Care Quality Commission

Howard Court Care Home Limited

Howard Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 28 September 2018 and was unannounced. A further visit was carried out on 3 October 2018 which was announced.

At the last comprehensive inspection of this service in August 2017 we found the provider had breached Regulations 11, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people's consent had not always been recorded. Also, there were shortfalls in relation to staff training in dementia care; and the provider's quality assurance system was not effective in monitoring the quality of the service.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective and Well-Led to at least good. At this inspection we found the provider had made improvements and had addressed these shortfalls. People's consent was now recorded. Staff had more training opportunities in relevant areas of care. The provider had put in place a schedule of audits as part of its quality assurance check of the service.

Howard Court 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.

Howard Court Care Home accommodates up to 28 people in one adapted building. There were 24 people living here at the time of this inspection, including people who were living with dementia.

The home had a registered manager who had worked there for several years. 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.

People and relatives said the home was a safe and friendly place to live. Staff understood how to report any concerns. The provider carried out checks to make sure only suitable staff were employed. People were assisted with their medicines in a safe way. The home was clean and comfortable.

People told us they were happy with the care and felt there were enough staff to assist them. They told us staff responded quickly to any requests for support. People's consent and permission was sought. If people were subject to any restrictions to keep them safe, such as giving medicines in a disguised way, this had been arranged in people's best interests.

Before people moved to the home their needs were assessed to make sure the home could provide the right care. Staff said they had good training and support to care for people in the right way. Staff worked well with

other health agencies and people were supported to access health services.

People said the meals were "very good". They had choices about their meals and where to dine. Staff encouraged people to eat and drink enough and used fortifying drinks to help people to keep their weight up.

People felt the staff were caring and friendly. There were good relationships between people and staff and a warm, positive atmosphere in the home. Staff spoke to people in a respectful and s sensitive way. People's individual choices were respected and their dignity was upheld. People's needs were supported with compassion at the end stages of their lives.

People received personalised care that was based on their unique preferences and needs. Staff were knowledgeable about people's individual care needs and how they wanted to be assisted. People had opportunities to join in activities or go out with staff from time to time.

People, relatives and professionals said the management team were open and approachable. People and staff had opportunities to make suggestions about the service.

The provider had made some improvements to its quality assurance checks to make sure any shortfalls were identified and acted upon. The provider was also introducing new technology to support the service. This included a computerised management tool to check when staff training was due. Computerised care records were also being developed so, in future, staff would have instant access to people's records wherever they were in the home.

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 and their relatives said the home was a safe and comfortable place to live.

There were enough staff to meet the needs of the people who lived there.

Risk to people's well-being were checked and kept under review.

The home was clean, warm and comfortable.

Is the service effective?

Good

The service was effective.

Staff had improved access to training in care.

People were supported with their nutrition and health care needs.

Staff helped people to access health care services when they needed them. The home worked well with other care professionals to support people's needs.

Is the service caring?

Good

The service was caring.

People and visitors were very positive about the caring, friendly and patient staff.

People were encouraged to make their own choices and these were respected.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People and relatives felt the service was personalised and met people's individual needs.

The home had a sociable atmosphere and there were daily activities for people to join in if they wished.

People and relatives knew how to make a complaint and would feel confident about doing so.

Is the service well-led?

Good

The service was well led.

People and visitors felt there was an open and approachable culture within the home.

There was a registered manager in place who had been managing the home for several years.

The provider had improved the systems for checking the quality of the service.

Care Quality Commission

Howard Court 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 28 September 2018 and was unannounced. An announced visit also took place on 3 October 2018. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We contacted commissioning officers of the local authority. We also spoke with a healthcare professional visiting the service during our inspection.

During the visits we spoke with nine people and six relatives. We spoke with the registered manager, deputy manager, a senior care worker, two members of care staff, two catering staff, the office manager and the owner.

We used the Short Observational Framework for inspection (SOFI) SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed four people's care records, looked at three staff files and reviewed records relating to the management of medicines, complaints, training and how the registered persons monitored the quality of the service.

Good

Is the service safe?

Our findings

People said the home was a safe place to live. One person commented, "I have no regrets about coming to live here. The staff are lovely." Other people described how they were "very relaxed", "comfortable" and "happy" at this home.

All the relatives we spoke with also felt the home was safe and comfortable. For example, one relative told us, "They're very good to her. [Family member] is well-looked after and I have no concerns about it."

Staff had training in safeguarding adults and were confident about raising any concerns. They understood their responsibility to protect the people who used the service from poor practices. Staff had access to the safeguarding policy and procedures which were kept in the staff office. There had been no safeguarding concerns about this service over the past year. A healthcare professional told us, "I have no concerns about the practices in this home."

Potential risks to people's safety and health were assessed, managed and reviewed. The assessments included risk of falls, poor nutrition and skin integrity. The risk assessments were kept under review unless people's needs changed.

Since the last inspection the service had put in place personal emergency evacuation plans (PEEPs) for each person which identified the individual support they needed in the event of an emergency. Routine safety checks of the premises were carried out by the provider. Certificates about the safety of the lift, gas and electrics were in place and up to date.

People and relatives told us there enough staff on duty. One person commented, "We get lots of attention from staff – they're always around to tend to us. I've got my buzzer (call alarm) if I need anything through the night and the staff come like a shot." A relative told us "There are enough staff, you can always see them. Staff are very good at spotting when people need something."

During the inspection, staffing levels were sufficient to meet the needs of the people who were living at the home. There were five staff during the day (including the deputy manager and senior staff) four staff in the afternoon and evening and two staff on duty at night. Management and care staff worked as a team to support people at key times of the day, for example, at mealtimes. Any unexpected gaps in the rota, for example due to staff sickness, were covered by existing staff including housekeeping staff who were trained in care. The home had not used agency staff as there were none operating in this area.

The provider had carried out safe recruitment checks before employing new staff. These included references and disclosure and barring service (DBS) checks which showed if applicants had a criminal record or were barred from working with vulnerable people. This meant the provider made sure staff were suitable to work with vulnerable people.

People's medicines were managed in a safe way. Staff were trained in medicines management and had

regular checks of their competency. Medicines were delivered by a pharmacist and staff recorded the incoming and disposal of medicines. Staff recorded when they had given medicines on the medicines administration records (MARs). We saw these were completed correctly. We found some minor points for improvement. Where people could have a variable dose of medicines, such as one or two paracetamol tablets, we saw on one day staff had not recorded which dose they had administered. In one case, staff had changed the MARs record to reflect the person's preferred number of daily doses. However, this can only be changed by the prescriber. The provider confirmed they would address these points immediately with staff.

People who needed assistance with their medicines were helped in a sensitive way. If people declined their medicines staff returned later to encourage them again. One person who needed to have their medicines at very specific times because of their medical condition was assisted with this. One person managed their own medicines and their continued independence was promoted by the service. Staff had completed a risk assessment to make sure that the person kept these safely so that other people did not have access to them by mistake.

There were a small number of minor decorative shortfalls in some parts of the home, such as scuffed paintwork, but there were no areas viewed that presented a safety hazard. A relative commented, "It's not the Hilton but it's warm, comfortable and clean."

All the areas of the home that we viewed were clean. Some visitors commented on a fluctuating odour at the home's entrance. The provider had already removed the carpet and replaced it with cleanable cushion flooring, but there were occasions when the odour was present. One small shower room also had a drainage odour because it was rarely used. The provider stated they were looking at possible changes of use for this room. The rest of the home was odour-free.

The home had an infection control policy and the office manager was the designated infection control lead. They carried out infection control audits to make sure staff were using the best practices to help prevent the spread of infection. On the first day of the inspection we found there were a small number of areas in bathrooms that were becoming difficult to keep clean because of wear and tear. For example, where the sealant had perished at the base of baths and toilets. By the end of the inspection these areas had been addressed.

The registered manager carried out analyses of accidents and incidents, such as falls. This meant they were able to check for potential causes. The registered manager used the lessons learnt from these events to take action to reduce the risk of these reoccurring. For example, one person was referred for adapted seating after sliding from a chair and another person had a medication review to try to prevent further falls.

Good

Is the service effective?

Our findings

At the last inspection in August 2017, we found the provider had not met the requirement relating to seeking people's consent. This was because there were no records of people's consent to photographs or sharing of records. During this inspection we found improvements had been made. People had signed consent records relating to images and information held about them. The registered manager had also provided people with a privacy statement that informed them of their rights under general data protection laws.

At the last inspection in August 2017, we found the provider had not met the requirement relating to the continuous development of staff. This was specifically in relation to training in dementia, mental capacity and behaviours which challenge. There were a number of people living with dementia so it was important that staff had support and training in these areas. During this inspection we found all except three new staff members had completed training in mental capacity and dementia care. Also, half the staff team had completed training in managing challenging behaviour and half had also completed training in understanding distressed reactions. The registered manager was committed to sourcing relevant training for staff to support them in their role and described potential future arrangements with a local college to support this.

People told us they had confidence in the staff and felt they were competent in their roles. For instance, one person told us, "They're all very good and can turn their hand to anything to help us." A relative said, "I take my hat off to all the staff. They're very good at their jobs, even the young ones."

Staff told us they were supported with essential training. This included necessary training in care and in health and safety, including moving and assisting, infection control, fire safety, food hygiene and first aid. The provider kept a training matrix which showed the dates when each staff member had attended necessary training and when refresher training was needed.

New staff completed induction training and were enrolled onto the Care Certificate (a national set of outcomes and principles for staff who are new to care settings). One staff commented, "I had an induction with the [registered] manager when I started and feel really supported." The registered manager carried out individual supervision sessions and appraisals with each member of staff, so they had the chance to talk about any issues, training needs or their roles and performance.

People said they always enjoyed "very good" meals at the home. For example, one person commented, "The food is lovely, it's all home-made and fresh. We're well-fed and spoilt. We couldn't ask for better." We joined people for a lunch meal and found the quality of the food was very good. A relative told us, "[Family member] enjoys their meals and loves the fruit bowl that is in the lounge so that they can help themselves to it."

The cook described how they got good quality fresh fruit, bread and meat from local shops and made home-made meals every day. The cook said they no longer used a four-week menu so there was more flexibility about what to make and less repetition for people. The cook decided on the main meal choices

each morning then asked people after breakfast which option they would like for lunch. This meant people made informed choices about their next meal. The catering staff were all aware of the special dietary needs of people and these were listed in the kitchen. These included people who had vegetarian, diabetic or softened diets.

People's nutritional health was kept under review. The cook said there was good communication with care staff about people's food intake and they described how they made fortifying foods and drinks if people were at risk of losing weight. People's weight was recorded at least monthly and any significant weight loss was reported to their GP. The deputy manager commented that the service had a good working relationship with dietitians and speech and language therapists. Food and fluid diaries were used if people needed additional nutritional intake. They told us, "We've had people arrive from living alone who were malnourished but we've built them back up and everyone has put on weight and become healthy."

The home was an old building that had been converted over 30 years ago to be a care home. The provider had adapted the home over the years to provide assisted bathing and a passenger lift for people with mobility needs. There were also adaptations to help people with memory loss or poor cognition to find their way around. For example, there was picture signage on doors to lounges, bathrooms and toilets. People had pictures on their bedroom doors that were very relevant to them to help them find their bedroom. There was a dedicated dementia-friendly lounge that was filled with various items of sensory and tactile interest.

The registered manager carried out an assessment of each person before a care placement was agreed. This meant the service checked whether the care needs of the person could be met and managed at the home. The registered manager could describe occasions where placements had been declined by the home, for example where the person's behavioural needs would have a negative impact on the people already living at the home.

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 authorisation 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. The registered manager had submitted DoLS applications to the local authority for people where appropriate. For example, where they did not have capacity to agree to their care or where they would be at risk if they went out without support or supervision. Also, capacity assessments and best interest decisions were carried out if people lacked capacity to consent to specific restrictions. For instance, one person was provided with their medicine in a covert way (that is, disguised in milk). This had been agreed by a range of care professionals in the person's best interests as the medicine was necessary for the person's health.

Records showed that people had access to dietitians, the speech and language therapist, the occupational therapist and the social work team. The home had regular visits from the district nursing team to review people's health care needs. The Care Home Educational Support Services (CHESS) team provided advice and training to the staff about caring for people who may have emotional or mental health needs.

The registered manager described staff as "absolutely brilliant" at supporting people with mental health

needs. They used reflective practice and debriefs to support each other after occasions when people had been upset or angry. The service had a good relationship with mental health professionals. One health professional told us, "The staff are very willing to support people and try very hard to prevent people from going into hospital if possible. They listen to our guidance and follow it so things do improve. They are very accommodating to us when we come at all hours and very engaged."

Good

Is the service caring?

Our findings

All the people and relatives we spoke to were consistent in their positive comments about the caring and friendly service. For instance, one person commented, "I love it here. It was my decision to come here. The girls (staff) are lovely and they make such a fuss of us." Another person commented, "The girls are very nice – so friendly and obliging. If you need anything you just have to ask."

Relatives said there were very good relationships between staff and the people who lived there. One relative commented, "My [family member] is very happy here. They love the staff and the staff seem to love them too." Another relative said "My family member wouldn't want to be anywhere else. They're very happy here and the staff are very good to them. They give people a cuddle and make them feel loved." Another relative said, "They're always so patient. They love my family member to bits!"

We saw all the staff, including housekeeping, management and office staff, took time to talk and assist people in a meaningful and caring way. For example, some people needed additional help to eat their meals and the whole staff team helped out at mealtimes. Other people were supported to get involved in activities and again the whole staff team, including office staff, helped. People, relatives and staff members told us the service was "like a family". We saw examples of this when staff welcomed relatives into the home and offered them drinks. Relatives joined in activities and chatted to staff. There were a lot of good humoured conversations and laughter between people, visitors and staff.

We spent time observing the care provided to people who were not able to comment on the service due to their cognitive decline. We saw staff chatted to them in a friendly, valuing and positive way that respected the person. For example, paying compliments about their hair and appearance, and frequently checking if they would like another drink. A relative commented, "They talk away to my [family member] even though [name] doesn't talk back but they include [name] in every conversation. [Name] laughs along with them."

People's dignity and privacy was respected. Some people preferred to spend all their time in the privacy of their own room and this was respected. People were assisted with their appearance if they needed that support. A relative commented, "My [family member] always looks nice and well-groomed. They were always immaculate at home and staff make sure they still are."

People's continuing independence was promoted wherever they were capable. For example, two people went out on their own into the local community. They told us how this was very important to them and they had fully discussed the risk involved with the registered manager. One person managed their own medicines and was supported to do this in a safe way. The service supported people to find advocacy services if they needed to independent help with life-changing decisions.

The service promoted and celebrated people's equality and diversity and the registered manager had included good examples of this in the Provider Information Return. For instance, for one person living at the home English was not their first language. The registered manager stated, "Staff have picked up some basic Dutch and use the person's translation book to have basic communication. Some staff have a translator on

their phones which can help them with communication." The staff also used the services of care professional who also spoke Dutch to help interpret the person's needs and wishes.

The service was aware of the requirements of accessible information standard. For example, one person found it difficult to communicate because of their long-term health condition. The registered manager told us that speech therapists had been involved in the past, and staff had also tried using picture boards as well as asking the person to write things down. None of these things had been successful so staff built their own communication care plan that works for the person based on their non-verbal communication such as hand gestures.

Good

Is the service responsive?

Our findings

People and relatives said they received a personalised service that met their individual needs. For instance, one person commented, "I'm very happy here. I do what I want when I want. I wanted my main meal in the evening so they swapped it over with my lunch and they're very happy to do that." A relative said, "It's a very individualised service – they do what each person wants."

After each person moved to the home individual care plans were designed with them, or their representative where appropriate. These set out how the person wanted to be supported, their personal preferences, their daily routines and their abilities as well as their needs. One relative told us, "My [family member] is frequently non-compliant but we have worked together to formulate plans for them."

A care professional told us, "They're very good at trying to manage each person's needs as long as possible. The care plans are always made available to us and they are always up to date."

It was clear from discussions with people, relatives and staff that, wherever possible, the service was tailored to people's preferences. One person had routines that were vital to their emotional well-being. They had a very detailed care plan about their specific needs in relation to what they would allow the staff to do for them and how to do this. For example, which mug they would use and how often it could be refilled and how staff could engage with the person about taking clothes for laundering without upsetting them. These very specific instructions were important for the person's emotional health and staff respected this and made sure they cared for the person in exactly the way they wanted.

Another person had stayed for short-term care whilst their home was being adapted after a stay in hospital. Staff had worked closely with the tissue viability nurses as the person had been admitted with serious skin damage to their feet. Staff made sure the person got regular district nurse visits to deal with the dressings as well as getting the equipment needed to prevent the wounds getting any worse. Staff worked with the local physiotherapists and occupational therapists to improve the person's balance and walking. They supported the person to do their daily exercises and helped them to build up their confidence when getting on and off the stair lift, so that when everything was in place at their home they would be able to manage as independently as possible.

People and relatives said there was a good range of activities in the home and there was a monthly calendar of social events and pastimes on display. People's comments included, "there's always something on" and "they're very proactive at trying to get the community and churches involved". Activities included, for example, a visiting musician, movie sessions, exercises, bingo, crazy golf, quizzes, church visits and trips out to local gardening centres. A music therapist provided music and exercise sessions in the home. These sessions were specifically designed to support older people, including those living with dementia, to engage in playing instruments, singing, ball exercises and dance to familiar music.

The registered manager stated, "We encourage families to continue to bring animals in so that the residents don't lose contact with their pets. Staff bring their pets in as the residents find this very therapeutic. We

encourage residents to share their talents and hobbies with the other residents, we also encourage those that like gardening to care for our outside area giving them a sense of purpose. Staff take residents out on trips in their own time."

Three people preferred to spend their day in a small lounge on the first floor where they enjoyed their own interests such as knitting and crosswords. They explained this was their preference but said they were always invited downstairs for social events.

Some people, who were living with advanced dementia, spent most time in a sensory lounge that was specifically designed to offer them a calm, relaxing but interesting place. This cosy room was fitted with coloured lights, a fish-tank television, bubble lamps, lots of soft toys, pictures of animals and a radio quietly playing an appropriate music channel. Some people who used this room were engaged with fiddle-mats. These were soft blankets that were fitted with tactile objects such as large buttons that gave them something interesting to hold and handle. Some of the fiddle-mats had been knitted by a person who lived at the home.

The home was part of the local community and was steps away from the main street in this market town. People were supported to go out to the local shops and to be involved with the community. School children visited the home to perform and people were invited to events at the local school. The daughter of a former resident held a regular 'knit and natter' group at the home. One person who lived at the home had knitted 100 poppies that were going to be used to cover a mannequin that would be displayed in the town. The provider invited local parish councillors to events and parties. The registered manager said, "At Christmas time, we advertise in the local magazine that any person from the local area who find themselves alone on Christmas day is invited to have Christmas lunch with us here free of charge."

There was an information pack in every bedroom which included details of how to make a complaint. The people and relatives we spoke with said they found the provider and registered manager approachable and they would be able to discuss anything with them. They told us they were very satisfied with the service and had no cause to complain. For example, one person said, "I've got no complaints but I would be able to go and see [registered manager] and talk about any issues." The registered manager kept records of any complaints, including the outcome and actions taken. We saw these had been dealt with appropriately.

The home provided care for people at the end of lives. Staff spoke in a sensitive and compassionate way about caring for people who had previously died at the home. Staff had training in end of life care. They felt it was an important part of their job that people were comfortable and cared for at the end of their lives. The staff spoke movingly about a former member of housekeeping staff who had moved into the home for palliative care. After their funeral the provider had held a commemorative gathering at the home.

People had emergency health care plans that were agreed with their GP to show their preferred place of care in the event of a decline in their health. We saw records of positive feedback from relatives about the care shown by staff whilst providing end of life support to their family member.

Good

Is the service well-led?

Our findings

At the last inspection in November 2017, we found the provider had not met a requirement relating to good governance of the service. This was because the provider did not have effective systems in place to always check the quality and safety of the service. During this inspection we found the provider had made improvements.

The provider now carried out and recorded their checks of the premises. They were currently auditing each bedroom's décor and furnishings as part of a premises improvement plan. The provider now carried out regular recorded meetings with the registered manager to discuss issues, such as premises, staff training, staff recruitment and any required actions. We saw these were signed off when completed.

We saw audits were carried out and actions were taken to address shortfalls from these. For example, the registered manager carried out a monthly analysis of any medicines recording errors. These identified which member of staff had not made correct recordings on the MARs. The registered manager then discussed the findings with the relevant staff members and where necessary provided additional supervision, training and competency checks. The registered manager showed how the number of error had reduced as a result of these audits, analysis and actions.

Equipment checks were carried out by external professionals in line with required safety regulations, for example hoists and the passenger lift. These checks made sure that equipment used by people was safe and in good working condition. The registered manager carried out a daily walk around to check the service. Staff were encouraged to report any premises issues and maintenance record showed the repairs or faults which had been highlighted and acted upon.

The provider aimed to continue to improve the service and had provided new hoists and overhead tracking in both main bathrooms in case someone with significant mobility needs required this equipment. The provider had also introduced a computerised management system to assist the management and care information held at the home. For example, the system included a training matrix tool that alerted the management staff when staff were due any refresher training. The system also included care planning system which was being piloted by the deputy manager and would then be rolled out to all staff. The computerised care records meant staff would be able to instantly access and update care records as a 'live' document so that it would always be up to date.

People, relatives and staff consistently told us that the registered manager was open and approachable. One person commented, "If anything needs sorting I discuss with it with [registered manager] and she sorts it out." A relative told us, "[Registered manager] and [office manager] keep us informed and we always feel we could come and ask them about anything." People and relatives told us the registered manager always made themselves available to them.

Staff also said they felt able to talk with the registered manager at any time and commented that she often worked alongside them. This helped her observe staff practices and how the staff worked as a team. Staff

meetings were also held and it was clear from minutes that staff felt able and encouraged to make suggestions and views about improving the service. One care worker commented, "I really feel valued and part of a team." The registered manager commented, "We all work together and the staff always do their best. I never worry about how the home will be when I go home."

People had opportunities to comments on the service they received. A Residents' Meeting had been held where people had set the agenda and discussed their suggestions for the menu, activities and trips out. One person had taken the minutes and typed them out using an old-fashioned typewriter that was a reminiscence object in the home. The suggestions raised were being acted upon. For example, these included having 'around the world' themed meals and catering and care staff had been involved in supporting this. So far people had tried dishes from Italy, China, Germany, Holland, Canada, Greece and France.

People and relatives had also been invited to complete an annual satisfaction surveys and the results were displayed in the entrance hallway. We looked at the completed surveys and saw these were all very positive comments.

The registered manager was fully aware of the regulatory requirements and had submitted any statutory notifications in a timely way. (Statutory notifications are reports about events or incidents that must be reported to the CQC.)