HC-One Limited

St Margaret's Care Home

Inspection report

St Margarets Garth
Crossgate
Durham
County Durham
DH1 4DS

Tel: 01913868949
Website: www.hc-one.co.uk/homes/st-margarets/

Date of inspection visit:
15 February 2016
17 February 2016

Date of publication:
13 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 and 17 February 2016 and was unannounced. This meant the staff and provider did not know we would be visiting.

St Margaret's Care Home provides care and accommodation for up to 60 elderly people who require nursing or residential care. On the day of our inspection there were 50 people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (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.

St Margaret's Care Home was last inspected by CQC on 27 April 2014 and was compliant with the regulations in force at that time.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and staff and described potential risks and the safeguards in place. Staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place to ensure that medicines had been ordered, stored and administered appropriately.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and training sessions were planned for any due or overdue refresher training. Staff received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act and was following the requirements in the Deprivation of Liberty Safeguards.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service, and family members, were complimentary about the standard of care at St Margaret's Care Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they moved into St Margaret's Care Home and care plans were written in a person centred way. The provider sought alternative methods in supporting people with their care needs.

The home had a full programme of activities in place for people who used the service to help meet their social needs.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

The service had links with the local community and local organisations. The service had a positive culture that was person-centred, open and inclusive. The provider had a robust quality assurance system in place. People who used the service, family members and staff were regularly consulted about the quality of the service.

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.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated.

Staff were trained in safeguarding vulnerable adults.

Risk assessments were in place for staff and for people who used the service.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were protected from the risk of poor nutrition, had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

People were encouraged to be independent and care for themselves where possible.

People were well presented and staff talked with people in a polite and respectful manner.

People were involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People had been involved in planning their care and care records were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the community and other organisations.

St Margaret's Care 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.

This inspection took place on 15 and 17 February 2016 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector and a specialist advisor in nursing took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff and district nurses. No concerns were raised by any of these professionals.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider 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 four people who used the service and four family members. We also spoke with the registered manager, deputy manager, a nurse, two care workers, the activities coordinator, one domestic staff, one maintenance staff member and a visiting professional.

We looked at the personal care or treatment records of four people who used the service, medicines records of eight people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at St Margaret's Care Home. They told us, "Certainly, 100%", "They do hourly checks. She is definitely safe" and "No doubt they would do everything in their power to make sure people were safe". A person who used the service told us, "Oh yes, I've always felt safe."

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports and birth certificates. We also saw copies of application forms and we checked these to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the registered manager and looked at staff rotas. The registered manager told us they used a dependency tool to calculate the number of staff required based on the dependency needs of the people who used the service. When it was last reviewed in January 2016, staffing levels were 22 hours per day over what was required. The registered manager told us they were recruiting new nursing and care staff and although there were vacancies at the home, would not take any more admissions until staffing was increased. The registered manager told us, "It's about people, not numbers." Staff absences were covered where possible by the home's permanent staff however agency staff were occasionally used to cover short notice absences. We saw there were sufficient numbers of staff on duty and people were attended to promptly. Staff and people who used the service did not have any concerns over staffing levels. This meant there were enough staff on duty to meet the needs of the people who used the service.

The home is a detached, two storey building. Entry to the premises was via a locked door and all visitors were required to sign in. The home was spacious and the layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home.

The home was clean and had recently refurbished bathrooms. Appropriate personal protective equipment (PPE), liquid soap and wall mounted dispensers were in place and available. We looked in the laundry and saw it was clean. All laundry was labelled and placed in individual trays on shelves. Infection control audits were carried out quarterly. A visiting professional told us, "It's always clean and spotless." This meant people were protected from the risk of acquired infections.

Risk assessments were in place for people who used the service and staff, and described potential risks and the safeguards that were in place. Risk assessments for staff included moving and handling, use of electrical and kitchen equipment and control of substances hazardous to health (COSHH). Risk assessments for people who used the service were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included

measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing and to ensure people were eating and drinking enough. Standard supporting tools such as the Waterlow Pressure UIcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used where needed. This meant risks were identified and minimised to keep people safe.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, a fire inspection and service had recently been carried out, fire drills took place regularly, fire alarm tests, emergency lighting and firefighting equipment checks were up to date.

The service had an emergency contingency plan in place and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We discussed safeguarding with the registered manager who was aware of their responsibilities. The safeguarding file included guidance for staff to follow when dealing with a potential safeguarding incident and what steps to take. We saw records of safeguarding incidents and saw CQC had been appropriately notified. There was a safeguarding notice board on a downstairs corridor wall, which included a copy of the safeguarding policy and provided information to people and visitors about types of abuse and how to report any concerns. Training records showed staff had been trained in safeguarding.

We saw a copy of the provider's incidents policy, which had been updated in August 2015. Accidents and incidents had been recorded and were entered on the provider's electronic system and were analysed to identify any trends. Each record included the details of the staff member reporting the incident, details of the people involved in the incident, where the incident occurred, whether there were any injuries, details of the incident and whether it was reportable.

Appropriate arrangements were in place to ensure that medicines had been ordered, stored and administered appropriately. Medicines were securely stored in a locked treatment room and only the nurse on duty held the keys for the treatment room. Systems were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

We saw staff explain to people what medicine they were taking and why. The nurse gave people the support and time they needed when taking their medicines.

Refrigerator temperatures were monitored and recorded together with the room temperature. Refrigerator and treatment room temperatures need to be recorded to make sure medicines were stored within the recommended temperature ranges. This meant the quality of medicines was not compromised, as they had been stored under required conditions.

People had 'Medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. One person self-administered their medicines and we saw a medicine capacity assessment in place, which was reviewed on a weekly basis.

The registered manager was responsible for conducting monthly medicines audits to check that medicines were being administered safely and appropriately. Action plans were in place for any identified issues that arose as a result of the audit and we saw these actions had been duly completed.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who lived at St Margaret's Care Home received effective care and support from well trained and well supported staff. People told us they were "Very well looked after" and were "Very happy". Family members told us, "The staff are unbelievable", "Nothing but praise", "I couldn't have put her in a better place" and "The senior carer was spot on. It's like it was their relative". A visiting professional told us, "The staff know what they are doing. No concerns whatsoever."

We looked at the provider's training matrix and individual staff training records. Mandatory training included safeguarding, mental capacity, how to handle and move people safely, fire safety, food safety, health and safety, infection control, medicines, nutrition, dementia and dignity. Records showed that staff had completed mandatory training and the majority of it was up to date. Where staff were due refresher training, it was planned. We also saw copies of workbooks staff had completed as part of their training. These included fire safety and how to handle and move people safely.

All staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Supervision records we saw included discussions about training, leadership, competency checks, support, safeguarding and whistleblowing, and documentation. Annual appraisals gave staff the opportunity to comment on their own performance and also included discussions with their supervisor about job knowledge, core values, initiative, teamwork, timeliness, attitude and appearance and areas for future development.

New staff completed an induction programme when they were employed at St Margaret's Care Home. This included an introduction to the company, policies and procedures, an introduction to the home and mandatory training. The registered manager told us all new staff were also enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

People had access to a choice of food and drink throughout the day and staff supported people in the dining rooms at meal times when required. People were supported to eat in their own bedrooms if they preferred. The menu file provided a guide for people and visitors on allergies and intolerances. A family member told us, "The meals have been superb." Diet notification records were kept in the kitchen, which made staff aware of people's dietary needs and preferences, whether they needed assistance with eating and drinking and whether they had any allergies.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition .We saw the speech and language therapy team (SALT) had been consulted when people had specific dietary needs and clear guidance was provided to 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments had been undertaken of people's capacity to make particular decisions. DoLS had been applied for to the local authority for the people who required them. Notifications of the applications that had been authorised had been submitted to CQC. This meant the provider was following the requirements in the DoLS.

Consent to care and treatment and consent to photography records were signed by people where they were able. If they were unable to sign a relative or representative had signed for them.

Do not attempt cardio-pulmonary resuscitation' decisions for people were in place. These were records of when people had made advanced decisions on receiving care and treatment. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

People's records showed details of appointments with, and visits by, healthcare and social care professionals. For example, General Practitioners (GPs), social workers, dietitian, speech and language therapy team (SALT), tissue viability nurses and podiatry. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

We looked at the design of the ground floor dementia unit and saw that memory boxes were in place outside people's bedroom doors. Bedroom doors were clearly identifiable and communal bathroom and toilet doors were appropriately signed. Carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. This meant the service incorporated environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at St Margaret's Care Home. People who used the service told us, "They [staff] are all caring" and "They [staff] are lovely". Family members told us, "The staff are on first name terms with us. They are so friendly", "They have involved us from the start" and "I think they are extremely caring. They treat people with dignity. They get to know the people very well". The registered manager told us, "It's as near to a family as we can make a 60 bed home."

Staff were patient, kind and polite with people who used the service and their family members. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. Overall, people looked clean, comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected.

We observed one person ask a member of staff for a cup of tea. The staff member agreed to get them one straight away. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. People were assisted by staff in a patient and friendly way. We saw staff assisting a person who was having trouble finding the toilet. Staff assisted the person to the toilet, shut the door and then waited outside in case the person needed assistance. This meant that staff treated people with dignity and respect.

Bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and occasions in people's bedrooms. All the people we spoke with told us they could have visitors whenever they wished. Family members we spoke with told us they could visit at any time and were always made welcome.

Personal care plans were in place for people's individual daily needs such as mobility, communication, personal hygiene, nutrition and health needs. Staff knew the individual care and support needs of people, as they provided the day to day support and this was reflected in people's care plans. The care plans gave staff specific information about how the person's care needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted.

People's preferences were recorded in the care records. For example, "Likes to have their breakfast or tea in their room and enjoys going to the dining room for their lunch when they are able to", "Methodist non practising", "Likes ITV1 on at all times" and "Person will attend activities when they are able to". Care plans also detailed what the person was able to do to take part in their care and to maintain some independence. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

Family members told us they were made to feel involved and were kept up to date with information and explanations. Family members told us, "They are always on the phone to us. They are in touch instantly" and "Excellently done. They kept me up to date". A family member also told us there had been some

disagreements among the family with regards to their relative's end of life wishes so the registered manager had arranged for an independent advocate to represent the person's wishes.

End of life care plans were in place for people, which meant that healthcare information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met. We discussed end of life care with a family member who told us, "You could see they knew what they were talking about. They made her feel comfortable." Another family member told us their relative had wanted to die at the home and not go into hospital. The family member told us the registered manager and staff were "Absolutely first class." The registered manager told us a remembrance service was held every year to remember people at the home who had passed away and they kept a 'Memory book'. They also put up a picture of the person in the home so they "Don't just disappear" and carried out six week follow ups with families.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

Pre-admission assessments were carried out and people's needs were assessed before they moved into the home. This ensured that staff could meet people's needs and the home had the necessary equipment to ensure their safety and comfort. Following an initial assessment, care plans were developed detailing the care needs and support, actions and responsibilities, to ensure personalised care was provided to all people. The initial assessment was also signed by the person, or if they were unable to sign a relative or representative had signed for them.
The care plans we looked at guided the work of care team members and were used as a basis for quality, continuity of care and risk management. They were regularly reviewed to ensure people's needs were met and relevant changes were added when needed. Overall, care plans were detailed and provided evidence that people received appropriate care. However, one person's wound care plan evaluation dated 1 December 2015 stated, "Dressings to be changed daily." We saw that changes to the person's dressing had not been documented daily throughout February 2016 so we could not confirm the care plan had been followed. A nurse told us that the dressings were renewed weekly and reassured us that person's care plan and wound assessment form would be updated to reflect this.

Records showed audits of care documentation were carried out and highlighted deficits, the details of the actions to be taken, the date they were to be completed by, together with the signature of the person completing the action. This ensured that the care planning, social profiles and risk assessments contained accurate and detailed information.

We reviewed the daily handover sheet, which was fully completed and signed off by each member of staff on duty. The daily handover sheet contained the person's brief medical history, their level of mobility and support needs, together with their nutritional support needs and any key information that needed to be handed over. The statement of daily living records were used to support the handover information. This meant that staff were kept up to date with the changing needs of people who lived at the home.

We saw the activities calendar for February 2016, which included armchair and weight bearing exercises, school visit, entertainer, coffee morning, Valentine's dinner, folk singers, arts and crafts, and quizzes. We observed people taking part in an exercise class during our visit.

An annual activities survey was carried out. We looked at the results of the 2015 survey and saw people were asked to comment on what additional activities they would like, how often they would like them and whether they would like to be more involved. Additional activities requested included folk music, craft sessions, clay pigeon shooting and craft sessions. We saw the registered manager had responded to the requests and a folk music group had visited the home, craft sessions had taken place and trips to the theatre and Beamish museum had taken place.

The activities coordinator told us they were always looking for new things to do and asked people for

suggestions. One person had wanted to visit a local garden to do a walk so the activities coordinator had telephoned staff at the garden to find out whether it was suitable for the person. One person who used the service told us, "She [activities coordinator] is a treasure" and "She [activities coordinator] remembers what people like. It makes you feel good". This meant person centred activities were provided for people who used the service.

The service had a Complaints policy and procedure that was made available to people who used the service and family members. We saw the complaints register, which recorded details of individual complaints, details of the action taken and date the complaint was resolved. We saw one complaint where a person had been unhappy about funding issues. The registered manager had offered to take the person to visit the local member of parliament to discuss the concerns and also agreed for funding to be discussed at the next residents' committee. We spoke with the person who had made the complaint who told us they were very happy with the action taken. We also saw a copy of a letter from the member of parliament who had offered to hold a surgery at the home.

People, and their family members, we spoke with were aware of the complaints policy but told us they did not have any concerns. This meant the provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

The service had a positive culture that was person-centred, open and inclusive. People who used the service, and their family members, told us, "[Registered manager] is a lovely person", "[Registered manager] wants staff to be here because they want to be here. There isn't a high turnover of staff", "

A visiting professional told us, "[Registered manager] is an excellent manager. They've always been very cooperative and helpful with us."

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. Staff told us, "[Registered manager] is very supportive" and "We can always ring them when they're on call, they always come if they're needed".

An annual staff survey took place and we saw the results from the 2015 survey, which 21 members of staff had responded to. Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings for day and night staff were held monthly. The minutes for the most recent day staff meeting showed discussions had taken place on training, vacancies, medicines, cleaning, local authority visit, occupancy and nominations for the 'Kindness in care' awards. We saw staff had been nominated as part of the provider's 'Kindness in care" awards. Staff were nominated by their colleagues, people who used the service and visitors for these awards, and certificates and photographs were on display in the foyer.

Daily 'flash' meetings took place at 11am. These were meetings between heads of department at the home and discussed any ongoing issues, information the registered manager wanted to make staff aware of and relevant updates from the provider. We observed a flash meeting and discussions included resident of the day, changes in the nurse rota, housekeeping, laundry, kitchen, activities, new admissions, congratulations, communication letters shared, concerns, tissue damage, infections, and additional support.

The service had links with the local community. These included the local church and community groups that were invited to use the premises, the Salvation Army and local schools. Tea parties and coffee mornings were held at the home. Links were also in place with the local university and college and students were provided with work experience at the home.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw a copy of the 'Audit calendar' which included monthly medicines, catering and care file audits, quarterly infection control and falls audits and a twice yearly health and safety audit. The registered manager or deputy manager carried out two different kinds of care file audits. Full, detailed audits were carried out if there were any concerns or if the individual care file had not been fully audited for some time. Shorter audits were carried out if there were no known issues. The care file audits had a grading scale and

included action plans for any identified issues. For example, an audit identified that a dependency score for one person was incorrect due to an incorrect Waterlow score. The action was to recalculate the Waterlow score and we saw this was carried out and the record signed to say it was complete.

The provider carried out monthly quality assurance audit visits to the home. These looked at residents' care, dining experience, medicines management, weight management, staffing levels and dependency, PEEPs, audits and meetings, working environment and occupancy. The visits also included discussions with people who used the service, family members and staff. An identified issue at the previous visit was a person in a wheelchair was not using the footplates. We saw the registered manager had made staff aware via handover documentation.

We saw records of residents' and family meetings, which took place monthly. Subjects discussed at these meetings included events, activities, refurbishment and new staff. At the most recent meeting, the registered manager had asked people if anyone was interested in helping to interview prospective new staff. Three people who used the service had volunteered.

In addition to residents' and family meetings, there was a residents' committee at the home, which was chaired by a family member of a former resident, who was still involved with the home. The registered manager had identified that people felt more comfortable talking openly about the service if they weren't chairing the meeting. Any issues raised at this committee meeting were then fed back by the chair to the registered manager for action.

The registered manager also held an 'Open surgery' every Wednesday afternoon, where people who used the service and family members could come and discuss any issues they had. People we spoke with confirmed this. One person told us, "[Registered manager]'s door is always open. She tells us if you see or hear anything that isn't right, come and see me straight away."

Respite and short stay surveys were carried out. These asked people and family members whether they had enjoyed their stay, whether they were made to feel welcome by staff and any other comments. A family member commented, "He is always greeted in a way which makes him feel remembered and welcome."

The home had an electronic feedback system, which was available to people and visitors in the foyer. Any feedback provided generated an email to the provider, which could be viewed and actioned straight away. 'Tell us about your care' cards were also made available to people in the foyer.

This meant the provider gathered information about the quality of their service from a variety of sources.