare. Safeguarding incidents had been reported to the local authority safeguarding team.

Staff received up to date training and support to enable them to carry out their duties.

We saw that staff supported people patiently and encouraged them to do things for themselves.

The provider's recruitment process ensured staff were suitable to work with people who need support.

Systems were in place to ensure that equipment was safe to use and fit for purpose.

People's nutritional needs were met and they were appropriately and patiently supported with their meals.

Activities were provided and had improved but some people and their relatives felt this was still not adequate. They told us they would like to use the garden and also to go out. The provider told us that there were plans to improve the garden and to buy garden furniture.

People's cultural and religious needs were identified and respected.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe. Although the system for medicines management had improved staff competency checks had not been fully completed. The monitoring and analyses of accidents and incidents was not yet in place.

Staffing levels had been changed and were sufficient to meet people's needs.

Staff were trained to identify and report any concerns about abuse and neglect. They were confident that any concerns would be followed up by the registered manager.

The provider's recruitment process ensured that staff were suitable to work with people who need support.

The premises and equipment were maintained to ensure that they were safe and ready for use when needed.

Requires Improvement 

Is the service effective?

The service was not consistently effective. Planned improvements to the environment were still pending.

People's nutritional needs were met.

Systems were in place to ensure that people were not unlawfully deprived of their liberty.

The staff team received the training they needed to support people who used the service.

People's healthcare needs were identified and monitored. Action was taken to ensure they received the healthcare they needed.

Good 

Is the service caring?

The service was caring. People told us, and we saw, that they were treated with kindness by a caring staff team. People's privacy, confidentiality and dignity were respected.

People were encouraged to remain as independent as possible

Good 

and to do as much as they could for themselves.

People's cultural and religious needs were identified and respected.

Is the service responsive?

The service was not consistently responsive. Care plans had improved and were more detailed. Some changes were still needed for clarity and to make these more person centred.

There was a small stable staff team who knew the people they supported and their needs.

People were encouraged to make choices about what they did and how they were cared for.

A programme of varied activities was in place but people said they would like the opportunity to use the garden and to go out.

Complaints were investigated and information on complaints and other topics was accessible for people who used the service.

Requires Improvement 

Is the service well-led?

The service was not consistently well led. Relationships between the provider and relatives and staff were not always positive or supportive.

Systems to monitor and improve the quality of service provided had improved and were more robust. Guidance had been sought from external consultants and an action plan was in place to address any shortfalls.

Staff told us that the registered manager was accessible and approachable and that they felt well supported by them.

Requires Improvement 

Greenmantle Care Home Limited

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 unannounced inspection took place on 18 and 20 April 2017. The inspection team consisted of one inspector 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 service.

Before our inspection, we also reviewed the information we held about the service. This included notifications of incidents that the provider had sent us since the last inspection. We contacted the commissioners of the service to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with ten people who used the service, three relatives, the registered manager, the provider, the business development consultant, the deputy manager in training and five staff. We also spoke to two relatives on the telephone. We looked at four people's care records and other records relating to the management of the service. This included three staff recruitment records, staff rotas, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Is the service safe?

Our findings

At the last inspection on 23 and 29 August 2017, we found systems were not in place to ensure people received all of their prescribed medicines safely. At this inspection, we found action had been taken and improvements made.

Systems were in place to provide staff with the necessary competency and skills to safely administer medicines. Staff who administered medicines had received medicines training in January 2018 and systems to check their competency to carry out this task were more robust than previously. This included three separate observations of medicines administration by a member of the management team. We saw that the registered manager had completed the first of these checks and the remainder were due to be completed within a week of the inspection.

Medicines were securely and safely stored. A 'treatment' room was now in use and the medicines trolley was stored in there. The trolley was kept locked and attached to the wall to ensure it could not be moved or opened by unauthorised persons. Only senior staff had access to the medicine storage keys. There was also a Controlled Drugs (CD) cupboard.

Since the last inspection the medicines trolley had been re-organised to make it easier to use. A medicines handover book was in place to share any medicines issues that had arisen with the next shift, such as someone refusing their medicines. In line with good practice, opening dates were recorded on liquid medicines, to ensure that they were not used after the expiry period from the date of opening.

When medicines were prescribed to be given 'only when needed', individual guidelines were in place to inform staff when these medicines should be given. This enabled staff to make decisions as to when to give these medicines, to ensure people were given these when needed and in a way that was both safe and consistent. Some individual protocols required additional detail. For example, to clarify what dosage should be given when a variable dose was prescribed. We discussed this with the registered manager and the business development consultant and they said they would add this detail.

People who received their medicines without their knowledge (covertly) had been reviewed by the GP. Records confirmed the GP had agreed that the covert administration of medicines was in their best interest and that they did not have the capacity to understand the implications or consequences of not taking their medicines. Since the last inspection, more detailed paperwork had been introduced and was with the GP for their consideration and signature. The system for managing covert medicines had improved and people's rights were protected.

We saw that a pharmacist audit had taken place and action had been taken to address points raised. In addition, the registered manager carried out monthly medicines audits and checked that the controlled drugs were correct.

At the last inspection, we found that staffing levels were not sufficient to safely meet people's needs. At this

inspection, we found action had been taken and improvements made to staffing levels so that there were enough staff to meet people's needs. There was still only one waking night staff and one sleep in. Sleep in was usually covered by the provider as they lived on the premises. The rota showed and staff confirmed that they slept in when the provider was not available. Some people needed the support of two staff but their care plans stated this was only for moving and handling and that if any personal care was required at night this could be carried out by one person. Rota changes had been made so that one member of staff started an hour earlier in the morning and another finished an hour later in the evening to give more flexibility in terms of people getting up and going to bed. Three members of staff were now on the afternoon shift instead of two. Although some relatives said the service was short staffed particularly at weekends, there was no evidence to substantiate this.

People and their relatives told us Greenmantle was a safe place to be in. A person told us, "I am not worried about anything." One relative said, "I have no worries about safety. Another relative told us, "[Family member] is as safe as can be."

People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening. Staff had received safeguarding training, were aware of different types of abuse, and knew what to do if they suspected or saw any signs of abuse or neglect. Staff were clear they would report anything of concern to the registered manager and confident that action would be taken. The registered manager had notified us about potential safeguarding incidents. They had worked with the local authority and taken action to make sure people living at the service were protected from risk of harm or abuse.

Risks were identified and systems put in place to minimise risk and to ensure people were supported as safely as possible. People's files contained risk assessments relevant to their individual needs and this gave guidance to staff on how to support people safely. For example, risk of falls. Accidents and incidents were recorded but not reviewed or analysed to determine if there were any trends or issues that needed to be addressed. This had been highlighted during an independent quality review and the registered manager told us they had designed an accident and falls log, which they would be implementing in the near future.

People were protected by the provider's recruitment process, which ensured staff were suitable to work with people who need support. This included prospective staff completing an application form and attending an interview. The three staff files we looked at showed that necessary checks had been carried out before they began to work with people. This included proof of identity, two references and evidence of checks to find out if they had any criminal convictions or were on any list that barred them from working with people who need support. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom.

Equipment was appropriately maintained and systems were in place to ensure equipment was safe to use and fit for purpose. Records showed that equipment was available, serviced and checked in line with the manufacturer's guidance. Gas, electric and water services were also maintained and checked by qualified professionals to ensure that they were functioning appropriately and were safe to use.

Systems were in place to keep people as safe as possible in the event of an emergency. The records confirmed that weekly checks were carried out on fire alarms and call points to ensure they were in good working order. A fire risk assessment was in place and staff were aware of what to do in the event of an emergency. Each person had a personal emergency evacuation plan, which provided information about their needs to assist the emergency services in the event of an emergency evacuation being necessary. To assist staff in the event of an emergency evacuation an 'emergency grab bag' containing basic supplies for

an emergency had been purchased and was situated near to the front exit.

Appropriate infection control systems were in place. Staff had received infection control training and protective equipment such as gloves and aprons were available and used when necessary. Since the last inspection new paper towel, bathroom tissue and hand sanitiser dispensers had been fitted and were in use.

Is the service effective?

Our findings

People were supported by staff who received appropriate training to enable them to provide a service that met their needs. Training was a mix of on line and face-to-face courses. Weekly in house training had recently started and had covered medicines, and fire safety. Records showed that staff had received a range of training including dementia, safeguarding adults, moving and handling, and mental capacity. Staff had also completed the Care Certificate. This is a set of standards that social care and health workers follow in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. Relatives felt staff were competent. One relative said, "Staff know what they are doing." In a letter to the registered manager, we saw that another relative had written, "Staff handled the situation professionally."

People were cared for by staff who received support and guidance to enable them to meet their assessed needs. Staff told us that the registered manager was approachable and supportive. They received supervision (one to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service) approximately every three months. One member of staff said, "You can tell everything to [registered manager]." Systems were in place to share information with staff including handovers between shifts, staff meetings and group messages via staff mobile phones.

There had not been any new admissions to the service since the last inspection. At that time people's individual records showed that a pre-admission assessment was carried out before they began to use the service. Information was also obtained from other professionals and relatives. Assessments considered issues in relation to equality and diversity, such as religion and ethnicity. The assessments indicated the person's basic needs and gave staff initial information to enable them to support people when they started to use the service.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training and understood the importance of seeking consent when supporting people. One person told us, "Yes they do ask before they help me. For example, to come in or wash me or to change me." For people with DoLS in place these had been agreed, by the relevant supervisory body. The manager was aware of when to make a referral to the supervisory body in order to obtain a Deprivation of Liberty Safeguard (DoLS). This meant that systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their liberty. None of

the people had a DoLS in place. The registered manager had made the relevant applications to the supervisory body. Staff had received MCA training and understood that people had the right to and should make their own choices as far as possible. People were not being unnecessarily or unlawfully deprived of their liberty.

People were provided with a choice of suitably nutritious food and drink. Food was freshly cooked and people made their meal choices in the mornings for lunch that day. At the last inspection, we found that the menu had not been changed since 2014. Since then a new menu has been developed with input from people and relatives. The service was able to cater for a variety of dietary needs and the cook knew people's likes and dislikes. Overall, people were satisfied with the meals provided. One person told us, "I like salads. They do them well here. I like roast beef and you get that here." Another person said, "Food is very good. No complaints. A relative commented, "The food smells good. [Family member] would tell me if it was not good." One relative felt their family member did not receive the culturally appropriate food they liked and they had to bring food in for the person. However, we found that this person had a separate menu relevant to their specific needs and staff were aware of the person's likes and dislikes.

People were supported to eat and drink sufficient amounts to meet their needs. At lunchtime, we observed that staff gave people the support they needed. Some people ate independently and others needed assistance from staff. People were not hurried and staff gently encouraged people to eat. We saw that staff had fold up chairs, which they used to sit next to people when helping them to eat. Staff explained to people what was on their plate. People were offered condiments and there was a choice of drinks.

People's healthcare needs were monitored and they were supported to receive the healthcare input they needed. One relative told us, "[Family member] had a fall and they informed me immediately. Staff dealt with it well and sent them to hospital." Another relative said that when their family member was unwell, "They [staff] took [person] to hospital and phoned straight away." However, we saw that one relative had made a complaint because their family member had been sent to hospital by ambulance without staff support. When the relative arrived at the hospital, the person had been incontinent and was very distressed. The registered manager told us that there had been a miscommunication issue between the provider and a member of staff. The registered manager had apologised for this and had reiterated to all staff that people should never be sent to hospital on their own.

The service was provided in a large house in a residential area. There was a lift and ramped access to the building making it accessible for people with mobility problems or who used wheelchairs. In addition, to individual bedrooms there was a large lounge dining area with a conservatory attached. There was an adapted bath and a walk in shower. The kitchen and bathroom were still in need of improvement and one relative commented, "The toilets are dreary."

The provider told us that they planned to refurbish those areas but there was no date for this to happen. There were pictures on the doors of the toilets, bathroom and bedrooms to help people, particularly those living with dementia, to identify these areas.

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. People said, "The people who work here are nice" and "It's a nice place here. I can relax here." One relative said, "[Family member] likes the carers, they are very friendly. There is a nice atmosphere." Another relative commented, "They look after [family member] and they are very happy here."

We saw that staff supported people in a kind and gentle manner and responded to them in a friendly and patient way. They took time to reassure people and explain things so they knew what was happening. We saw that one person was unable to understand some instructions for a game. The activity coordinator tried different ways to demonstrate this and as the person started to become anxious they engaged them in conversation about their home country, which calmed the person. A relative told us, "They are so good with [family member] They are very tolerant."

People were supported to maintain contact with family and friends and they were invited to social events held at the service. Systems were in place to give people and their relatives information about what was happening at the service and why. Residents and relatives' meetings had taken place. A newsletter was published three times a year and this gave information about the service including any changes, improvements and staff training.

People's privacy and dignity was maintained whilst being supported with personal care. We heard a member of staff discreetly suggesting to a person that they might want to use the bathroom on the way to lunch. At the last inspection there was an open storage box containing incontinence pads in the lounge. This meant that anyone in the area could see when staff took an incontinence pad from the box when supporting people. Incontinence pads were now stored in cupboards in the bathroom and therefore people's privacy and dignity was not compromised. There was one shared room with curtains to screen off areas when people were being supported with their personal care needs and to maintain their privacy.

People's personal information was kept securely in a lockable cupboard in the lounge area and in terms of records their confidentiality and privacy was maintained.

People were encouraged to remain as independent as possible and to do as much as they could for themselves. For example, we saw that when one person with some mobility issues got up to walk staff offered them support but the person said they could walk alone. The member of staff respected this and walked behind the person to be available to support them if needed.

People's cultural and religious needs and wishes were identified, respected and as far as possible met. This was helped by the fact that some staff were able to communicate in languages other than English. For a person who, due to their dementia, had reverted back to their first language there was a list of some key words to assist staff to communicate with the person. We also saw that staff who were able to, spoke to the person in their first language.

Is the service responsive?

Our findings

This was a small service with a long standing staff team and changes in people's care needs were communicated to staff during the handover between shifts. Staff knew people well were able to tell us about people's needs and how they met them.

Each person had an individual care plan which set out the care and support they needed. We saw that care plans were reviewed monthly and updated when necessary. Care plans continued to improve. For example, one person's plan contained details of their cultural needs and included some basic words in the person's first language to help staff to understand what the person wanted. However, further work was needed to ensure that all care plans were sufficiently detailed and person centred and that staff had the right information available to respond to people's needs. For example, some people needed the support of two staff for moving and handling and this was specified in their care plan along with the type of hoist and sling required. The plans went on to say two staff were needed to assist the person to bed and one carer to support them and carry out personal care when they were in bed. However, there was no detail as to how this should be done or if any other moving and handling aid should be used. We discussed this with the registered manager and they told us that additional details would be added.

People were not always aware of their care plans and this was possibly due to their dementia. Feedback from relatives about their involvement and review of people's care was mixed. For example, one relative told us, "There are no care review meetings." A second relative said, "There is no meeting. Things should be discussed more." However, a third relative commented, "They keep us in the picture. We were involved in a meeting. They sometimes call." There were not any records of individual review meetings in people's personal files. Although care plans were updated this was based on staff knowledge and did not give people the opportunity to influence change or to give their opinion on the content of their care plan and how their care was provided.

An activity coordinator worked for two hours a day for four days each week. They told us they got support from care staff and that care staff got involved in the activities. Celebrations had been held for Christmas, Easter, Mother's Day and Valentine's Day. One person was from a different culture and religion and the activity coordinator told us they would be organising something of interest to that person in line with this. A monthly activities plan was displayed and activities included reminiscence, painting, knitting, glass decorating, movement, board and ball games, puzzles, bingo and music. The service's newsletter contained photographs of people participating in activities and celebrations. On the day of the inspection, we saw a bowling activity, singing and one to one discussions with people. There was also a demonstration of a new sensory activity the provider was considering buying and four people tried this. A member of staff said, "Activities are much better, something different every day."

However, feedback from relatives was that activities were not satisfactory. One relative said, "Shame there are not more things to do. There are no trips out and they would appreciate it. It would be nice if they would develop the garden. [Family member] would like going out there and would like lunch out in the garden." Another relative told us, "There are no activities except pass the ball. There is no garden furniture." A third

relative commented, "[Family member] is very bored. They don't go out."

People were encouraged to make choices about what they did and how they were cared for. For example, we saw that when a person asked for a drink they were offered a choice. At lunch time people were offered the choice of sitting at the table or having their meal in their chair.

A system was in place to receive and look into complaints and staff were aware of what to do if a complaint was made to them. The service's complaints procedure was clearly displayed on a notice board in the hallway to make it accessible to people and their relatives. There were also signs saying, "If you feel unhappy, worried or need to talk you can talk to us. We are here for you." Records showed complaints were logged and actioned by the registered manager. Relatives knew the registered manager and were clear that they could and would speak to them if they were not happy about something. One relative said, "If I had a complaint I would make it and they would sort it out. I sent a letter and it happened. They don't hide anything." Another relative told us, "I have had no reason to complain, but if I did I would talk to [registered manager], they know everyone."

The management team were aware of the need to provide accessible information that met people's different needs and had started to work on this. More information was being made available in picture formats and there was picture signage in toilets and bathrooms. Those people who wished had photographs on their doors to help them to identify their room and the registered manager told us that they were working on a picture menu.

Staff had received end of life care training. The service had good links with the district nurse team and this meant that support with end of life care was available should staff need this.

Is the service well-led?

Our findings

At the last inspection on 23 and 29 August 2017, we found the overall governance of the service was inadequate. At this inspection, we found action had been taken and the provider had commissioned external consultants to assist with improvements. We saw that two separate consultants had visited and provided feedback on their findings. One consultant also provided advice and up to date paperwork for the service to use. There was an action plan in place following the consultant visits and the registered manager had been working to complete the required actions and make the necessary changes.

We saw that the registered managers monitoring and development of the service had improved. Their quality assurance was more robust and they were carrying out new daily and weekly checks and audits. These included the environment, medicines and care plans. The registered manager had also completed out of hours spot checks and had taken action to address issues found during these. Feedback regarding the registered manager was positive. One relative told us they felt comfortable raising issues with the registered manager. A member of staff said, "[Registered manager] is brilliant and holds the place together." Another member of staff told us, "[Registered manager] does a lot of hard work and tries to put things right. Their main concern is residents and they look after staff as well."

The provider had also subscribed to a 'Quality Compliance System' and changes were being made in line with this to help support improvements and developments in the service. In addition, the provider's representative was working in the role of business development consultant focusing on overall business developments and ensuring policies and compliances were in place in line with regulations. They also delivered staff training and as they lived on site provided day-to-day support including second on call. The rota indicated that the consultant worked from 11am to 5pm from Monday to Friday. The provider told us that they and the consultant made daily checks that "everything was okay".

However, feedback about the provider from staff and relatives was not positive. One relative told us they were not comfortable to raise issues with the provider. Another told us, "The staff are good. Issue is [provider]." After the inspection, a relative told us, "The Greenmantle management is unable and unwilling to receive or to listen to feedback. The management is unable to see any perspective except their own. The management is unable to show any empathy." The provider told us there were two people's families they "had problems with" and did not speak to one of these families. Staff said the provider did not foster an open or supportive culture and that they could not "talk back" or give any ideas or opinions. Their suggestions and feedback was not recognised. The provider said the issues with staff were because they and the business consultant were pushing change and improvements and this was not popular with staff. We discussed this with the provider, who acknowledged that there were issues with some relatives and some staff. We recommend that the provider works with staff and relatives to address any issues and to foster positive professional relationships.

The provider had sought feedback from people and their relatives by means of a quality assurance survey. Responses from this were analysed and the action taken was included in the service's newsletter. For example, a relatives meeting was held on a Sunday. However, one relative told us, "There is no check to see

if family is happy." Therefore, although feedback was sought the process was not robust enough to ensure that everyone had the opportunity to voice their opinions about the service provided. An improvement in professional relationships as recommend above will help to improve the situation and ensure that there is an open culture that welcomes feedback.