Hampton Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Hampton Care on 4 and 5 April 2016 and the inspection was unannounced. Hampton Care is a care home with nursing providing accommodation and personal care for up to 76 older people including people with dementia. On the day of our visit there were 74 people living in the home. The premises are in the form of a large residential home with lifts to all floors, with nursing staff and facilities on all floors as well as ordinary domestic facilities.

There was a registered manager at the home. 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.

At the last inspection on 17 and 20 April 2015 we found that the staff supervision and training in place was insufficient. We also found that the quality assurance systems in place were not sufficient and did not take into account the views and experiences of people living in the home. We asked the provider to submit an action plan detailing the improvements to be made.

These actions have been completed and on this inspection we found that the relevant requirements were being met.

People's feedback about the safety of the service described it as good and that they felt safe.
People were safe because the service had provided training to staff and had systems in place to protect them from bullying, harassment, avoidable harm and potential abuse.

Staff protected people's dignity and rights through their interaction with people and by following the policies and procedures of the service Feedback from people and their relatives was that staff were caring in their attitude and responsive to people's needs. A caring attitude was observed during the inspection and personalised care, dignity and respect formed part of staff training.

Staff training and supervision had improved since the previous inspection. There was a structure and system in place for regular staff supervision and each member of staff had a training record which was relevant to their role.

The service managed the control and prevention of infection well. Staff followed correct policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene. Medicines were well managed, with staff displaying a sound understanding of the medicines administration systems, recording and auditing systems.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by the manager and acted on appropriately.

People at risk of poor nutrition and dehydration were sufficiently monitored and encouraged to eat and drink. The quality of the food was good, with people getting the support they needed and the choice that they liked.

Care, treatment and support plans were seen as fundamental to providing good person centred care. The service had moved to a new computerised system which meant that all staff would be able to access and update these plans at any time. Care planning was focussed upon the person's whole life, including their goals, skills, abilities and how they prefer to manage their health.

The service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and companionship. The service enabled people to carry out person-centred activities within the service or in the community and encouraged them to maintain hobbies and interests.

This was supported by policies and procedures which emphasised the rights of people and developments in care planning which included people's life histories written from their own perspective, which enabled staff to work in a person-centred way.

People described the responsiveness of the service as good. People received personalised care, treatment and support and were involved in identifying their needs, choices and preferences and how they are met. People's care, treatment and support was set out in a written plan that described what staff needed to do to make sure personalised care was provided.

Improvements had been made to quality assurance systems to ensure that people's views were sought and that quality audits take account of the experience of people living at the home. The roles of deputy manager and matron had been introduced and meetings with relatives and residents been held.

Records and personal information were kept in a secure and confidential manner.

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 bullying, harassment, avoidable harm and abuse that may breach their human rights. Staff had received appropriate training in safeguarding people and were knowledgeable about how to report any concerns.

Risks to individuals and the service were managed so that people were protected whilst maintaining their autonomy and freedom. They were reviewed to ensure people could lead meaningful lives whilst keeping them as safe as possible.

The service ensured that there were sufficient numbers of suitable staff to keep people safe and meet their needs, with planned staff rotas and clear descriptions of staff duties each day.

People's medicines were managed so that they received them safely. Staff were trained in the handling, management and administration of medicines.

Is the service effective?

Good

The service was effective. People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff received support and training which enabled them to care and support people effectively.

People's consent to care and treatment was always sought in line with legislation and guidance. Decisions made on behalf of people that did not have the capacity to consent were made in their best interests. Staff showed a good understanding of the Mental capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink enough and maintain a balanced diet. People's individual support needs were taken into account and their preferences were respected and menus planned in advance.

People were supported to maintain good health, have access to

healthcare services and receive ongoing healthcare support, which was provided by both community and specialist services, where required.

Is the service caring?

Good

The service was caring. People were supported by staff who had developed positive caring relationships with them and who supported them maintain their connections with families through flexible visiting hours and involvement of relatives in discussions about people's care.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

People's privacy and dignity respected and promoted through staff ensuring that people had personal space, that their rooms were personalised and their belongings looked after securely.

Is the service responsive?

Good

The service was responsive. People received personalised care which was responsive to their needs. People were supported to have care plans that reflected how they would like to receive their care, treatment and support. These included their personal history and individual preferences.

People had control over their lives and were supported to follow a range of interests according to their preference.

The service used a variety of approaches to listen and learn from people's experiences, concerns and complaints. These included making use of a keyworker system to develop personal and individual understanding of people, engaging with relatives, using feedback collected through external assessors and through information shared at staff handover sessions.

Concerns were followed up promptly and outcomes recorded.

Is the service well-led?

Good

The service was well-led. The Provider and manager had developed a culture which promoted openness and transparency for staff and a person-centred and inclusive environment for people who lived in the home.

The provider had improved on the use of quality audits, both internal and external, and through seeking regular feedback from

people and relatives.

Records were held in a secure and confidential manner.

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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 took place on 4, 5 and 11 April 2016 and was unannounced.

The inspection team consisted of one inspector and an expert by experience who was experienced in care for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.

We reviewed the information we held on the service including previous reports, notifications and feedback from the public. During the inspection we observed care practice and tracked the care provided through looking at records, care plans and speaking to a variety of people.

We spoke with 17 people and nine relatives. We also spoke with the registered manager, operations director, activities co-ordinator, as well as three nursing staff and five care staff. We looked at three care records, two staff records and four medicines records. We also looked at the policies and procedures of the home.

Good

Is the service safe?

Our findings

People told us they felt safe in the home, and relatives felt the same way. One person said, "I definitely feel safe living here." A relative told us, "I feel [my relative] is safe here…. I'm not supposed to put [my relative] in a wheelchair on my own and the carers willingly help me."

During our visit we saw that staff observed safe working practices with regard to moving and handling, ensuring there were no hazards in the home and in administering medicines.

Staff told us, and training records confirmed that they had received safeguarding training. Staff were able to describe different types of abuse and how they would report any abuse/allegation/safeguarding concern to the manager. There were no current safeguarding matters relating to the home.

There were policies and procedures with regard to safeguarding. The manager had also provided a comprehensive guide to people living in the home called "Safe and secure at Hampton Care". This guide described the different types of abuse, outlined the homes commitment to individual's rights and included the home's procedures for acting on concerns about abuse or harassment. This document was written clearly and in large type and provided to each person.

There was a culture of learning from mistakes and a "no blame" approach with regards people's safety, for example in recording medicines. The manager described how this approach encouraged people to raise issues early, so that they could be put right in a swift manner. Examples included occasional omissions in medicine records or reporting falls, where the matter was discussed and rectified. This meant that risks to people's safety were reduced.

Risks to people's safety were managed well so that people were protected and their freedom supported and respected. Staff had received training on how to assess risks and we saw that people's care plans included risk assessments. These included risks associated with falls, nutrition, weight loss and use of the emergency call system. Where it was appropriate to people's needs, risk assessments included the Waterlow and Malnutrition Universal Screening Tool (MUST) assessments.

Other risk assessments included moving and handling, call bell assessments, continence, social and psychological care, communication, night care, pain management, nutrition, general physical care, environmental. There were body maps, consent forms for bedrails, personal care and end of life wishes.

Accidents and incidents were recorded and appropriately signed by the nurse on duty in accordance with the procedures. The Care Quality Commission (CQC) had received notifications of accidents in the home, in accordance with the requirements of regulations. There had been four notifications made in the previous 12 months.

People with dementia were cared for in a safe manner. When people behaved in a way that may challenge others, staff managed the situation in a positive way and protected people's dignity and rights. For example,

people were supported to walk where they pleased, to hold on to items that made them feel comfortable, and where people left their meals unfinished they were gently encouraged to return and eat and drink some more. These approaches meant that they reduced the causes of behaviour that distressed people. Restraint was not practised..

The premises were clean and well maintained and equipment and hoists were clean. Domestic staff used colour coded cleaning equipment. The home kept a record of maintenance checks and any small repairs to equipment and there were up to date maintenance and audit logs of major items such as lifts and specialised beds.

The staffing levels in the home were sufficient to meet the needs of people and ensure their safety. Each floor had a designated nurse in charge with up to four care assistants. In addition there were staff responsible for activities, domestic work, maintenance, catering and "hotel services" (such as ensuring meals were delivered), which ensured care staff were not taken away from their care role.

People told us they thought staffing levels in the home were good. People had noticed the turnover of staff over the previous year and they felt that this had now stabilised. Everyone we spoke to told us that they preferred the permanent staff to any agency staff. Agency staff had been used until full time nurses were recruited and were still being used to cover sickness and holidays.

The registered manager confirmed that agency staff were kept to a minimum and felt confident that people would see the difference now that the nurses were permanent employees, together with the appointment of a deputy manager and matron.

Staff files all showed evidence of criminal checks through the Disclosure and Barring Service (DBS), photo ID, application form and previous employment history. References had been followed up.We saw health declarations, signed job descriptions and contracts. There were policies and procedures in place relating to staff and their work and conduct.

We checked the medicines trolleys and the medicines administration record (MAR) charts. All blister packs were aligned as per the MAR charts. All bottles of medicines were dated when opened. Records of covert medicines were accurately kept. Covert administration of medicine is where medicine is given in a disguised form to individuals who are unable to give informed consent to treatment and refuse to take tablets/capsules or liquid preparations when they are offered openly.

The controlled drugs (CD) corresponded to the tally in the CD book. The home medicines books and running totals were aligned. We found that the RGNs, had a good knowledge of the safety issues behind medicines and they were able to explain procedures confidently and expertly.

The service managed the control and prevention of infection appropriately. Staff followed policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene.

Good

Is the service effective?

Our findings

At the previous inspection in April 2014 we had found that staff did not receive sufficient appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. We had asked the provider to send us an action plan setting out the improvements that would be made.

The action plan outlined that all staff were updating the mandatory training requirements, supported by sixteen week training programmes on specialist subjects, for example, dementia and end of life care. Individual supervision was implemented as was group supervision amongst teams to discuss specific topics relevant to their area of the home. An annual appraisal system was implemented.

During the inspection of 4 and 5 April 2016 we saw evidence that this had been implemented and was working and that the standard was met. In addition, staff feedback was positive regarding the training and support they received in the course of their work.

One staff member commented, "It's a lot better than it was last year. We talk a lot more about things and I am up to date with training and can speak about issues at supervision."

New staff completed their induction within 12 weeks and covered the Skills for Care Common Induction standards and 31 staff had a diploma at level 2 or above in health and social care.

Supervision and appraisal was conducted through the nurses in charge of each area for their team. Records of supervision were held securely.

People's feedback about the effectiveness of the service was positive. One person told us, "I am happy living here, the services provided are excellent and the physiotherapist is excellent." Another person said, "We get three good meals a day and more; sherry before lunch and if I wanted a whisky at night I could have one."

Relatives were also positive in their comments. One said, "I am over the moon. My [relative] has been here for 10 months, was properly assessed and staff know their likes and dislikes and [my relative] is so much better now." Another relative spoke about how their relative had received a cut to her arm which needed stitches. The nurses had been trained to put in sutures effectively which avoided an unnecessary and distressing visit to the hospital.

Several people and their relatives expressed the view that agency staff were not as friendly or effective as the permanent staff. One person told us, "The agency staff are not as good as our own carers. Even the way they wash you is different. I said once: 'Please can you dry me properly'; I have sensitive skin and otherwise I get a rash. They said: 'You are dry' but I wasn't and I got a rash. I always insist now that they dry me properly." Another said, "What I can't get over is the fact that I can't understand what a lot of them say and they can't understand what we say. [Consequently] they can't talk to me whilst they are giving me personal care"

We spoke to the registered manager about this and she acknowledged that during the period of a large turnover of staff and while they were recruiting permanent nurses they were reliant on agency staff more than at present. The situation had improved and the home now had over 100 staff and agency staff were only used during times of sickness or annual leave if bank staff could not be used.

We saw that people signed decision specific consent forms, for example, for consent to take a person's photo, bedrails and covert medicines, as well as consent and wishes with regard to resuscitation and end of life care.

Staff understood and had a good working knowledge of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005. They put these into practice effectively, and ensure that people's human and legal rights are respected.

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.

During our inspection we saw records of applications and authorisations under DoLS. 50 people in the home were subject to authorisation under DoLS.

In other areas where consent was an important consideration, the home held 49 records of Do Not Attempt Resuscitation (DNAR) forms. In all, 73 records contained a care plan which set out people's advanced care preferences.

People were supported to eat and drink enough and maintain a balanced diet and people were happy with the quality of the food and the flexibility of mealtimes to suit them. On the various floors where people had lunch we observed staff attending to people and supporting them in a professional manner, and the atmosphere was pleasant and relaxed. Portions were suited to the wishes of people and there was easy access to drinks.

The hospitality staff were efficient in offering drinks and fluids when appropriate and were familiar with people's requests and needs. They also checked people's menu preferences in the morning. People who required special assistance with eating, or who required specialist preparations of food were supported in a friendly and caring manner. People who did not wish either of the choices on the menu were able to request something else. The food was served hot and presented in a way that was appealing.

People were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. People were positive about their access to healthcare services and their ongoing health support, which included speech and language therapy, chiropody and physiotherapy, which one person described as "excellent".

The service engaged proactively with health and social care agencies and acted on their recommendations and guidance in people's best interests. Appropriate referrals were made to other health and social care services, for example care managers, tissue viability nurses, community psychiatric nurses and dentists.

Premises were suitable for people and access to different floors was available by elevator. Each resident had a room with modern fittings and an en-suite toilet/washbasin. All rooms had call bells which were within reach of beds/chairs. Some rooms were personalised with photos/pictures/items of furniture. Bathrooms and toilets had suitable fittings and equipment for those with limited mobility and emergency cord pulls were accessible. There were communal lounges and dining rooms which were spacious and easily accessible for wheelchairs/other mobility aids.

On the floor which accommodated many people with dementia there had been improvements to the design and layout of the rooms and corridors and had built on the previously stated plan to improve this area, including door furniture and reminiscence memorabilia.

Good

Is the service caring?

Our findings

People and their relatives were positive about the caring attitude of the staff. People received care and support from staff who knew and understood their history, likes, preferences and needs. The relationships between staff and people receiving support demonstrated dignity and respect at all times.

One person told us, "They're very caring. They're very kind and they are well trained. Ask for a carer and there's someone there straightaway. My family can come in at any time." Another person said, "The carers are super. I know if we had any problems there wouldn't be any difficulty."

A relative said, "The carers up here (2nd floor) are really lovely." Another relative told us, "I like it that [the carers] speak to [my relative]; always a greeting and 'How are you?' even though [they] can't always respond."

However, one person told us that sometimes agency staff did not display the same caring attitude as permanent staff. "Someone switches the lights on and begins to wash me. Some of [the carers] don't even talk to me. They speak bits and pieces of English which I don't understand, and they blame me."

Another person said, "I prefer [care staff] who I know. There's a difference; our ones, they know what we want whereas the agency staff are: 'Boom, boom, boom and that's it'. But on the whole they are pretty good."

We saw that the staff had received training in person-centred care and that the home's policies and procedures placed importance on dignity and respect. We spoke to the registered manager about how some people perceived agency staff. She described how the home had moved towards a full complement of permanent staff and that agency staff were a last resort in times of sickness or annual leave. She told us that now there was a deputy manager and a home matron, they would be able to monitor the agency staff who worked in the home with the aim of ensuring they carried out their work with the correct values.

During the inspection we observed the interaction between staff and people and saw that staff knew people well and were caring and attentive. Staff were in colour coded uniform to indicate designation and all were wearing name badges to help people know their names.

We saw the Service Users Guide, which is a booklet provided to everyone. This gave clear and practical information about the home's services, and emphasised person centred care as part of its overall ethos. Care plans and other records which referred to people used language that was clear, respectful and person centred.

People were supported to express their views and staff were skilled at giving people the information and explanations they needed and the time to make decisions. The home had an activities organiser who was actively involved in working with people to ensure that their views about the service and the events and activities it offered met people's interests and needs. We saw that short summaries had been prepared for

people titled "This is me", which outlined a summary of the person, their interests and how they liked to be cared for from a personalised viewpoint.

People were satisfied that they were treated with dignity and with respect for their wishes. One relative told us, "[My relative] moved here with her husband in December 2015. She seems a lot more contented since she came to live here. She has settled remarkably well. My relative chooses not to stay in her room but sits with the others. I feel very at home here; everyone is very friendly. I think the dementia unit has improved recently with the wall decorations and the birds twittering. I like the fact there are activities to do, but sometimes [my relative] chooses not to."

We observed that staff were caring, knew people's names and spoke with people in a friendly and respectful manner. Staff knocked on people's doors prior to entering their rooms and waited for a response before entering. People were not rushed when being assisted to move from bed to chair/ taken to toilets. Staff answered call bells/calls for attention promptly. We saw that people's rooms had their own pictures and furniture in rooms.

Care plans and records and daily reports referred to people in respectful language.
Policies inspected included policies on people's rights, dignity and privacy and confidentiality.
Person centred care was part of the home's overall training programme as was dementia.

Care plans included sections on end of life preferences and wishes and the home had developed strong links with a hospice in order to ensure sound practice in palliative care.

Good

Is the service responsive?

Our findings

People received personalised care, treatment and support and their care, treatment and support were set out in a written plan that described what staff needed to do to make sure personalised care was provided.

Care plans contained sufficient detail on individual needs which included details of physical and health care needs, social interests, spiritual and cultural preferences. The home had completed the transfer of people's records to a computerised system and staff were able to demonstrate how it worked in a confident way. This enabled staff to update care plans, daily notes and share information about people from any floor in the home.

Staff were confident that they understood people's needs and could explain individual requirements and behaviour when asked. Staff were briefed verbally by the unit manager about people's needs and progress.

People were able to describe the various hobbies and activities they took part in and spoke positively about how the activities and choice in the home had improved over the year. Positive comments were made regarding the activities co-ordinator. One person told us, "The new [activity] person produces a sheet with activities for the week. Music is being brought here; I enjoyed a jazz quartet and two classical musicians recently. Activities are extremely important as otherwise people sit slumped in front of the TV."

Another person said, "I have the paper to read and these puzzles to do. I go into the sitting room in the morning for breakfast and then return to my room. Sometimes they say to go to activities; if they have music on I might go. We have singers mainly and they are very good. They sing all sorts from 20's to 60's to cover all tastes. My family visited recently and we all had lunch together. They provided pureed food for my sister who needs it because of a throat problem."

The activities coordinator described how she saw her role as someone who supported care staff to engage with people in non-caring tasks, such as hobbies and interests. We saw that on at least one floor the nurse in charge had ensured that designated time was provided to care staff to enjoy activities with people.

Activities were based on people's personal interests and on ideas that arose through meetings between people and manager. This had resulted in extra staff being trained to drive the mini bus for outings, petting animals which visited the home and trips on the river.

One relative told us that the home was open to suggestions and complaints. As an example we were told of the instant approval given by manager when they requested to keep a pair of budgerigars in a cage in their relative's room and the subsequent adoption of the idea by manager who recently placed a pair of canaries on each floor.

For people who did not wish to be part of a group activity, or who were confined to bed, opportunities were open for individual sessions such as chatting, painting and physiotherapy.

People were supported to live in the home in as independent way as possible, according to their preferences. One relative told us, "[my relative] is better here. [My relative] cannot walk but wants to crawl sometimes and they accommodate that; there's plenty of space. But they take him to his room when he starts to get distressed. I've fitted up a DVD in his room so he can watch sports videos, which he enjoys."

During the inspection we observed someone making a cup of tea for themselves. A carer told us that they liked to do it themselves so they made that possible for them by ensuring that the kettle was designed so it could be safely tipped on its base to pour into the cup, so lifting was not required. This enabled the person to do things for themselves as a result of staff assessing and minimising risk.

The home had a complaints policy which was clearly stated and made available to everyone both in the service user guide and in the document "Safe and Secure". We looked at copies of complaints records and forms, including sections on following up the complaint and a complaint sign-off. Staff confirmed that they completed a form if any relative or resident complained.

In the last 12 months the home had received eight compliments and eight complaints. All complaints were resolved within 28 days.

Good

Is the service well-led?

Our findings

People and relatives spoke positively about how the service promoted a positive culture that is person-centred, open, inclusive and empowering.

At the previous inspection in April 204 we found that there had not been sufficient input or involvement by the providers in carrying out quality assurance audits which assessed or monitored the quality and safety of the services provided in the home (including the quality of the experience of people) or which sought the views of people, staff or relatives with the aim of evaluating and improving the service.

We had asked the provider to send us an action plan setting out the improvements that would be made. The provider sent us an action plan which outlined that a new Quality assurance system and clinical governance system had been initiated and implemented within the home. During the inspection of 4 and 5 April 2016 we saw that improvements had been made to the quality assurance systems and that these were designed to incorporate the views of people living in the home.

We saw that, in addition to technical audits of safety, maintenance and health and safety issues, the provider had implemented a programme of visits called "The Owner's Journey". This was a quality audit which included speaking to staff, people in the home and relatives.

In addition, meetings between the manager and relatives and people had improved with monthly meetings taking place. Questionnaires had been developed for people which asked for their feedback on all aspects of the care and facilities of the home, including questions about staff attitude, the management of the home and the quality of care. We saw the outcome of the survey which was positive, and saw that the owner had completed several audits of his visits.

Staff were positive about the atmosphere in the home. One staff member said that, "changes had had to be made and they are for the better".

People living in the home were also positive about improvements made to the management of the home. One person told us, "It's a highly organised and structured home. There were some problems recently; two people responsible for the activities left very suddenly. It was silly. They fell out with the new manager and she wasn't happy with them. Certainly there were some problems with the provision of activities previously. I get on well with the manager. I think real progress is being made regarding the criticisms [in the last CQC report]."

The reception and administrative staff were also complimented for their friendliness and availability when relatives had questions. One relative told us, "I don't know the management. Our friendly face is the lady on reception."

The service demonstrated good management and leadership. Improvements to the staffing structure meant that staff had a named person for supervision, roles were clearly defined and there was a structure that

allowed staff to understand their roles and responsibilities clearly. A deputy manager and matron had recently been employed and these roles would provide overall clinical governance management and support throughout the home.

The registered manager understood her responsibilities and CQC registration requirements and management audits were developed to reflect the fundamental standards as described by CQC.

The manager was supported by an operations director and the main provider of the home.
We saw that records were maintained and held securely.