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Bradfield Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on the 23 January 2019 and 29 January 2019. The inspection was unannounced on 23 January 2019 and announced on 29 January 2019.

Bradfield residential home is a 'care home.' People in care home services receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation was provided over three floors. A lift was available to take people between floors. Residential accommodation and personal care were provided for up to 37 older people. Double rooms were offered for couples. There were 33 people living in the service when we inspected. Some people had memory loss or health issues associated with ageing or were living with dementia.

We carried out our last comprehensive inspection of this service on 22 October 2015 and we gave the service an overall rating of 'Outstanding.' At this inspection, we found the service Requires Improvement.

Since our last comprehensive inspection in 2015, two new registered managers had registered and shared the responsibility for the management of the service. A registered manager is a person who has registered with CQC 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 design, decoration and signage in the service did not meet current standards for individual people living with dementia or with a visual impairment. We made a recommendation about meeting best practice in the design of the premises.

The premises were well maintained, clean and odour free. Risk assessments were in place with actions to minimise risks, to people, staff and visitors. Safe systems of work were used by staff to manage infection control. For example, good hand hygiene, the use of disposable gloves and the use of planned cleaning schedules. However, the registered managers had not properly minimised the risk from waterborne infections, for example legionella. We made a recommendation about meeting health and safety guidance.

Systems were in place to enable the provider to assess, monitor and improve the quality and safety of the service. These systems were not fully robust as they had not identified the areas for improvement we found during the inspection.

Safeguarding procedures were in place and staff understood their individual responsibility to protect people from harm and report concerns to the registered managers or if required externally in line with the providers whistle blowing policy. Incidents and accidents were reported and appropriately investigated.

Emergency response contingency plans were in place to maintain the levels of care. For example, if the

premises had to be evacuated. Fire systems were tested and staff practised the fire evacuation procedures to maintain their skills. Equipment such as hoist, lifts, gas appliances and electrical systems and equipment were regularly tested.

Comprehensive needs assessments were carried out with people and or with relatives so that the service staff could meet their needs. A care plan was in place based on people's current needs. The care plans provided personalised information, including people's life stories. Likes and dislikes, medical needs and lifestyle choices.

Staff understood the risks to people's individual health and wellbeing and risks were clearly recorded in their care plans. This included hydration and nutrition and health care management. People were supported to eat and drink according to their needs, staff supported people to maintain a balanced diet. Referrals were made to external health care professionals when required. For example, GP's.

We observed that staff were friendly and caring. There were appropriate systems in place to enable people to make complaints.

People's right to lead a fulfilling life and to a dignified death was understood and respected at all levels. People, their relatives and health care professionals had the opportunity to share their views about the service either by internet forums, face-to-face, by using feedback forms or by responding to formal provider quality surveys.

Staff consistently demonstrated they shared the provider's vision and values when delivering care. People were supported to maintain friendships and contacts with those they chose. Activities were planned to assist people to their purpose and pleasure in life.

The procedure in place for the safe administration of medicines was effective and followed published guidance. Staff had been trained to administer medicines. Medicines administration was audited by the registered managers.

The registered managers were aware of the Accessible Information Standard (AIS) and its requirements and made information available to people in different formats.

The registered managers understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

There continued to be enough staff on duty to meet people's physical and social needs. The registered managers checked staffs' suitability to deliver personal care during the recruitment process. Staff received training and supervision.

The registered managers had sent statutory notifications to CQC when required. The CQC rating from our last inspection had been displayed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Infection control risks were not effectively minimised.

Medicines were administered and recorded in line with guidance.

Risk assessments were used to minimise general and individual risks.

Staff understood how to reduce the risk of abuse.

Recruitment for new staff was robust and sufficient staff were deployed to meet people's needs.

Incidents and accidents were recorded and investigated.

Is the service effective?

Requires Improvement

The service was not effective.

The premises had not been adapted to meet people's individual needs.

People's needs were assessed. Staff referred people to health services when needed.

Staff monitored people's health and welfare by keeping accurate care records.

People were supported to eat and drink to maintain their health.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were understood by the provider and staff received training about this.

Staff received training and met with their managers to discuss their work performance.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it and a person-centred care plan was developed around their needs.

Information about people was updated so that staff were aware if people's needs changed.

People were encouraged to participate in activities.

People knew how to raise concerns and complaints.

People received compassionate end of life care.

Is the service well-led?

Good

The service was well-led.

Potential risks and the quality of the service were monitored through regular audits.

The registered managers maintained their skills and knowledge of social care practice.

The management team and staff were clear about the values of the service.

People and their relatives were asked about their experiences of the service.

Bradfield Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced on 23 January 2019 and announced on 29 January 2019. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

We used information we held about the service and the provider to assist us to plan the inspection. This included notifications the provider had sent to us about significant events at the service. We also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people and three relatives about what it was like to live at the service. We spoke with seven staff members which included the two registered managers, two senior carers, three care staff. We asked for feedback about the service from two external organisations involved in contracting and monitoring the service.

We contacted Healthwatch who are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change.

We observed care being delivered in communal areas. We looked at risk and quality audit records, policies and procedures, complaint and incident and accident monitoring systems. We looked at five people's care files, five staff recruitment files, the staff training programme and medicine records.

Requires Improvement

Is the service safe?

Our findings

The registered managers assessed risks from the premises and equipment. Checks of the premises and servicing of the fire alarm and essential services such as the gas and electricity took place. Equipment, such as hoists, were serviced. Assessing and managing potential risks reduced the risks of harm.

However, people at higher risks from contracting waterborne illnesses were not protected from potential harm. The risks from waterborne illnesses such as legionella had not been minimised by proper testing in line with guidance published for care homes by the Health and Safety Executive. For example, a proper risks assessment of the water system had not been carried out. Cold water storage tanks had not been regularly cleaned and the frequency of annual water testing had not been maintained. This was an area for improvement.

We recommend that the service seek advice and guidance from a reputable source, about the management of legionella.

The registered managers assessed risks to individual people, for example, they assessed people's mobility, nutrition and health needs. If people were at risk of falls, equipment was provided such as wheelchairs and walking frames. We observed staff supporting people to move around the service safely using this equipment. Staff received moving and handling training and we observed them using hoist to move people or assist them to stand.

Risks that were specific to people's health and welfare, for example choking and skin pressure area care were assessed and managed appropriately. Where people were at risk, their care in these areas were monitored by the registered managers.

The premises and grounds were well maintained, cleaned and odour free. Staff followed recognised infection control practice. Staff were provided with infection control training and we observed staff using gloves and aprons. Cleaning was ongoing throughout this inspection and staff confirmed that they followed an auditable system of cleaning, for example they signed to confirm they had cleaned areas of the service in line with the cleaning plans. Cleaning plans included deep cleans of rooms and carpets. One person said, "Both the cleaning and laundry are excellent, you just leave your washing by the door and it comes back the next morning." Another person said, "The cleaning is very good."

Staff understood how to report accidents and incidents to the registered managers and these were recorded, investigated and responded to reduce future incidents. There was a learning culture from incidents to minimise them happening again. For example, where people had fallen, pressure mats were to place to alert staff of people mobilising or additional staff checks had been made. Doing this reduced the continued risks from falls.

We observed people received their medicines safely and as prescribed to protect their health and wellbeing. One person said, "I'm happy with the way I receive my medicines." Another person said, "They (staff) are

regular with medicines." The policy on the administration of medicines had been updated and followed published guidance and best practice. For example, the medicines policy followed guidance issued by the National Institute for Health and Care Excellence. Senior staff were trained to administer medicines and their competence was checked by the registered managers to check safe practices were maintained. Staff administering medicines were able to demonstrate to us that they followed the medicines policy. Staff administering medicines to people were friendly and encouraging.

Medicines were stored at recommended temperatures to within secure storage containers. Storage temperatures were recorded within recommended ranges to maintain the effectiveness of medicines. The registered managers now audited medicines to check they were being administered and accounted for correctly. Stocks tallied with administration records. Staff described how they kept people safe when administering medicines. 'As and when' required medicines (PRN) were administered in line with the provider's PRN policies. The medicines administration (MAR's) records were correctly completed. A system of verifying changes to medicines with health and social care professionals was in place. This involved two senior staff double checking changes. For example, after a GP medicines review. This provided an auditable process confirming changes and communications with health care professionals in relation to medicines.

The provider's recruitment policy and processes minimised the potential for new staff being employed who may not be suitable to work with people who needed safeguarding. Applicants were interviewed, had references, work histories were recorded and they had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Recently recruited staff confirmed the recruitment process they experienced matched the recruitment policy.

We observed enough staff were available to meet people's care needs. Staff had time to spend with people, for example walking with them or sitting with them. Staffing was planned in line with people's assessed needs. For example, the staff rota showed staffing levels were consistent with the levels we observed on the day of this inspection. People assessed as requiring higher levels of staff care had this provided. For example, after they had fallen. Staff confirmed they consistently provided this level of care and support.

People described a service that was safe. One person said, "I feel safe living here there is always someone around." People were protected from the risks and from potential abuse. Staff told us they could recognise poor practice and report it appropriately. Training about this had continued for staff. Staff had read and told us they knew how they could use the provider's whistleblowing policy to report concerns. One member of staff said, "I Understand about going to outside bodies if I was not happy about something." Records showed the registered managers took steps to reduce risk and notified the CQC when they referred concerns to the local safeguarding authority.

The risks to people from foreseeable emergencies was minimised. Contingency plans were in place. Staff had training in fire safety and practised the routine. Evacuation policies were based on moving people most at risk from away from the area of danger until they could be rescued. Signage advised the 'fire plan' for everyone to see and people's personal evacuation plans were kept for emergency use.

Requires Improvement

Is the service effective?

Our findings

People told us that their needs were being met by staff who knew what they were doing. People told us they felt staff were provided with training that enabled them to do their jobs.

The premises continued to meet the needs of people living with poor mobility. The internal and external parts of the premises were accessible with ramps and flat surfaces. Decoration was clean and fresh, people's bedrooms were personalised if people chose to do this. However, the registered managers told us that there were people using the service that had dementia or cognitive impairment. There were also people living in the service with visual impairment. For one person with a visual impairment, the lighting in their bedroom had been changed. However, the wider premises had not been adapted to meet the needs of these individual people. For example, the walls, floors and doors in corridors leading to bedrooms were the same colour. This would make it difficult for people to orientate themselves within the building so that they did not get lost or assist them to find their bedrooms. There was limited use of pictorial reference points, for example if people wanted to find a toilet, the lounge or the dining room. We did not see any adaptations that would enable people with a visual impairment to move around the premise independently or safely. For example, hand rails were supplied throughout the premises, but there was no indication to tell people when the hand rail was coming to an end. This was an area for improvement.

We recommend that the service seek advice and guidance from a reputable source, about the design of the premises in relation to people living with dementia and/or visual impairment.

A relative said, "The staff are well trained and very competent in my opinion." The registered managers trained and supported staff to develop the right skills for their role. Training included the Mental Capacity Act (MCA) 2005, dementia and end of life care. Training was planned and monitored so that staff were kept updated. This included mandatory training in infection prevention and control, first aid and moving and handling people. Care staff understood when to report concerns they may have about people's health. This protected people's health and wellbeing.

Staff told us about the training they had attended. The training staff received included equality, diversity and human rights. The provider had a policy about equality and the protection of human rights that staff could access.

The registered managers had regularly met with staff for supervisions and annual appraisals had been planned and were taking place. This gave staff the opportunity to discuss what had gone well for them over the previous year, where they had weaknesses in their skills and enabled them to plan their training and development. Records showed and staff confirmed they received supervision.

People's health and wellbeing were maintained and reviewed in partnership with external health services. Accurate records about people's care were kept by staff. Referrals had been made as necessary to community healthcare teams, for example to GP's, and mental health teams. People had access to the community nursing and mental health teams. One person said, "They (staff) call the doctor if you need one

and they are here in no time." There were records of contacts and advice given by health care professionals.

Staff appropriately communicated information to others about people's care. The registered managers kept records of relatives with a lasting power of attorney. [A lasting power of attorney is a written authorisation to represent or act on another's behalf for health and welfare and/or financial matters].

People were supported to have enough to eat and drink and were given choices. A relative said, "I'm delighted with everything that happens for mum here. Mum had a spell in hospital and when she came out her appetite was poor but they cooked for mum whatever she fancied just to get her to eat again."

Meals were planned to encourage people to eat and drink to maintain their nutritional health. Lunch and tea were served based on people's needs and choice. There were two lunch serving times. The first gave people who needed higher levels of staff support with eating the opportunity to have one-to-one staff time. There was a second sitting at 12.30. People were able to choose where they ate, some chose to eat in their room, two were assisted in their bedroom. People were approached individually by the cook each day and asked their preferences for meals. One person said, "Very good food, they tell me what the choice is in the morning and if I don't like the choice, I can choose anything I like." Between meals people had access to drinks, snacks and fruit. Staff were aware of people's individual dietary needs and their likes and dislikes. We observed people being supported and encouraged to eat and drink at lunchtime and throughout the inspection. Meals were served straight from the kitchen and looked fresh and appetising. Staff created a pleasant and relaxed atmosphere during lunch, people were engaged in conversation with each other and with the staff.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. People were supported to make decisions about their daily lives including how they spent their time and what they had to eat.

People had been assessed and DoLS applications had been made as appropriate. There was a system in place to ensure that when the DoLS authorisations were due to end, staff reapplied for them in a timely manner. The registered managers checked and monitored the implementation of any conditions imposed by the DoLS authorising body. There was an up to date policy in place covering mental capacity. Staff had received training in relation to protecting people's rights.

Good

Is the service caring?

Our findings

We observed that people continued to be treated with kindness, compassion and respect. For example, we saw that staff sat with people, listened and joined in the conversation. Staff asked people for their permission before providing support and explained clearly to people what they were going to do before they did it. A relative said, "The care was just lovely. X went to hospital late at night and I wasn't sure where the hospital was and the manager offered a carer to come with me in my car to show me the way. I think that was amazing and beyond the call of duty."

When speaking to people, staff got down to eye level with the person so that the person could clearly see them and staff used eye contact and caring gestures, like a gentle touch on the arm or back to reassure people. Staff used people's preferred names when addressing them. One person said, "All the carers are lovely they have a great sense of humour." Another person said, "Staff are all very good."

People told us that staff continued to respect their privacy and that staff supported them to maintain their dignity. One person said, "Staff are always discrete with personal care and put a towel over me to keep me covered up." People's care plans were stored securely. We observed people eating lunch and saw that staff actively supported people to maintain their dignity whilst eating. A health care professional confirmed that when they visit the service, they have observed staff being respectful to people. They said, "Staff show respect towards the person I visit."

Choice and independence were respected. People told us they were involved in day to day decisions about their care. One person said, "I am quite independent, I am able to get to the toilet on my own. Mostly I get dressed myself but I feel a bit safer when the staff help." All of the people we spoke with told us they chose when they went to bed and got up. One person said, "I shower when I like."

Our conversations with staff confirmed this practice was embedded in the staff culture. One member of staff said, "In the mornings we offer choice, some people like breakfast first, others like to have a wash. People chose what they want to wear, chose where they dress, chose how we provide personal care." And, "Managers so caring, they work with us, they are with us most of the time."

We observed staff walking with people either offering hand on hand support or walking beside people with walking frames. People were individually dressed, people looked at home and relaxed, wearing slippers and going to their favourite places to sit. For example, in the lounge.

People's views were taken into account when their care was planned. People's rooms had been personalised with their own belongings. The registered mangers said, "People can choose what colour walls' they want." People's religious needs were considered as part of the care planning process. One person said, "People come from St Mary's and we have a little service about once a month." People's care records included an assessment of their needs in relation to equality and diversity and sexuality.

We observed that people's relatives were free to visit people when they wanted to do so. Visitors came and

went freely during the inspection.

Staff appropriately communicated information to others about people's care. A health care professional told us that staff communicated well. They said, "When I visit my client staff are always on hand to give me the information I need." The registered managers kept records of relatives with a lasting power of attorney. [A lasting power of attorney is a written authorisation to represent or act on another's behalf for health and welfare and/or financial matters]. The registered managers confirmed advocacy services were available, but these were not required at the time we inspected.

Good

Is the service responsive?

Our findings

Peoples care needs, preferences and choices were discussed and agreed with people and recorded in a care plan about them for staff to follow. Care plans were individualised and gave clear details about each person's needs and how they liked to be cared for. Sections included family, interest, health and wellbeing and independence. Care plans contained information on a range of aspects of people's needs including mobility, emotional wellbeing and specific physical and mental health support. People were asked about their sexuality, culture and gender choices as part of the assessment process.

Care plans were accurate and up to date. People's communication needs were assessed against accessible information standards 2016 to check if they required any specialised aids. Care plans were reviewed with regularity. A relative reported they had done the care plan together with their loved one and staff. People and their relatives, where appropriate met with staff to discuss and review their care. A relative said, "It has been reviewed recently because X had some medication changes." Where people were not able to be involved in these reviews records showed that care had been discussed with relatives and professionals where appropriate and decisions made were based on people's life history and personal preferences.

People's health care was managed in line with their assessed needs. People were registered with a local GP practice of their choice. The care plans recorded people's progression with heath care professional interventions such as physiotherapy by measuring changes at intervals. For example, in response to falls, people were referred for specialist assessment and their falls had reduced. One relative said, "Staff respond very quickly if she needs any medical care, they are so kind."

To promote wellbeing and reduce isolation activities were planned and coordinated. We observed that the staff were a positive close working team which created an engaging atmosphere for people, whom we observed looked content, busy and satisfied. For example, people were smiling and interested in what was going on around them. Activity participation was recorded so that it could be monitored. We could see which people had attended activities. Pictures and photographs displayed key events on the notice board. This included social, physical and one to one activities based on people's feedback. For example, the registered managers told us that a volunteer with skills in working with the visually impaired visited the service weekly to take a person with a visual impairment out. On the day of the inspection we observed people being actively engaged by an entertainer singing songs people would recognise from their past.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they felt that the care that they received was appropriate for them. People told us they felt comfortable raising any concern or a worry that they may have. We observed that there was a relaxed and happy relationship between all the staff and the people using the service. One person said, "You can speak to anyone, you don't have to worry about anything the managers are so approachable they will sort any problems." Another person said, "Problems of any description are sorted out really quickly."

There had been no complaints received about this service. The provider had a comprehensive complaints

and compliments policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was openly displayed in the service. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. All people spoken with said they were happy to raise any concerns. The meetings and communication in the service reduced the risk of situations requiring people to make complaints.

People received end of life care based on recognised best practice based on a Gold Standard Framework (GSF). The GSF involved staff working together as a team and with other professionals in hospitals, hospices and specialist teams to help to provide the highest standard of care possible for people and supporting their families. Staff had worked closely with a nearby GP and community nursing teams to support people at the end of their life to make sure people receiving end of life care were supported with dignity. A relative said, "We observed X being cared by staff for in a compassionate, kind and dignified way, explaining what they were going to do to make her more comfortable." People's wishes for their end of life had been documented in care plans. People also had a section in their care plan detailing how any pain they may be experiencing could be managed. A relative said, "The registered manager explained to the family at each stage of the end of life care, including the administration of the pain relief and the care to reduce the risk of pressure areas."

Good

Is the service well-led?

Our findings

People told us the service was well managed. One person said, "The managers are very approachable and if I needed to, I would be happy to talk to them about anything." A relative said, "Slightest problem the manager is on the phone even if mum just wants to hear my voice."

There were two registered managers in post. A registered manager is a person who has registered with the CQC 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. We observed the registered managers were well known by people and the staff. They knew people's names and assisted with care when needed.

The registered managers audited and undertook reviews of the services quality and performance. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. We found good practice had continued in areas such as care plan reviews. However, at this inspection we found that the registered managers were unable to fully demonstrate that they were appropriately assessing, auditing and managing risk to the health and safety of people living at the service. They had also been unable to demonstrate they understood their responsibility to make adjustments to the premises to meet people's assessed needs. After the inspection, we took account of further evidence sent to us that demonstrated the registered managers were commitment to the management of health and safety and to making adjustments to the premises. For example, they had contracted with a specialist firm to undertake a risk assessment of the water system at the service.

The registered managers continued to seek people's views about the service from a range of people including people using the service, relatives, staff and external healthcare professionals. People told us that they were frequently asked their opinions on matters such as the menu and the decorating sometimes and the activities. There were resident, relative's and staff meetings. One person said, "We have meetings every now and then and they always listen and take notice of what we have said." Information was shared via a newsletter. The provider's quality assurance system included an analysis of people's responses to measure their performance.

Staff told us that Bradfield Residential Home was a happy environment to work in and that they all valued the people who lived there as interesting individuals. There were regular staff meetings at the service and hand over meetings between shifts. The staff meetings gave staff the opportunity to discuss people's care and issues they may want to discuss about the quality of the service. Staff felt they receive appropriate supportive management time and told us that they were listened to by the registered managers. One member of staff said, "The provider and registered managers are very approachable." The registered managers now regularly met with an experienced external social care consultant. This gave them the opportunity to develop their skills and practice as managers and keep up to date with changes and developments in social care.

Policies and procedures governing the standards of care in the service took new legislation into account. For

example, medicines policies followed guidance issued by the National Institute for Health and Care Excellence. The registered managers referred to external published guidance when managing risk. For example, safety alerts from the Health and Safety Executive. The service worked with others including community mental health teams in relation to people with dementia and the community nursing teams.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had clearly displayed their rating at the service and on their website.