Sentinel Health Care Limited

Fordingbridge Care Home

Inspection report

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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

About the service
Fordingbridge Care Home is a residential care home providing personal and nursing care to 46 people aged 65 and over at the time of our inspection. Fordingbridge Care Home is a purpose-built service providing nursing care to up to 60 people.

People's experience of using this service and what we found
People were supported safely by suitably trained staff who would not hesitate to report poor practice by colleagues or concerns about people.

We found some incomplete employment histories; however, the provider had already changed their recruitment procedures to reflect changed requirements and more recent records had improved. The incomplete histories were updated following the inspection.

The provider had effective systems of monitoring safety aspects of the premises.

People had person-centred risk assessments which considered their abilities as well as assessing possible risks.

Medicines were safely managed however there had been two occasions when medicines had run out and were not administered as a result. There had been no negative impact on people as a result of missing their medicines on these occasions however reviewing the medicines ordering procedures would minimise future risks of this happening.

The premises were very clean, bright and airy and staff had a good understanding of how to minimise infection risks.

The provider reflected when things went wrong and learning was shared across their organisation.

Staff participated in an induction when commencing with the service and shadowed experienced colleagues before working independently.

Staff were regularly supervised and there were monthly staff meetings.

The provider followed the 'Food First' strategy and fortified foods for people at risk of malnutrition. Meals were prepared for people's individual needs to current best practice guidelines.

The service was purpose built with large reminiscence areas on each floor.

People were supported to maintain and improve their health and well-being and the provider utilised good

practice tools such as NEWS2.

The provider was compliant with the principles of the MCA.

People and their relatives told us staff were caring and kind and we saw positive interactions between staff and people using the home. Staff supported people respectfully and promoted their independence while maintaining their dignity

People were involved in planning and reviewing their care if able and if not, relatives contributed, or decisions were made in their best interests.

The provider had a person-centred approach to providing care and support. People were approached in the most appropriate way to enable them to fully understand and participate.

The provider treated people as individuals and approached communication in the same way providing resources to facilitate effective communication.

An activities programme ran, and people could choose to participate in group sessions.

Reminiscence areas were evident throughout the service and a shop contained items that people could take to use such as CD's or books and either keep or return once they had finished with them.

Relatives mostly knew how to complain and if they were unsure of the procedure knew that approaching senior staff would result in complaints being concluded in a timely way.

No-one was receiving end of life care when we inspected however there was a robust policy and procedure in place and staff received training at a local hospice.

The provider promoted person centred care and was committed to enabling people to lead fulfilling lives. The registered manager completed notifications and required ad regular audits ensured there was clear oversight of the service.

People and their relatives completed surveys to inform the provider of their views of the service and regular residents meetings ensured people could be involved in discussions about aspects of the service.

Positive relationships had been developed with health and social care providers.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 11 May 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Fordingbridge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors, a specialist advisor in nursing and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before we inspected Fordingbridge Care Home, we looked at the information we already held about the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We looked at notifications. Notifications are sent to us by the service to tell us about significant events.

During the inspection
We spoke with nine people living in the home and seven of their relatives. We also spoke with 13 staff members including directors, the registered manager, registered nurses, care assistants, activities officers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The provider forwarded us additional information as requested following the inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• Staff had been trained in safeguarding and received annual training updates. Staff told us what the signs and symptoms of abuse could look like and were very clear that they would act on any concerns.
• Staff were also aware of what to do if they observed a colleague showing poor care practice. One staff member told us, "I would raise the concern and go straight to someone who is senior to me and let them know the situation, write a statement and they would take action. I can go to the director of care if I'm concerned about my senior staff". Staff received copies of policies when commencing in post including a copy of the whistleblowing policy and procedure.

Staffing and recruitment
• Staff were safely recruited. We found some staff files did not hold full employment histories, we saw gaps between posts and reasons for these were not clear. The registered manager obtained the missing information and showed us that the application process had already been adjusted to reflect that a full employment history was required and to ascertain reasons for any gaps.
• Staff told us they thought that there were enough staff to care for people safely. One staff member told us, "Yes we've got enough staff. Some days we've got more agency staff. The good thing is we are getting the agency staff who come regularly here so, have enough staff, but it's still not the same as having permanent staff". The service had recently commenced taking new people into the service following a period of time being closed to new residents. Recruitment was underway to improve staffing levels as numbers of people living in the home had increased quickly, faster than they had managed to recruit staff.
• A new dependency tool had been introduced and was saw that staffing levels reflected its findings. People's needs were inputted into the system and each month these were reviewed to ensure that staffing was always sufficient.
• Relatives told us there were sufficient staff. They told us, "[Person] was restricted in their previous home, but here he can sit where he likes or walk about. There's plenty of staff about to help people". Another relative said, "If there's five staff on duty, three will be regular staff. They know the residents and recognise their behaviour patterns".

Assessing risk, safety monitoring and management
• We asked people and their relatives if they felt safe at Fordingbridge Care Home. One relative told us, "Most definitely. It's one of the calmest places we have been." Another relative said, "I don't have any qualms about [person] being here, I know he's safe and being cared for when I'm not here"
• Individual risks were assessed, and plans were in place to reduce residual risks. Areas assessed included

skin integrity, moving and handling and falls. Each area assessed considered people abilities and identified outcomes appropriate to them. For example, when considering infection control the outcome was to reduce the risk of contracting infections, detect infections early, enable prompt diagnosis and treatment and minimise cross infection. Any infections had been recorded with additional actions taken.
• Checks were completed at required intervals to ensure the safety of the premises and equipment. All equipment such as hoists and stand aids, catering equipment and the fire alarm system were serviced and if defects found repaired as soon as possible.
• Following a death from legionella, expert advice had been sought. Water safety management had been completed to a very high standard with additional filters added, regular sampling of water and daily flushing of all outlets.

Using medicines safely
• Medicines were administered safely. We observed a medicine round. Staff remained focussed throughout and medicines were carefully checked, administered and signed off. The medicines were kept locked away when the staff member moved from the trolley.
• During our inspection we noted that the medicines storage area did not lock. A keypad entry system was in place however the door did not close correctly. Medicines were locked inside cabinets within the storage area. The provider arranged for repairs as soon as we informed them of this.
• Both the medicines storage room and fridge temperatures were monitored daily and two registered nurses checked the controlled drugs were accounted for on a daily basis. Controlled drugs are medicines required to be stored more securely by law.
• Two people's medicines had run out; one person had not received medicine to relieve a dry mouth for up to five days and another person did not have a topical medicine for dry skin. The impact on people was minimal, we were assured their conditions had not deteriorated however a review of medicines ordering may reduce future occurrences of medicines running out.

Preventing and controlling infection
• The premises were very clean, bright and airy and there were no malodours throughout the time we were inspecting. Communal and en suite bathrooms were clean and people's rooms, though personalised, were clean, tidy and uncluttered.
• All care records we looked at held a sepsis care plan detailing signs and symptoms that may indicate the onset of sepsis. A urinary tract infection, UTI assessment was also in place for staff reference though not in use for specific people at the time of our inspection.
• We saw staff using appropriate personal protective equipment, PPE during mealtimes, the medicines round, and when delivering personal care. Staff told us, "We use PPE and hand washing, aprons, disposing of waste properly, using yellow bags and washing mattresses and changing the bed linen regularly. There are hand gels (anti-bacterial) in corridors as well for our hands".

Learning lessons when things go wrong
• The provider reviewed accidents, incidents and dangerous occurrences and adjusted risk assessments to minimise future reoccurrences.
• A monthly clinical governance meeting reflected on people's care and concerns that had been raised. Participants discussed the issues, what went well, what went less well and what they would do differently in future. We saw three records of these meetings and on two occasions missing information on admission had contributed to the issues experienced providing care. The provider had become more assertive in gaining a full picture of people's needs and previous issues prior to admitting them to the service.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before being admitted to the service. Recent reflective practice sessions had identified that on one occasion, if the provider had additional knowledge about people prior to their placement they would not have been admitted. On a second occasion, the lack of information that had been forthcoming prior to admission affected the care provided immediately after admission. Care improved with the additional knowledge gained about the person. More thorough assessments were being completed to ensure that people did not have needs that the service would be unable to meet and that a complete information set was being provided.
• Peoples protected characteristics under the Equality Act 2010 had been considered within care planning and specific needs associated with, for example, their gender, religion, disability and sexual orientation were met.

Staff support: induction, training, skills and experience
• When commencing in post, staff participated in an induction which included online training, competency checks and face to face moving and handling training. Staff then shadowed more experienced colleagues to familiarise themselves with the role. One staff member told us, "You shadow, you're with someone the whole time you are here and work with that person for a good couple of weeks until you are comfortable. Dementia is a difficult thing to learn about".
• Staff new to caring completed the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of job roles in the health and social care sectors.
• Staff participated in regular supervisions with senior staff and registered nurses had clinical supervisions with the registered manager. One registered nurse told us, "If there any changes or we need updating on new things, Matron (registered manager) will discuss it at a clinical meeting. Matron is good with that. We meet monthly really but if something comes up or we have concerns then they will meet us then".

Supporting people to eat and drink enough to maintain a balanced diet
• The provider completed a malnutrition universal screening tool, MUST assessment for people. This identified those at risk of losing weight to the extent it would negatively affect their health and well-being. The provider followed a strategy called 'Food First'. This was a process of fortifying foods for people rather than increasing the amount they needed to eat.
• Staff knew people nutritional needs and though they offered people choices, if they were unable to choose, staff knew their likes and dislikes so could make a choice on their behalf.

• People had meals prepared to suit their individual needs and preferences. For example, one person had no teeth and did not wear dentures so had their meals pureed, other people who had swallowing difficulties had meals prepared to specific consistencies to ensure they could eat safely. The service had recently changed the definitions they used for food and fluid consistencies in line with best practice guidance.
• Drinks were thickened as required. Fluid thickeners are prescribed, and the specific consistency is achieved by using the prescribed amount of granules. We saw that in the dining area there was just one container of granules in use for everyone that needed their fluids thickened. We were told by a registered nurse that this was to reduce confusion in the care staff. As these items are prescribed, individual products must be used. We found there was no impact on people because of this as when asked, staff knew how many people needed their fluids thickened and to what consistency.
• Mealtimes were relaxed, and people were not rushed. We saw that people were still having their breakfast at 11 o'clock. We saw people having second helpings of their chosen foods, having cooked breakfasts and eating where they wished, in their rooms, the lounge or dining areas.
• People appeared to enjoy the food served. A relative told us, "Sometimes I have lunch. If I'm here, they always offer me lunch. The food is very good." A person said, "It's very good and plenty of choice." Drinks and snacks were offered regularly throughout the day.

Adapting service, design, decoration to meet people's needs
• The home was purpose built with large, airy rooms and communal areas. Decoration was in good order and the provider had used recent research to inform them on appropriate paint colours to use that would be beneficial to people living with dementia.
• Each of the three floors had reminiscence areas including a train carriage, a greengrocer's shop and a seated wooded area. People were supported to use these areas to trigger memories and for activities.
• Accessible bathrooms, hoists and appropriate seating was provided and there were large, accessible gardens with flowers and vegetables that people had helped to grow.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to maintain or improve their health and well-being. The National Early Warning Score 2, NEWS2 was in use. Observations were taken at regular intervals and if findings were at defined levels either additional more frequent monitoring would take place or medical attention would be sought. This aided in diagnosis of medical conditions such as infections or sepsis.
• Each person had a hospital passport in their care record. This document contained all the necessary needs, preferences and wishes that would be useful for a healthcare professional to know if the person had to be transferred to a hospital setting.
• The registered manager told us that they had positive working relationships with the local health care providers such as a physiotherapy provider, dietician, speech and language therapist and GP surgeries. People were supported to attend local services such as dentists however if this was not possible a special care dental service would attend the home.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA. 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.

• We saw that for each area of care assessed and planned for an MCA assessment had been completed and if the person lacked capacity to consent or make choices then an appropriate best interest decision had been made. For example, one person lacked the capacity to make decisions about medicines, they did not understand why they needed the prescribed medicines and what the effect would be if they did not take them. A best interest decision involving selected staff working in the home and a relative considered the issue and a decision to give medicines covertly was made. A care plan detailed how this was to be done.

• Several residents had DoLS authorisations in place due to lacking the capacity to decide where they should live and no longer being able to stay safe alone in the community. Authorisations were applied for and the provider ensured these were renewed before they expired.

• The service was working to the principles of the MCA.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People received quality care and were fond of the staff that supported them. One person told us, "The regular staff, on the whole, are very good. One or two I don't find as wonderful, but the majority are fab."
• A relative told us that they found staff were also caring towards them. They had been worried following their relative falling and after visiting returned home to find that staff had left them a phone message to say the person had had a sleep and was feeling much better. The message was reassuring and made the relative feel much better.
• Another relative told us, "The staff are lovely with [person]. After a few weeks here, the staff said, 'we love [person] who is lovely'. It was lovely to hear the staff talk about [person] in that way."
• The provider supported people from different cultures and faiths. They told us that in supporting a person who observed the Sikh faith, they had been trained by the persons relatives how to tie their turban and how to care for their hair and beard.

Supporting people to express their views and be involved in making decisions about their care
• Staff consistently offered people choices about food, drinks and activities and waited for responses. Some people were not able to respond to staff however they were still offered choices and staff chatted with them about what was happening.
• Some people had been involved in the assessment and care planning process. We saw some evidence of this in people's care records. When people were not able to express their views or make decisions, options were considered, and decisions made in their best interests.
• Care plans were reviewed each month which provided people and their relatives opportunities to offer ideas how the plans could be fine-tuned. This ensured that people felt involved in the care planning process as fully as they could be.

Respecting and promoting people's privacy, dignity and independence
• We saw that some people liked to remain in their rooms and at times had their doors closed. Staff knocked and waited for a response before entering.
• Staff spoke to people respectfully and with genuine fondness. We saw staff joking with people and encouraging them to participate in activities or to eat and drink at mealtimes. All interactions were appropriate and respectful of people's dignity.
• The provider had started a dignity forum involving people, relatives and staff. They had a remit of

generating ideas that might improve the service and giving staff feedback about the care they were providing and what may improve it.
• People's care records were securely stored however we saw that some daily records were stored on clipboards in boxes in communal areas. Though we did not see anyone other than staff access these, they could be seen and read by unauthorised people. We mentioned this to the provider and these were moved to the nurse's stations and only bought into the communal areas when staff were using them.
• People were encouraged to maintain their independence. One staff member told us, "We try to ensure that they get to participate in their own care and encourage them to mobilise and do things by their own. Some people are very capable of washing their own face or brushing their own hair or putting their shirt on, so we always encourage them to do this or to feed themselves".

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Peoples care records evidenced a person-centred approach to care. Peoples likes, and dislikes were recorded and there was information about their history, so staff could approach them in an appropriate manner.

• Staff approached people according to their knowledge of them. For example, the registered manager described how one person responded to different approaches, "There is a gentleman and if you say to him, 'do you want your dinner?' he'll say no and walk away. If you say, 'here is your dinner, sit down and eat,' he will. He comes from a military background". Identifying that the person responded better to a statement rather than a question when it came to ensuring he ate well had a positive impact on the person's nutritional intake as without this approach he would not sit to eat.

• Staff we spoke with were person centred in their approach. One staff member told us, "Individually, everyone is unique and so we can't do everyone the same way, some people don't want to get up in the morning, some don't want to have personal care like a shower in the morning, some don't like the food. One of the residents doesn't like male carers so we plan for that and they are supported by female carers, some people choose on the day their preferences, sometimes it's different faces they want".

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The provider ensured that people received information in the most appropriate way. One person had significant hearing loss and though they wore hearing aids, still struggled with hearing the television. The provider ensured that subtitles were available when the person was watching the television. They also provided them with a white board so that important information could be written to avoid misunderstandings.

• Staff knew people they supported well and could interpret communication from them and emphasised their own communications with them using gestures and vocal tones for example. They could also interpret changes in behaviours which may indicate increased anxiety or a need to use the toilet.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
• There was an activity programme and activities coordinators supported people in one to one activities or group sessions. The provider told us they were recruiting additional activities staff to ensure that people were more fully occupied.
• People were supported to maintain relationships. There were married couples living with dementia living in the home who were supported to maintain contact with each other. Relatives were encouraged to visit the service at any time, one relative told us, "I came to look around a number of times, and at different times of day". Even before their relative moved into the home they had been welcomed.
• Reminiscence areas were available on each of the three floors. We saw people sitting in the railway carriage and a group was chatting about their memories of the green grocers.
• Other activities included pamper sessions and nail care, boat trips, art therapy, garden walks and various entertainers.
• 'Tilly's shop' was set up on one of the lounges. People could take items from the shop such as CD's and books and could keep them or return them to the shop once they had finished with them.

Improving care quality in response to complaints or concerns
• The provider had received three complaints since January 2019. The complaints varied in their content and there were no themes. Each had been dealt with according to the complaints procedure and were concluded in a timely way.
• People, staff and relatives were provided with information on how to complain. We spoke with three relatives and asked if they knew how to complain, one knew the procedure but the other two, while not knowing the procedure would speak with a senior staff member or the registered manager if they had any concerns. All were confident their concerns would be taken seriously and dealt with appropriately.

End of life care and support
• The provider had supported people at the end of life however when we inspected, no one was receiving end of life care.
• Registered nurses completed the 'Six Steps' palliative care training at a local hospice to give them the necessary skills to support people at the end of their life.
• The Dying and End of Life policy was thorough detailing all the aspects of care that should be included in the end of life plan. This included reducing pain, restlessness, agitation, nausea and relief of pressure points.

• We saw numerous thank you cards and letters from relatives received after their person had died. These were very complimentary and praised staff for the high quality of care especially during the end of life period.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The registered manager and staff team were committed to providing person-centred care and enabling people to live fulfilling lives. Staff spoke positively about the people they supported, and care records reflected the person-centred approach.
• People living in the home could not tell us who the registered manager was however all relatives asked knew their name. We saw the registered manager visit each floor during our inspection and addressing people by name as though they knew them well.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider and registered manager were open with us throughout the inspection discussing fully actions taken following a death from legionella.
• The registered manager ensured that relevant people and agencies were informed if things went wrong in the home. Families were informed if their relative had an accident and Care Quality Commission were informed of all significant events. We had not received a notification of one person's death, this had been due to their being in hospital for some time at the time of death. The provider submitted the notification and will do so for all deaths, including those while people are in hospital in future.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• There was a clear staffing structure, the registered manager was supported by the director of care and in turn the registered manager and registered nurses supported the team in the service.
• Notifications had been completed as needed. Providers are required to complete notifications about incidents or events that affect a service or the people who use it.
• There was an auditing programme that ensured the provider had oversight of the service. Learning was shared with the providers other services.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• A 'resident and relative' survey had been issued in 2018 and responses had been very positive. There were

22 responses and of these, 18 would always recommend the service and 18 were satisfied with the speed of any responses to queries. There was only one low scoring answer of 10 people either always or usually felt involved in decisions about their relative's care. The survey had been analysed and plans put in place to address issues raised.
• Residents meetings were held on each of the three floors. We saw minutes that covered topics such as a review of activities and information that new staff were being recruited. In addition, people were asked their opinion about the catering and reminded they could choose meals that were not on the menu and were reminded and reassured about the confidentiality of the complaints procedure and about how to complain.
• The provider had previously held a regular support group for relatives. These had ceased due to a lack of interest from relatives at that time. There were plans in place to try to reintroduce the group as there were several new people living in the home and their relatives may need support.

Working in partnership with others
• The service worked closely with other care homes owned by the provider. Learning was shared, and new initiatives trialled and reviewed across the organisation.
• There were positive relationships with health and social care professionals including GP's, dieticians, a local hospice and dental surgeries.