Beech Lawn Care Home Limited

Beech Lawn Care Home

Inspection report

48 College Street
Sutton-on-Hull
Hull
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HU7 4UP

Date of inspection visit:
07 August 2018

Date of publication:
25 October 2018

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 comprehensive inspection took place on 7 August 2018 and was unannounced. Beech Lawn Care Home is registered to provide personal care and accommodation for up to a maximum of 28 older people, including those who may be living with dementia related conditions. The provider operates with 21 places. At the time of this inspection the service was being provided to 18 people. Beech Lawn 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.

At the last inspection in June 2017 the service did not meet all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that inspection the service was rated 'Requires Improvement'. This was because the provider was in breach of regulation 17: Good governance, with regard to not having effective systems in place to monitor and improve the quality of the service or to mitigate risks. The provider had not made applications to the local authority where they restricted people's freedom.

At this inspection the service was rated 'Good'. This was because the provider met the regulation on good governance. They had systems in place to monitor the quality of service delivery, which included action plans for making changes. We saw no evidence of how conclusions were reached and information was processed within these systems and discussed with the registered manager how these could be developed.

The provider was required to have a registered manager and the same one had been in post for the last seven years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

People were protected from the risk of harm. Systems were in in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in this area and understood their responsibilities. Risks for people were managed and reduced so that they avoided injury or harm. The premises were safely maintained and we saw documentary evidence of this. Staffing numbers were sufficient to meet people's needs. Recruitment practices were safely carried out. The management of medication and prevention and control of infection were safe.

Qualified and competent staff supported people and were themselves regularly supervised and appraised regarding their personal performance. People's rights were protected regarding their mental capacity and staff understood the importance of obtaining people's consent. Decisions were only made in peoples' best interests where they lacked capacity to make them. People received adequate nutrition and hydration. The premises were suitable for providing care to older people and those living with dementia.

People received compassionate care from kind staff who knew about people's needs and preferences. People were involved in the management of their care and decision making. Information was provided to people in an accessible format. People's wellbeing, privacy, dignity and independence were monitored and respected.

People had person-centred care plans, which reflected their needs well. These were regularly reviewed. There were opportunities for people to engage in pastimes and activities. People were supported to maintain family connections and support networks. An effective complaint procedure ensured people's complaints were investigated without bias. Support to people at the end of life was sensitively and suitably provided.

The culture of the service and the management style were both open and approachable. People had opportunities to make their views known through satisfaction surveys. Records were stored securely which helped to maintain confidentiality.

Further information is in the detailed findings below.

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.

People were protected from the risk of harm by the systems in place to detect, monitor and report safeguarding concerns.

Risks were managed so that people avoided injury or harm.

The premises were safely maintained. Staffing numbers were sufficient to meet people's needs and recruitment was appropriate.

People's medication and the prevention and control of infection were safely managed.

Is the service effective?

Good

The service was effective.

People were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal of their performance.

People's mental capacity was appropriately assessed and their rights were protected.

Appropriate nutrition and hydration was provided and people were supported with health care needs. The premises were suitable for providing care to older people and those living with dementia.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff. Staff were aware of people's individual needs and involved them as much as possible in the management of their care. Principles of equality and diversity were considered.

People's wellbeing, privacy, dignity and independence were monitored and respected.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed.

People's complaints were investigated without bias. They were encouraged to maintain relationships with family and friends and had the opportunity to engage in pastimes and activities.

End of life care was sensitive and suitable for people's needs.

Is the service well-led?

Good

The service was well led.

Quality assurance systems were in operation to help determine improvement of the service delivery.

The culture and the management style of the service were open and approachable.

People had opportunities to make their views known through satisfaction surveys. Records were securely held to protect people's privacy and confidentiality.

Beech Lawn 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.

The inspection of Beech Lawn took place on 7 August 2018 and was unannounced. One inspector and an assistant inspector carried out the inspection. Information had been gathered before the inspection from notifications sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received information from local authorities that contracted services with Beech Lawn Care Home and reviewed information from people who had contacted CQC to make their views known about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with nine people that used the service and carried out a Short Observational Framework for Inspection (SOFI) with four people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three relatives as well as the registered manager and three other staff that worked at Beech Lawn Care Home. We looked at care files for six people that used the service and at recruitment files, supervision records and training records for nine staff. We viewed records and documentation relating to the running of the service, including records held on the quality assurance and monitoring systems, the management of medicines and the safety of the premises. We also looked at records for equipment maintenance and complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People told us they felt safe living there, risks to their safety were reduced, sufficient numbers of staff were on duty to meet their needs, they preferred staff to manage medicines for them and the premises were clean and comfortable.

People said, "I feel very safe living here", "The staff are good people and I feel safe and secure", "Everyone has their medicines managed by staff and so that means it is safer" and "I really would not want to manage my tablets, as I would get mixed up." Relatives we spoke with also confirmed that people were safe. They said, "[Name] is very settled here and safe from harm" and "I believe [Name] is very well cared for and protected."

The service had systems in place to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of their safeguarding responsibilities and knew how to refer suspected or actual incidents to the local authority safeguarding team. Safeguarding records were held in respect of handling incidents and the referrals that had been made to the local authority.

Discussions with staff revealed they were aware of the people that used the service who may behave in a particularly anxious way. For example, people living with dementia who may have refused personal care or put themselves in situations where they or others were at risk of harm or injury. We were told about examples of one person's recent behaviour and we found that staff had learned when the person was likely to act out their anxieties that put them and others at risk of harm.

Risk assessments were in place to reduce people's risk of harm. These included those relating to falling, poor positioning, moving around the premises, inadequate nutritional intake and the use of bed safety rails. People had personal safety documentation for evacuating them individually from the building in an emergency or in case of fire.

The premises and equipment were regularly maintained and this was evidenced by safety certificates. The provider supplied documentary evidence of safety checks on electricity, gas, fire safety and lifting hoists shortly after our inspection as these were not held on the premises. While the passenger lift was not unsafe it had been recommended on the last two maintenance inspections in January and April 2018 that all parts were old and worn and needed a full upgrade. Quotes were obtained and the provider was looking to replace the passenger lift. Audits were carried out to ensure fire safety and equipment safety measures were followed. All of this ensured people, staff and visitors were safe.

Staff used various equipment to assist people to move or transfer and we saw that this was used effectively. People were assessed for the use of equipment and there were risk assessments in place to ensure it was use appropriately and safely used.

Staffing rosters showed the number of staff on duty during our inspection: one senior, one step-up senior and two care staff each morning and one senior and two care staff each afternoon. There was also two care

staff at night and two on call. A cook and a cleaner were also employed during the day. The provider had installed a new nurse-call system that monitored the time calls for assistance had been made and when they were responded to. This had highlighted no concerns. People told us they thought there were enough staff to support them with their needs. Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities to meet people's needs.

There was a recruitment procedure in place, which was safely followed. Evidence to support this included job application forms, references and Disclosure and Barring Service (DBS) checks. A DBS check is a legal requirement for anyone applying to work with children or vulnerable adults. It checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions. During the inspection we looked at five staff recruitment files. We saw that while two were in line with the provider's policy and contained relevant documentation such as full DBS checks and references, three others did not. None contained interview records or risk assessments when starting staff on DBS first checks (quick checks made ahead of the full DBS being received). Following the inspection the provider provided statements to show that safe recruitment practices had been followed.

Medicines were safely managed within the service. Medicines were obtained in a timely way so that people did not run out of them. They were safely and securely stored, administered on time, recorded correctly and disposed of appropriately. We saw medicines being administered appropriately by staff. Where medicines were given to people covertly (without their knowledge because they had refused medicines and were unaware of the importance of taking them), arrangements were in place that legally protected people's rights and these were reviewed every six months.

The local NHS City Health Care Partnership provided medicine audit checks on medicines management systems at the service and had supplied its guidance document 'Care to Share Medicines Matters', to assist staff with safer systems. The last audit was completed in September 2017 and we saw that recommendations made in the report had been met. Staff completed a daily check on medicines management to ensure any concerns were raised at the earliest possible moment.

Systems in place ensured that prevention and control of infection was appropriately managed. The premises were clean and appropriately maintained, staff had completed infection control training, followed guidelines for good practice and had personal protective equipment that they required to carry out their roles. Cleaning staff were employed and they did a good job of keeping the premises clean and free from unpleasant odours. Laundry services were out-sourced to a local company.

The registered provider had accident and incident policies and records in place. Documents showed that events were recorded in detail as they occurred and action was taken to treat injured persons. This was so that lessons were learned to prevent events re-occurring.

Good

Is the service effective?

Our findings

People told us they received a full assessment of their needs before receiving the service and staff understood them well. They told us staff had the knowledge to care for them, their health was promoted by good nutrition and hydration and health care professionals were called upon for support when necessary. They said their consent to care was sought by staff before being delivered. People said, "I get a good choice of meals and there is always plenty", "There is a choice of menu and we have the best cook in the world", "Staff know what my needs are and know how to meet them" and "I get to see my doctor when I want and am always asked about the care before staff provide it." One relative told us, "[Name] is afforded choice in all things and is happy here."

People that used the service exercised choice as much as possible with regard to care planning, individual care and treatment, their relationships with others and as citizens in the general community. They were encouraged to remain independent in all aspects of their lives and staff observed when changes in people's needs required changes in service delivery.

The provider had systems in place to ensure staff received training and learned the skills they required to carry out their roles. We saw staff had completed training in relevant areas and courses were planned in safeguarding, moving and handling, fire safety, mental capacity, health and safety and first aid.

Staff were supported in their roles through induction, one-to-one supervision and an appraisal scheme. We also saw that staff competences in moving and handling, administering medication, hand hygiene and good communication were assessed through recorded observations. Staff confirmed the support they received and acknowledged they had the opportunity to study for qualifications in health and social care, should they wish to. Staff received an employee handbook that contained a large variety of information on what they and the employer should expect from their performance as employees.

People were provided meals that respected their religion, culture and dietary preferences and were offered choice. We saw that vegetarian and gluten free options were provided to some people that required them. Nutritional needs were met through consultation with people about their dietary likes and dislikes, allergies and medical conditions. Staff sought the advice of a Speech and Language Therapist (SALT) when needed.

The kitchen staff ensured three meals a day were provided, plus snacks and drinks for anyone that requested them, including at supper time. Nutritional risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink and people were regularly weighed to monitor their general health. People were asked for their menu choices each day, which were recorded and passed to the cook and then provided to them. People told us they were satisfied with the meals on offer.

Staff consulted people and their relatives about medical conditions and liaised with healthcare professionals. We saw evidence of when referrals to health care professionals had been made. Information was collated and reviewed with changes in people's conditions. Staff told us that people could see health care professionals whenever necessary. Health care records held in people's files confirmed when

professionals had been seen and the reason why. They contained guidance on how to manage people's health care and recorded the outcome of consultations. Diary notes recorded when people were assisted by staff with the health care that was suggested for them.

The provider was making efforts to ensure the environment was suitable for its use, without detracting from homeliness or discriminating against those living with dementia. For those people that used the service and were living with dementia there was some signage for directing them to facilities or their bedrooms, and colour schemes were suitable to reduce people's confusion. There was an enclosed safe patio area off the dining room. Guidance had been sought from external consultants on dementia care. A dementia care mapping exercise on the environment in April 2018 revealed the premises were suitable for those living with dementia and that more signage would have enhanced it further. Safety bed rails were in place for people's use and where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes are called 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. Nine people had been granted DoLs in the last year and the provider was following MCA principles around assessing people, aiding them with decisions using the 'best interest' process and reporting on and recording of the measures taken to uphold people's rights. While most documentation in relation to MCA and DoLs was appropriately completed and signed by those involved, one person's best interest form indicated that only the registered manager had approved the decision, as family and the social worker had yet to sign it.

People consented to care and support from staff by either agreeing to it when asked or cooperating through their body language and accepting support when staff offered their assistance. Some people signed documents that gave permission for their care plan to be implemented, photographs to be taken or medication to be handled. People participated in their care and support as much as possible.

There were seven people assessed using the 'best interest' process to use wheelchair safety belts as they were at risk of sliding from their wheelchairs. This ensured people's right were protected when restraints were placed on their movements.

Good

Is the service caring?

Our findings

People we spoke with told us they had good relationships with staff and each other and that their individual needs were respected. They said any information they required was supplied so they understood it, advocacy services were available and confidentiality of information was respected. They felt their privacy, dignity and independence were encouraged and respected. People said, "The girls are discreet", "We all get on very well", "Staff tell us what is going on and when activities are due", and "Staff fully understand my condition and support me well." A relative told us, "Staff promote [Name's] independence with use of their walking frame and are very kind towards them."

Staff had a pleasant but professional manner when they approached people. We saw some very good interactions between people and the visiting hairdresser. There was also a key worker system in place that enabled people to have named staff for extra support with personal shopping, representing them in meetings or spending one-to-one time communicating with them. Staff knew about people's needs and preferences and were kind when they offered support. When people's wishes were unknown staff treated them with compassion and offered them support in a way they believed people would like.

The registered manager led by example and was polite, attentive and informative in their daily approach to people that used the service. They were happy to stand in when required to help support people, as they felt this kept them in touch with people's needs. They preferred to know the details regarding people's support.

At the time of our inspection the service was providing care and support to people with protected characteristics (age, disability, gender, marital status, race, religion and sexual orientation) under the Equality Act 2010. We were told that people's diverse needs were adequately provided for. People who used the service did not experience any discrimination or unequal treatment which could have resulted in their needs not being recognised or met. This included the needs of people who might have experienced discrimination or disadvantage for more than one reason.

Staff completed equality and diversity training and were mindful of people's diverse needs and wishes. They understood the importance of identifying the differences that people had and knew how they would address these. People had menus changed to suit their culture and these were written in their first language when that wasn't English. One person had a mobile telephone on which the staff gave information in messages that translated into their first language. They also used picture cards to make requests of staff about care needs. People had large button equipment and specialist crockery and cutlery if they had visual impairment and used hearing aids and visual communication aids if their hearing was impaired. People were supported to attend churches and services of their denomination. People were encouraged to speak about and maintain relationships with their chosen partners. All of this enabled staff to care compassionately and effectively for the people that used the service and ensured people were not discriminated against.

Care plans recorded people's individual routines, preferences for outings with family members, people's

differing food choices, their religious beliefs and cultural backgrounds, details of significant people in their lives and how they wanted to be addressed. Staff knew these details and responded to them accordingly.

While almost everyone living at the service had relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. One new person to the service was visited for the first time by an advocate on the day we inspected. The advocate was beginning to build a relationship with them so they could be represented in decisions about their care and support and they would be listened to. We found that staff maintained people's confidentiality of information and shared details only on a 'need to know basis'.

Staff explained to us and we saw that they only provided personal care in people's bedrooms or bathrooms, knocked on bedrooms doors before entering and ensured bathroom doors were closed quickly if they had to enter and exit, so that people's dignity was respected.

Good

Is the service responsive?

Our findings

People we spoke with felt their needs were being appropriately met. People and their relatives talked about the care they received, the activities they engaged in, whether or not they were listened to and if their complaints were appropriately addressed and resolved. People said, "I can complain if I need to but have never had to", "Staff often have time for a chat", "I get my newspaper every morning" and "We are offered activities, the manager is always about and all I have to do is tell her if something is not right."

People were assessed regarding their individual needs, using an electronic care system, which covered nine areas of care. Sometimes people were also assessed using a recognised dementia care mapping tool. From these assessments a one-page care profile was devised as well as a comprehensive 'care needs summary' and care plan with actions for staff to carry out. Life booklets showed people's past histories, their likes and preferences.

Care files and care plans reflected people's needs. For example, one person living with dementia, required a lot of emotional support, some of which they obtained from family members and staff and some from holding onto their possessions. We also saw that one person with a tendency to experience a specific health condition, that caused them additional confusion, had clear and precise instructions for their care when this occurred and how vital it was to seek medical treatment. There were clear and precise instructions for another person's positioning and repositioning. However, these had not been updated to reflect that the person should no longer be placed on their back unless eating. The registered manager completed this amendment.

Care plans were person-centred and contained information for staff on how best to meet people's needs. They contained personal risk assessment forms to show how risk to people was reduced, for example, with pressure relief, falls, moving and handling, nutrition, elimination and bathing. We saw that care plans and risk assessments were reviewed monthly or as people's needs changed and this was recorded on people's electronic care notes.

Activities were held in-house and included crafts, jig-saws, ball therapy, armchair exercises, puzzles, quizzes, magazines, books and board games. People told us they enjoyed activities and receiving visitors and there were several visitors in the service the day we inspected. Some people attended external activities and pastimes, for example, art classes at a local church, tea out with relatives and trips to the local shops. They said they also joined in with poetry and reading aloud, reminiscing, listening to music and sitting in the garden.

Staff understood the importance of and provided people with choice wherever possible, so that they continued to make decisions for themselves and stayed in control of their lives. We observed people making choices and decisions for themselves. Communication was good between people and staff as staff understood people's needs well, were familiar with their preferences and knew the important people in their lives. While the registered manager was aware of the Accessible Information Standard (AIS), informed people through suitable written materials and supported them with communication aids and equipment,

they had not formally included an AIS check in their assessment of needs. This just needed formalising. For people who used hearing aids, hearing loop equipment could be accessed, large print documents were available and they could be translated into different languages where people might not have English as their first language.

The registered provider had a complaint policy and procedure in place and this was on display in the entrance. Records showed that complaints and concerns were handled within timescales. There had only been two complaints in the last 12 months and these had been amicably resolved, with assurances made that people would not have cause to complain on these topics again. Staff were aware of the complaint procedure and had a positive approach to receiving complaints as they understood that these helped them to improve the care they provided. Compliments were also recorded in the form of letters and cards and two had been received in the last year.

We assessed how people were cared for at the end of their life and found that staff sought appropriate healthcare support to enable people to have a comfortable, pain-free and dignified death. All care and end of life arrangements were recorded within people's care plans. We were told that three staff had completed some 'Namaste healing' training, which is a Hindu approach to providing hand massage and music for people to enable them to have a sensually tactile and relaxed experience of care before their death. Staff gave an example of a person that had lived at the service for two years, contracted a terminal illness and quickly deteriorated. They chose to remain at the home instead of going into hospital, received doctor's visits and district nursing support and used anticipatory medicines. Family members stayed with them all through their last days and so their end of life experience was as good as it possibly could have been.

Good

Is the service well-led?

Our findings

People we spoke with felt the service had a pleasant, family orientated atmosphere and was appropriately managed. They said, "We are one happy family", "The manager does a good job" and "We know each other well." Staff we spoke with said the culture of the service was, "open", "responsive" and "honest". One relative said, "My family member's son is kept up-to-date with details about their care and he tells me he is always contacted by the manager when necessary."

At the last inspection the provider was in breach of the regulation on governance, because audits had not included all areas of the service provision. At this inspection we found systems in place to improve the quality of the service were used.

Quality monitoring had been completed by an external consultant early in 2018. Internal monitoring included monthly checks on catering, safety of the environment, housekeeping, personnel, training matters (not audited previously), administration and accuracy of records. A staff training record (matrix) was used to show completed training and which courses were required.

Some monitoring charts for recording people's positional changes and nutritional intake had gaps and others that were no longer needed had not been removed from use. However, the registered manager was aware of these and took action to address them. Action plans were in place to put issues right and action had been taken to do so where any shortfalls had been identified in areas that were audited, but there was no evidence in these audits to show how the shortfalls had been determined. The registered manager assured us that findings would be logged going forward.

The provider was required to have a registered manager and on the day of the inspection there was a person in post, who had been the registered manager for the last seven years. This meant they knew people and the service well and were firmly established in their role.

The registered manager and provider knew about the need to maintain a 'duty of candour' (responsibility to be honest and to apologise for any mistake made). The registered manager sent notifications to the Care Quality Commission and so fulfilled their responsibility in this. However, there had been very few made in the last 12 months and so this was discussed with them. They told us there had been no serious injuries, incidents involving the Police or events that stopped the regulated activity from running. There had been no work-related staff accidents that required a report sending to the Health & Safety Executive under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). There had been no work-related accidents in which people that used the service were injured that needed notifying to us. The registered manager told us they'd ensure that if a person was injured in a work-related accident they would inform us. Other accidents experienced by people that used the service had been notified to CQC in the past.

The management style of the registered manager was open and approachable. Staff told us they expressed concerns or ideas freely and felt these were fairly considered. The registered manager was supported in

their role. The service was run so that people were protected and encouraged to maintain independence and good mobility, which sometimes meant their choices were limited. For example, sometimes the service was run in a way that was thought best for them rather than assisting people to decide what was best for themselves. We found people were discouraged from eating meals in the lounge areas and it was preferred that they always went to the dining room or stayed in their bedrooms to eat at meal times. We were told that snacks could be taken in the lounges. While reasons were provided for such decisions, people non-the-less lacked the opportunity for self-determination in this daily routine.

The registered manager oversaw care and support tasks each day, which meant they had to manage their time well between care support and management duties. They told us they 'worked the floor to carry out supervisions and check the quality of care given' to people. They had minimal contact with other managers and didn't attended the local authority manager forum meetings and so compensated for this by using internet information, reading and completing refresher training.

People maintained links with the local community, where possible, through the church and visiting local services and businesses: shops, pubs and cafes. Relatives played an important role in helping people to keep in touch with the community by supporting people on outings and taking part in local entertainment or by just bringing the outside world into the service.

The provider kept records regarding people that used the service, staff and the running of the business. These were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held. The provider was registered with the Information Commissioner's Office and understood their responsibilities to inform them of any information security breaches.

Satisfaction surveys were issued to people that used the service and their relatives. Responses were positive and the registered manager had responded to suggestions made about life in the service. Staff and other meetings were held to obtain people's views of service delivery.

We saw that partnership working with other agencies and organisations was effective and relationships between staff and health care professionals were good.