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Holmwood House

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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 25 June 2015 and was unannounced. The previous inspection of Holmwood House was on 22 January 2015. There were four breaches of the legal requirements at that time. These related to:

- Consent to care and treatment
- Supporting staff
- Record keeping
- Assessing and monitoring the quality of service provision

Holmwood House is a care home with nursing for up to 41 older people. Thirteen people were living at the home at the time of this inspection.

The home did not have 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 last registered manager left the home in August 2014. A new manager started in October 2014 and they applied for registration with the Commission in May 2015. Their application was being assessed at the time of this inspection.

Summary of findings

We found that checks were not always being made to ensure good information was available about staff and whether they were safe to be providing care to people. There were also risks to people's safety because of actions being taken which compromised the home's fire precautions.

People spoke positively about the staff. One person described staff as "very kind". We were told that staff were friendly and "good company". People also commented favourably about the meals. A staff member said they enjoyed their work and found it very rewarding.

People's care needs were being assessed. Staff were aware of people who were at risk, for example because of poor nutrition or pressure damage to the skin. However people's care was not always well planned and monitored. People were at risk because of a lack of appropriate information about their care and support.

Action had been taken since the last inspection to develop some aspects of the service and to achieve the standards expected. However, as at previous inspections, there were shortcomings in the service which were not being identified and addressed. The provider was not effectively monitoring the service and making all the improvements needed.

We found five breaches of regulations during our inspection. This is being followed up and we will report on any action when it is complete.

Summary of findings

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 always safe.

Checks were not always undertaken to confirm that staff were suitable to be providing care to people.

People's medicines were being managed in a safe way. Checks were being undertaken of the environment. However, there were risks to people because of actions being taken which compromised the home's fire precautions.

The manager and staff worked in a flexible way to ensure the planned deployment of staff was maintained.

Is the service effective?

Requires improvement

The service was not always effective.

Clear procedures were not in place to ensure that people at risk of poor nutrition were well supported. People who were able to manage independently told us they enjoyed the meals.

Action had been taken to develop the home's procedures in relation to mental capacity.

Staff felt supported in their work and competent to undertake the tasks expected of them.

People had access to a GP when required to ensure their healthcare needs were followed up promptly.

Is the service caring?

Good

The service was caring.

Staff spoke respectfully about the people they cared for and showed a caring approach.

People's relatives were welcome in the home. They were encouraged to contribute information which helped staff get to know people and their individual preferences.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were assessed. However, not all aspects of their care were well planned and responded to. There were risks to people because of a lack of accurate information about their care.

People had the opportunity to take part in some in-house activities which they enjoyed.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

As at previous inspections, a number of regulations were not being met.

The arrangements being made for quality assurance were not effective in ensuring that suitable standards were being maintained.

Holmwood House

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 June 2015 and was unannounced. The inspection was carried out by two inspectors.

The inspection also followed up the actions the provider had taken to meet the legal requirements following the last inspection where four breaches of regulation were found.

Before the inspection, we reviewed the information we had about the home. This included looking at any notifications we had received from the service. A notification is information about important events which the provider is required to tell us about by law.

We met with eight people who were living at the home. We made observations during the day in order to see how people were supported and their relationships with the staff. We spoke with three staff members, two relatives and with the home's manager. We looked at three people's care records, together with other records about people's care and the running of the service. These included employment records, audits, and records relating to medicines.

Requires improvement

Is the service safe?

Our findings

We found the service was not always safe for people when we inspected Holmwood House in January 2015. We had also found shortfalls in the safety of the service at previous inspections of the home.

Improvements in the safety of the service were needed at this inspection. Checks were not always being made to ensure there was good information about staff working at the home. This meant there was a risk that people received care from staff who were not suitable. The manager told us about a staff member who had been employed in 2012. They said a process had been started in May 2015 to assess this person's fitness to work at Holmwood House again following their employment with another care provider. This had included an interview and the completion of a risk assessment. However, a written reference had not been obtained from their last employer, nor information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults.

A record of the risk assessment relating to the employment of this person was not available in the home. The manager told us two assessments had been undertaken following matters raised with them relating to how staff performed at work. A record of the risk assessment in relation to the other staff member was available in the home.

This was a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received support from staff which made them feel safe, such as when they had help with a bath. Staff were aware of people who were at risk, for example because of pressure damage to the skin or because of poor nutrition. We were told one person was at risk because they tried to leave the premises and were not safe to do so. We looked at the person's care plans for Dementia and for 'Behaviour Management Strategy'. The plans did not refer to this person leaving the premises. There was a lack of information about how to respond in a consistent way which ensured people's safety.

Staff told us they distracted this person when there was a risk they would leave the home and they took action to prevent this happening. This included positioning a tall potted plant in front of a fire exit door. We spoke with the home's manager when we saw this as it compromised the home's fire precaution arrangements.

There were shortcomings at the last inspection in respect of the home's fire precautions. We had recommended that advice was taken about the fitting of appropriate mechanisms which enable fire doors to be safely kept in an open position. During the inspection on 25 June 2015, we saw some doors that had been fitted with devices so they could be left open safely. Other doors to bedrooms were being held open by chairs. Staff were not present with the people in these rooms at the time. The practice of holding fire doors open in this way is not safe and we have brought this to the provider's attention at previous inspections. We have discussed our concerns about fire precautions at the home with the fire officer.

Staff were aware of the risk of abuse to people and the need to act on any concerns. One staff member, for example, described the term safeguarding as "Doing the right thing to make sure people are safe." Staff described a situation they were currently responding to, involving one person shouting and their occasional physical contact with another person. We observed this during the inspection and one person told us they were upset by the actions of another. Staff at the time provided reassurance and sought to distract the people involved; they told us this was a regular occurrence. We read about this in people's care records; shortly before our inspection an incident involving "verbal aggression" had been reported by staff.

The manager told us they were aware of such incidents and said matters were being discussed with the GP. However, the potentially abusive aspect of the incidents had not been followed up with a referral to the local authority. Under the local authority's safeguarding procedures, providers have a duty to report concerns relating to abuse, or allegations of abuse. If allegations and incidents are not reported to the appropriate authorities, then there is a risk the people involved will not receive the support they need.

At the last inspection we had reported on the checks being undertaken to ensure the environment and facilities were safe for people. However the lack of a control on a shower had meant there was a risk that the hot water would not be maintained at a safe level. We saw this had been responded to by the insertion of a bolt into the shower unit to limit the movement of the temperature dial. A chart by

Requires improvement

Is the service safe?

the shower showed that the temperature of the water was being checked and recorded. The manager told us they continued to carry out 'room checks' and checks of the environment on a regular basis. This was to identify any maintenance issues or where they might be a risk to people's safety.

We saw that a record was being kept of any accidents and incidents. The manager kept a monthly log of these so that any trends could be identified and further action taken where necessary.

We found at the last inspection that suitable arrangements were being made for the ordering, storage and administration of people's medicines. However there had been shortcomings in relation to the recording of medicines that were no longer required. We had recommended that practice was updated in the light of current guidance.

During this inspection we found that recording practice for medicines had been amended. This meant there was now an audit trail to show that medicines had been used and safely disposed of. Our checks of the other arrangements being made for people's medicines, such as their storage, showed that these continued to be suitable.

People were given their lunch time medicines in a safe manner by the manager. The manager explained to people what their medicines were for and checked that people had taken them. Where people did not want their medicines, this was recorded on their medicines records. A relative told us that the situation with their family member's medicines was complex and, in their experience, was being well managed.

The manager was administering the medicines because they told us they were working as a nurse on the day we visited, in addition to having management tasks. They said there was always a nurse deployed throughout the day. The number of care staff was confirmed to be three in the morning, reducing to two in the afternoon and one from 8pm until 8am the following day. As at the last inspection, the manager told us a system was used to calculate the number of staff required to meet people's needs.

Feedback from people indicated that staff were available when needed, with the majority of tasks being undertaken in the mornings when there were more staff working. The manager acknowledged that the staffing between 8pm and 8am was at a minimum, but said this was manageable because most people were in bed by that time. We were told the staffing arrangements were being kept under review in line with the home's level of occupancy.

Requires improvement

Is the service effective?

Our findings

We found at the last inspection that improvements were needed in the effectiveness of the service. This included protecting people's rights by ensuring the appropriate procedures were followed in relation to the Mental Capacity Act 2005. We had also found that staff were not being well supported through the provision of training and supervision.

We looked at these areas again at this inspection and at the arrangements in place for supporting people with eating and drinking.

At the lunchtime meal we saw that people had a choice of main dishes which included a vegetarian option. Most people ate in the dining room and were able to manage their meals independently. Prior to the meal, staff had told us that one person in the dining room needed support with eating. We saw this support being provided in an individual manner by a staff member who was well positioned to provide assistance. People told us they enjoyed the meals. One person commented "Nothing to complain about with the food". Another person told us they were always offered a choice of drinks.

During the morning we saw people in the lounge had been given drinks and were encouraged by staff to have these. There was a system in place for assessing people's needs and this included identifying those people at risk because of poor nutrition and hydration. Staff told us that two people in particular were at risk; this was consistent with the outcomes of the assessments which were recorded as "high risk". These people received care in their own rooms.

In these people's care records we saw a range of actions had been identified in relation to support with eating and drinking. These were not all being implemented; from talking with staff we found there were inconsistencies in how support was being provided and information recorded. Staff, for example, told us about one person who was only having fluids; their plan referred to their food needing to be cut up. There were no records to show people's current intake on a day to day basis and whether they had received an adequate amount. The manager told us that, in the case of one person, such a record would not be relevant as they were now on end of life care. However, the rationale for this was not reflected in the person's care plan for nutrition and hydration. The plan did not provide guidance for staff about the support the person needed with their fluid intake to ensure they were comfortable and their needs were met.

There was a lack of accurate information about the support people needed with eating and drinking and a risk that their needs would not be met. Failings in the planning, monitoring and recording of people's nutrition and hydration were a breach of Regulation 14(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we had found shortcomings in the assessment process relating to the Deprivation of Liberty Safeguards (DoLS). DoLS is the process by which a person in a care home can be deprived of their liberty if this is agreed to be in their best interests and there is no other way to look after the person safely. The manager told us at the last inspection that applications to the local authority for DoLS authorisations had been made for all except two people at the home. The manager said there had been no developments in relation to these applications and their outcome had not yet been determined. In relation to one person who tried to leave the premises, there was no plan in place to guide staff about how to support them in the least restrictive way possible.

Action had been taken to develop the home's procedures in respect of mental capacity. The manager told us they had worked on developing the documentation in people's care records. This was so there was better information about people's individual circumstances and the action taken when they lacked capacity to make their own decisions. We saw new forms were being used to record this information. They set out the subject about which a decision was needed and the action to be taken that was in the person's "best interests". We read for example that a decision had been made about the use of bedrails.

The forms were being kept in a file which the manager described as a "quick reference" file. We were told the file was designed to give staff relevant information in a summary form about people's needs and individual circumstances. This included forms in relation to 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders. At the last two inspections we reported on a lack of clarity in how some forms had been completed. Following the inspection in January 2015, the manager told us the forms had been reviewed. However we again found

Requires improvement

Is the service effective?

shortcomings, including one person's DNACPR form which was still a photocopy, rather than an original. The Resuscitation Council (UK) recommends that only original forms are used as a DNACPR decision record as this avoids the risk that the copy is not up to date.

At the last inspection we had commented on the risk that arises when information is transferred from one record to another; for example when reference was made to people's current DNACPR status on a daily handover record. This was highlighted to the manager again and we saw information about one person's current medicines that was not up to date in the quick reference file. The information referred to a medicine that we later found had been stopped earlier in the month.

People's records included information about their contact with healthcare professionals. We reported at the last inspection that the current GP arrangements were working well. There had been no change in the arrangements and the manager told us that health services were available to people when required.

Records showed the on-going involvement of a GP, through regular visits to the home and their availability on the telephone. This helped to ensure that any concerns about people's health could be brought to the GP's attention at an early stage. In the care records we saw that people's weight was being checked on a regular basis. The care recording system flagged up when there had been a change in weight and whether this was significant. This provided a useful prompt for looking into the reason for the change and whether this was something that needed to be followed up.

Staff said they had got to know people well and felt confident in being able to recognise any changes that would be a cause for concern. People's records showed that matters relating to people's health and well being were being reported by staff. Relatives also felt that staff had got to know their family members well and the care they needed.

Staff told us they felt competent to carry out the tasks expected of them. They were also able to raise any issues with the home's manager and had meetings to discuss their work. We saw a supervision record which the manager maintained to record when meetings had taken place and when the next meetings were due.

Another record showed the training that staff had undertaken and the further training that was planned. The manager told us staff were up to date with their mandatory training. They said a priority since the last inspection had been to provide training in relation to mental capacity. This was to ensure staff were knowledgeable about the law and how it affected their work. Training in dementia had been arranged and a staff member said they were shortly to be receiving this. We were told that a new development involved short 'in-house' training sessions for staff which were led by one of the nurses. These covered a range of health and care related subjects.

Good

Is the service caring?

Our findings

We found at the last inspection that this aspect of the service required improvement. This was to ensure people consistently received a caring and personalised approach from staff.

During this inspection we observed a number of positive interactions between people and staff. Staff spoke respectfully about the people they cared for. People commented favourably about how they were being treated. Staff, for example, were described as "very kind" and we were told there was "never a problem with the staff". One person said they had just enjoyed having a bath and had been well supported by staff. We heard the staff were friendly and good company. A relative told us the quality of relationships between staff and people at the home was good.

We saw that staff were not always present in the lounge, but they checked on occasions to see if people were settled. People in the lounge looked well supported with their personal appearance and clothes. People said they were comfortable where they were sitting and some people were using recliner chairs with leg rests in place.

When staff provided support they took the opportunity to engage with people. For example, when the home's administrator brought one person their newspaper, they chatted with them and the person responded positively. At lunchtime, a staff member noticed that one person wasn't eating their meal; they asked them if there was a problem and whether they needed anything. This included checking with the person if they needed their pain relieving medicine. Later in the day we heard the home's activities co-ordinator explaining to people what the planned activity was going to be and asking whether they would like to take part.

Staff spoke respectfully about the people they cared for. One staff member commented "The job can be difficult" but added that it was very rewarding and they enjoyed the work.

We heard from the manager and staff about situations which required a careful and sensitive approach. This included responding to one person who was living with dementia; we were told this affected their short term memory and their awareness of a family member's bereavement. We were told that, in order not to upset the person, staff referred to the family member as being in hospital, rather than to the bereavement. This was a well intended and caring approach which the manager said had been discussed at a meeting with other people. A record of the meeting had been kept although this did not make reference to the ethical and human rights issues (when staff are not truthful to people who are living with dementia) which should be considered in such situations. We brought this to the manager's attention.

Staff described how they supported people who were receiving end of life care and were very dependent on them. One staff member said there was a risk of a person being isolated because their bedroom was away from the busier parts of the home. They told us they made a point of visiting this person regularly. Staff also described how they made people feel comfortable and a staff member mentioned the importance of ensuring people received good mouth care.

We heard that relatives were encouraged to contribute information which would help staff get to know people and their individual preferences. The manager said one relative helped by providing certain foods which reflected one person's cultural heritage. People's records included information about their faith, or lack of faith, and the manager said they had talked to people about their religious needs. There was also a section on advanced decisions. This provided information on whether the person had made a statement of wishes and who may need to be involved in any decision making process.

A relative told us they were kept well informed about their family member's care. Relatives also said that staff made them feel welcome when visiting. The manager told us a relatives meeting had not been held since the last inspection but said they had regular contact with relatives on an individual basis. A range of information about the home was displayed in front hall where it was readily accessible to visitors. This included information about inspections and the home's current rating.

Requires improvement

Is the service responsive?

Our findings

There had been shortfalls at previous inspections in how people's care and treatment were being planned and delivered to meet their needs.

At the last inspection, we found there were risks to people arising from a lack of appropriate information about their care. Following that inspection, the manager told us about the actions being taken to ensure appropriate information was recorded, for example in relation to people's care plans.

A computerised system was being used as a means of creating assessments and care plans. The system was also designed to provide a record of the care and treatment people received. We saw that people had a range of care plans covering different areas of need. The manager said the care plans were reviewed each month and we saw examples of care plans that had been updated during June 2015. Previous inspections have highlighted shortcomings in relation to pressure area care and we looked at how people's needs in this area were being responded to.

The manager told us about two people who were assessed as being at very high risk of developing pressure ulcers. This was confirmed in their care records. Actions had been identified in order to reduce the risk, including the introduction of a repositioning schedule that was tailored to the person's needs. The manager told us there was no specific care plan for tissue viability. They said information about a repositioning schedule and pressure area care would be documented in people's care plans for personal care or for mobility. This information however had not been recorded. This meant there was lack of guidance in the care plans about how staff were to respond to people's needs and reduce the risk of pressure ulcers developing.

Staff told us they supported people with repositioning. They recognised the importance of pressure area care and said that one person had developed an area of redness on their skin. However this aspect of care was not being approached in a consistent way. One staff member said they repositioned people every hour throughout the day; another told us that this took place every two hours during the day and every three hours at night. Staff were not aware of any guidance in care plans and about the best way to respond, for example if the person was sleeping. There was therefore a risk that people were not receiving care which met their needs and individual preferences.

In people's records, we saw information about the care they had received. This included a 'Daily Turning Record' form which was being used with two people. The manager provided us with these records for the three days prior to the inspection. A section on the forms for recording the 'Turn Frequency' had not been completed. The records showed that people were not receiving regular support with repositioning; on certain days no support had been recorded or repositioning had only taken place two or three times throughout a 24 hour period. Our findings in relation to pressure area care meant that people could not be confident they had received the right care to meet their needs and individual preferences. There were risks to people arising from a lack of appropriate information about their care.

The manager told us two people were receiving end of life care at the home. We saw some information in their records which referred to a deterioration in general health. This stage of their life however was not covered in a specific care plan; information in plans covering subjects such as personal care, mobility and nutrition did not reflect a personalised approach to end of life care.

Failings in the planning and monitoring of people's care was a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

More general information about people's wellbeing and routines was included in the 'Daily Notes' section of their records. This included comments from staff about people's moods and how their care needs had been responded to. The completion of the records was not consistent from day to day, although they provided some useful information for review meetings.

Records showed that people's participation in social and therapeutic type activities varied; the manager said that it was hoped to be able to develop this aspect of the service in the future. The current arrangements were centred on the work of an activities co-ordinator who spent 10 hours a week at the home.

The activities co-ordinator told us they planned a variety of activities for the month ahead. They said they had been given a list of people's interests and this helped them to

Requires improvement

Is the service responsive?

arrange activities that people would enjoy. We heard it was difficult to engage some people in activities, although there were usually five or six people who chose to be involved. The feedback we received from people showed they enjoyed the activities and the occasional entertainments that were arranged.

People also had the opportunity to attend an informal service at the home that was led by representatives of a local church. The manager told us that people's involvement in these regular services was continuing to meet their faith needs. At the last inspection we had seen a number of people attend this service in one of the lounges and be actively involved.

Meetings when people could discuss aspects of the home together were not taking place. The manager said the current level of occupancy meant they were able to have regular contact with people and their views were obtained on an individual basis.

A survey had been conducted earlier in the year in which people and their relatives were asked for views about different aspects of the service. The manager said the response to the survey had been disappointing with only four replies being received. We were told however that it provided some feedback about what people were happy with and where improvements could be made. An analysis of the feedback showed that storage was an issue and the manager said this was something they were hoping to address. Comment had also been made that relatives did not know which staff member was their family member's 'key worker'. A relative we spoke with said they were aware and that it was useful to have this point of contact with a particular member of staff.

Information was displayed in the home about how a formal complaint about the service could be made. The manager said they had not received any complaints since the last inspection. They described the procedure that would be followed if a complaint was received. A range of letter templates had been produced to use during the course of an investigation and to advise a complainant of the outcome.

Inadequate

Is the service well-led?

Our findings

Our findings from previous inspections have shown a history of non-compliance with the regulations. This has covered a range of areas and when improvements had been made these had not always been sustained. The home has been without a registered manager since January 2013, apart from having a manager who was registered in June 2014 and who left in August 2014. The current manager was appointed in October 2014.

The manager told us the time since our last inspection in January 2015 had been a settled period for the home. Occupancy had remained at a similar level and there had been few changes in the staff team. The manager had been in post for over eight months; they had applied for registration in May 2015 although the outcome of their application had not yet been determined. The lack of a registered manager meant the provider continued to be in breach of a condition of their registration.

Information received at the time of the inspection showed that we had not received all relevant notifications from the service. These concerned notifications which tell us about abuse and allegations of abuse. We had not been informed of the incident involving one person's behaviour towards another (referred to under 'Is the service safe?) which we judged to be a safeguarding matter. We have also been made aware by the local authority of a safeguarding referral that was made in April 2015. This concerned a person who was admitted to hospital from Holmwood House. The service was informed of this allegation at the time, but had not then reported it to the Commission as a notification.

The failure to submit notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Action had been taken since the last inspection to develop some aspects of the service and to achieve the standards expected. However, improvements were needed to ensure good standards were achieved and there was compliance with the regulations.

Procedures in the home did not always reflect current guidelines about best practice. This included the actions being taken in relation to pressure area care and end of life planning. At the last inspection we highlighted the importance of referring to clinical guidelines and national guidance. Without this, there was a risk that practice in the home would not meet the expected standard, or that the quality of the service would not improve.

As at other inspections, a number of the shortcomings related to matters which had been brought to the provider's attention on previous occasions. The provider had failed to act on the risks that had been identified. These related to key aspects of the service such as the planning of people's care and the home's fire precautions. The lack of improvement in these areas was not consistent with the provider's policy on quality assurance. This stated that external feedback enabled the home to 'measure its achievements against the required standards and make changes where needed to make improvements'.

The failure to achieve good standards also raised questions about the effectiveness of the provider's own systems for quality assurance. The manager told us they undertook audits in relation to different aspects of the home. A record of the audits was being maintained although this did not show that all audits had been undertaken within the timescales identified.

We saw an infection control audit had been carried out earlier in June 2015. This highlighted some shortcomings, including a 'general untidiness' in bathrooms and a lack of paper towels. We found that the paper towel dispensers in three toilets were empty when seen during the inspection. One toilet was without its seat and there was a tile on the floor that had come away from the wall. We brought this to the manager's attention.

The failure to have an effective system in place for assessing, monitoring and improving the quality and safety of the services provided was a breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they met with the provider about every two weeks and discussed matters relating to the home. There were no reports of provider visits to give an overview of their findings and any actions arising from these. The manager told us there was no overall development plan for the home, but said that action was

Inadequate

Is the service well-led?

being taken with a view to an increase in the home's occupancy. This included the refurbishment of rooms; carpets, for example, were being replaced with vinyl floor coverings which the manager said would be more practical.

The manager was supported by a nurse who was in the role of deputy manager. The manager told us that in addition to their meetings with the provider, they received support through attendance at care home forums. These were also an opportunity to keep up with developments affecting care services.

People and their relatives said they saw the manager on a regular basis. They appreciated this contact and how the manager approached them.