

Stonehaven (Healthcare) Ltd

Kent House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 8 and 9 November 2018. Kent House 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. Kent House provides accommodation and personal care to a maximum of 27 people who may have a physical condition or are living with dementia in one adapted building. At the time of our inspection there were 21 residents at the service and two people were in hospital.

Following the last inspection in January 2018, we met with the provider in February 2018 and asked them to complete an action plan to show what they would do, and by when, to improve the key questions safe and well-led to at least good. We also met with the provider with the local authority Quality Improvement Team in November 2018 to discuss governance and quality arrangements across all of the providers services.

At the previous inspection, we found the provider had failed to ensure risk management was robust, infection control procedures were not safe and medicines were not always managed safely. The providers audits had failed to identify these issues as part of their monitoring of the service.

This inspection found significant improvements had been made, with regards to risk management being more detailed for staff to follow; the areas of concern identified had been remedied and medicines were now managed effectively. However, we found further improvements needed to be made to cleanliness, information for staff about people's specific needs whilst in bed and minor maintenance actions. Each of these concerns, were immediately corrected during our inspection.

This is the third time that the service has been rated as Requires Improvement.

There was a registered manager in post. 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.

Staffing levels met people's personal care needs. The service provided safe care to people. One person commented: "I feel very safe here." Measures to manage risk were as least restrictive as possible to protect people's freedom. People's rights were protected because the service followed the appropriate legal processes. Medicines were safely managed on people's behalf.

Care files were personalised to reflect people's personal preferences. Their views and suggestions were taken into account to improve the service. People were supported to maintain a balanced diet. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were caring and supportive. Staff were motivated to offer care that was kind and compassionate. There were effective staff recruitment and selection processes in place. People received effective care and support from staff who were well trained and competent. Staff spoke positively about communication and how the registered manager worked well with them.

A number of more robust methods were used to assess the quality and safety of the service people received. The service made continuous improvements in response to their findings.

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?

Requires Improvement ●

Some aspects of the service were not safe.

Improvements were needed to cleanliness, information for staff about people's specific needs whilst in bed and maintenance of the premises. Concerns identified during the inspection were corrected immediately.

Risk management had improved.

Staffing levels met people's personal care needs.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

There were effective recruitment and selection processes in place.

Medicines were safely managed on people's behalf. Previous concerns had been addressed.

Is the service effective?

Good ●

The service remained effective.

Staff were skilled and competent and they received training which equipped them for their work.

A programme of staff supervision was in place. Staff felt supported in their work.

People received support with food and nutrition and any concerns were followed up.

People received support to remain healthy.

People's legal rights were upheld. Staff understood that people must consent to the care they receive.

Is the service caring?

Good ●

The service remained caring.

People spoke highly of the care and kindness provided.

People's privacy and dignity were upheld and they were supported to remain independent.

People's views were sought and taken into account.

Is the service responsive?

Good ●

The service remained responsive.

Care plans provided the information needed to inform staff how to provide people's care.

The need for effective communication with people was understood and met.

People were encouraged and supported to enjoy activities and maintain relationships with friends.

People knew how to make a complaint and felt any would be responded to properly.

Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well led.

Audits had failed to identify loose environmental and cleanliness issues. An aide memoire provided for night staff lacked some information about certain people's risks. These issues were remedied immediately during our inspection.

Staff spoke positively about communication and how the registered manager worked well with them.

People's views and suggestions were used to improve the service.

The organisation's visions and values centred around the people they supported. The values had been embedded in staff practice.

Kent House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 unannounced comprehensive inspection took place on 8 and 9 November 2018.

The inspection team consisted of two adult social care inspectors and an expert by experience on the first day and one inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses older people care services.

Prior to the inspection we reviewed the Provider Information Return (PIR) and previous inspection reports. The PIR 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 also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke with eight people receiving a service; three relatives and 14 members of staff, which included the registered manager and one of the organisation's directors. We also spoke with two visiting health professionals. We spent time talking with people and observing the interactions between them and staff.

Some people living at the service were unable to communicate their experience of living at the home in detail with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We reviewed four people's care files, three staff files, staff training records and a selection of policies, procedures and records relating to the management of the service.

Is the service safe?

Our findings

At our previous inspection in January 2018, we found the provider had failed to ensure risk management was robust. Infection control procedures were not safe and medicines were not always managed safely. This inspection found improvements had been made.

At our previous inspection, people's individual risks were identified and the necessary risk assessments were carried out. For example, risk assessments for falls management, moving and handling, personal care, nutrition and skin integrity. However, these were not meaningful because care plans lacked sufficient details for staff to follow to ensure appropriate care and treatment. This inspection found improvements had been made. Risk assessments and care plans were detailed and provided staff with all the relevant information to support people in a safe manner. For example, where a person had been assessed as at risk of falling out of bed, there were measures described to reduce these risks. These included, the need for beds to be as low to the floor as possible, mattresses besides the bed, and sensor alarms in situ to alert staff if a person had got out of bed.

Moving and handling risk assessments detailed the necessary equipment required to support people to move safely. Skin care and nutritional needs assessments detailed the need for staff to check people's pressure areas, apply appropriate creams and the need for a fortified diet.

The registered manager had implemented a night time aide memoire for staff to know people's specific needs. For example, specific health conditions, continence needs and mobility needs. Whilst these provided a lot of detail some specifics, such as the need for sensor alarms to be on, mattresses next to beds and whether any specific equipment was needed to enable people to move safely, was not included. We raised this with the registered manager. They explained that the document was purely for night staff to know people's needs through the night as people would normally be in bed when the night staff started their shift. Also, all agency staff were introduced to the layout of the home and people's individual needs. A senior staff member confirmed that any agency worker would visit each person's room with a senior staff member and have this information explained to them. This would mean that people's needs would be met appropriately. The registered manager acknowledged our concern and agreed to update the aide memoire. By the second day of our inspection the aide memoire had been updated and contained much more detail.

At our previous inspection, aspects of infection control were not safe. The sluice was not clean, Control of Substances Hazardous to Health (COSHH) products were not always stored securely and staff were not always wearing personal protective equipment, such as gloves. This inspection found improvements had been made. However, concerns about infection control and cleaning regimes were identified. A person's mattress (crash mat) beside their bed was marked and dirty and in need of replacement. The document called 'daily cleaning/hygiene check and monthly report did not include the crash mats being a part of the routine cleaning schedule. The registered manager accepted our findings and asked the cleaner to clean the mattress immediately, which they did. They also agreed to get the damaged mattress replaced. When we returned on the second day of our inspection, a new mattress was in situ.

On arrival at Kent House on the first day of our inspection we noted an unpleasant odour in some parts of the home. This decreased as the day went on, but malodorous pockets were still evident. One person's

family member, who we asked about cleanliness said, "Cleanliness could be a bit better. Sometimes there's a smell down the corridor and the corners of the room can be a bit grubby." We raised this with the registered manager. They explained that some parts of the home had recently had new flooring to enable floors to be cleaned more thoroughly. When we returned on the second day of our inspection, the home smelt much more pleasant. However, one area remained malodorous. We discussed this with one of the directors of the organisation. They immediately contacted a contractor to measure up this area for new flooring.

During our tour of the building we found some radiator covers were loose and one was not attached at all and actually fell down when one of us passed it later. The maintenance person said the attachment was there but the cover had not been put back on properly. We raised this with the registered manager who immediately ensured all covers were checked and the covers identified as of concern made secure.

The premises were maintained through a maintenance programme. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. People had personal emergency evacuation plans (PEEPs), which are individual plans, detailing how people will be alerted to danger in an emergency, and how they will then be supported to reach safety. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

At our previous inspection, we found no plans were available for medicines which were prescribed for people on an 'as required' (PRN) basis; therefore, there was insufficient information for staff to administer these medicines in a consistent manner. This inspection found improvements had been made. PRN care plans were now in place to guide staff on how and when people should receive this medicine.

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis. When the home received the medicines, they were checked and the amount of stock documented to ensure accuracy.

Medicines were kept safely in a locked medicine cupboard. The cupboard was kept in an orderly way to reduce the possibility of mistakes happening. The service had identified the storage was too hot in the summer and put in air conditioning to correct this. Medicines were safely administered. Medicines administration records were appropriately signed by staff when administering a person's medicines. Audits were undertaken to ensure people were receiving their medicines as prescribed. The checks also ensured medicines remained in date.

People felt safe and supported by staff. Comments included: "The staff listen and respond if there are any problems" and "I feel very safe here." A relative commented: "If I had any worries or concerns I would tell the manager or speak direct to a carer."

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally, to organisations such as the local authority, police and the Care Quality Commission (CQC). Staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The registered manager demonstrated an understanding of their safeguarding role and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant

health and social care professionals on an on-going basis. There were clear policies for staff to follow. Staff confirmed that they knew about the safeguarding adults' policy and procedure and where to locate it if needed.

Staff confirmed that people's needs were met promptly and they felt there were sufficient staffing numbers. We observed this during our visits when people needed support or wanted to participate activities. For example, staff spent time with people engaging in meaningful conversation and supporting them at their pace. People commented: "They respond to the bell fairly quickly"; "I think there are enough staff" and "I am never rushed."

The registered manager explained that any reasonable staffing requires was sanctioned by the provider. They said, during the daytime there were a minimum of five members of care staff in the mornings, three care staff in the afternoon and then four until nine in the evening. At night there was two waking night staff. Staffing decisions had been decided after listening to staff views about this. In addition, the organisation employed an activities coordinator, three part time cleaners, a part time laundry worker, two cooks, a general assistant and a maintenance man.

We asked how unforeseen shortfalls in staffing arrangements due to sickness were managed. They explained that generally regular staff would fill in to cover the shortfall so people's needs could be met by staff who knew them. If regular staff were unable to cover, the service used agency staff. In addition, the service had on-call arrangements for staff to contact if concerns were evident during their shift.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, care plans and risk assessments were updated. Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, involvement of other health and social care professionals, where needed, was requested to review people's plans of care and treatment. This demonstrated that the service was both responsive and proactive in dealing with incidents which affected people.

Is the service effective?

Our findings

The service continued to provide people with effective care and support. Staff were competent in their roles and had a good knowledge of the individuals they supported which meant they could effectively meet their needs.

Care continued to be taken to ensure staff were trained and supported to meet people's current and changing needs. People commented: "We all get on well. The staff are very, very good"; "All the staff and cooks are very good and helpful" and "All the carers are very good and I don't have a favourite. We are certainly well looked after." A relative commented: "They (staff) seem to know how to deal with the hoist, etc."

Staff received training and supervision, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that, to support people appropriately, it was important for them to keep their skills up to date. Staff received training on subjects including safeguarding vulnerable adults, the Mental Capacity Act (MCA) (2005), moving and handling, first aid, incontinence, catheter care, nutrition, skin care and diabetes. Staff had also completed nationally recognised qualifications in health and social care, including the Care Certificate. The Care Certificate equips care staff who are new to health and social care with the knowledge and skills they need to provide safe, compassionate care. One staff member commented: "There was loads of training."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's legal rights were protected because staff knew how to support people if they did not have the mental capacity to make decisions for themselves. People's capacity to make decisions about their care and support was assessed on an on-going basis in line with the MCA. People's capacity to consent had been assessed and best interests discussions and meetings had taken place. For example, the need for a person to be in a residential care setting due to their vulnerability in the community. This demonstrated that staff worked in accordance with the MCA.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (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 liaised with appropriate professionals and made applications for people who required this level of support to keep them safe. One person had a DoLS authorisation in place and eight people were awaiting DoLS assessments.

People were supported to maintain a nutritious and balanced diet. People were involved in choosing what

they wanted to eat to meet their individual preferences. There were always alternatives for people to have if they did not want what was on the menu. People commented: "The food is good"; "The food is great" and "The food is very good – steak and kidney pie today and ice cream. You can have anything you like. It's better than a hotel." A relative commented: "The staff encourage (relative) to feed herself." For example, on the first day of our inspection, people enjoyed steak and kidney pie and the second day fish and chips. The mealtime experience was a social occasion for people.

People were supported to have equal access to facilities and activities and for preventative barriers to be overcome. For example, where specialist equipment was required to enable independence and where faith needs were important to people. This enquired equality and diversity was promoted.

Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. People's weights were monitored on a regular basis. Where a person's ability to eat or drink changed, staff consulted with health professionals. For example, speech and language therapists had been involved with people who had issues with communication and/or eating and drinking. As a result, people were prescribed specific diets to reduce any risks, and staff followed the guidance.

People were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GPs and community nurses. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. People were referred in a timely way to various professionals to manage changes in their mobility and the effects of medicines.

People's individual needs were met by the adaptation, design and decoration of the premises. The home was set over three floors and was accessible by a lift. This was regularly serviced. People had a variety of spaces in which they could spend their time, such as the lounge and dining room and their bedrooms were personalised. Reasonable adjustments had been made to enable people to move around as independently as possible, such as grab rails and ramps.

Is the service caring?

Our findings

Kent House continued to provide a caring service to people and was very much people's home. People had built strong relationships with staff. There was a happy atmosphere. People commented: "I'm so grateful that there's somewhere like this to come to. It's like being in a hotel"; "They are all very kind"; "We're very well looked after here" and "I don't think you can find a better home than this one." Relatives commented: "They (staff) treat (relative) as an individual. (Relative's) room is personalised with photos, etc." and "The staff are very caring – they will put a protective hand on (relative's) shoulder."

Throughout the inspection there were kind and friendly interactions between people and staff. Staff knew people well and were able to communicate effectively with everyone. Staff took time for people to communicate their wishes through the use of individual cues. For example, looking for a person's facial expressions, body language and spoken word.

Staff showed patience and supported people in a way that promoted their dignity. For example, a person needed support with personal care and a member of staff quietly took them to a bathroom where they could assist them in private. People had unrestricted access to their bedrooms and were able to spend time alone if they chose to. Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example, by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. A person commented: "They (staff) always ensure my privacy and dignity."

Staff adopted a positive approach in the way they involved people and respected their independence. For example, encouraging people to do as much as possible in relation to their personal care. A person commented: "I am encouraged to stay as independent as possible." Staff recognised how important it was for people to be in control of their lives to aid their well-being. For example, offering people choices of how they spent their time. Staff demonstrated empathy in their discussions with us about people.

Staff gave information to people, such as when activities were due to take place and when lunch was ready. Staff communicated with people in a respectful way. Their relationships with people were caring and supportive and they spoke confidently about people's specific needs and how they liked to be supported. Staff offered care that was kind and compassionate. For example, we saw staff working closely with people, engaging with them in a way they responded positively to. Staff were interacting with people in a kind and gentle way throughout our inspection. Staff explained it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything. One person commented, "I know I have a care plan."

The service had received several compliments about the care provided to people. These included: 'Very good service. There is always the sound of laughter, safe, caring environment': "The staff are very caring and do all they can for the residents. There is always a warm welcome when visiting" and 'The care and attention is first class. Mum is loved and cared for in every way. The care is second to none.'

Is the service responsive?

Our findings

Staff knew people very well and provided care and support which was person centred and took account of their needs and wishes.

Care files included personal information and identified the relevant professionals involved in people's care, such as their GP. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate.

Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care. Staff commented that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as their physical and mental health. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked. This helped them to provide appropriate care and support.

Care plans were up-to-date and were clearly laid out. They were broken down into sections, making it easier to find relevant information. Examples included, physical and mental health, nutrition, continence, skin care, mobility and personal care. Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care records contained information about people's communication needs and preferences. For example, one care record described the need to speak clearly due to the person's hearing difficulties.

Activities formed an important part of people's lives. The service employed an activities coordinator who enabled people to engage in a variety of activities and spend time in the local community. For example, outside entertainers, arts and crafts, singalongs, coffee morning and visits to places of specific interest. One person commented: "We have lots of activities. Monday mornings I sing and everyone joins in. (Activity coordinator) plays the guitar" and "We have crafts and art and puzzles." People were encouraged to maintain relationships with their friends and family. For example, care plans documented the importance to people of seeing their family and friends.

There were regular opportunities for people, and people that matter to them, to raise issues, concerns and compliments. This was through discussions with them by staff on a regular basis and knowing people's behaviours when unhappy. Relatives were also made aware of the complaints system. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. Following our feedback, they said they would include contact details for the local authority Ombudsman, the next time the complaints procedure was in print. The complaints procedure ensured people were given enough information if they felt they needed to raise a concern or complaint. The service had not received any complaints. However, the registered and home

managers recognised that if they received a complaint, they would attend to it in line with the organisation's procedure.

People were supported at the end of their life. However, at the time of the inspection there was no-one receiving this type of service. The registered manager said, in the event of this type of support being needed, they worked closely with the community nursing team; GP's and family to ensure people's needs and wishes were met in a timely way.

Is the service well-led?

Our findings

At our previous inspection in January 2018, we found the provider's audits had failed to identify the issues associated with risk management, infection control and medicines management as part of their monitoring of the service. This inspection found satisfactory improvements had been made. However, this inspection identified further issues where audits had failed to pick up on concerns. This included loose radiator covers, the cleanliness of one piece of equipment and the night time aide memoire lacking some information about certain people's risks. These identified issues were remedied immediately during our inspection and also included in future quality monitoring. For example, a daily care workers checklist included cleanliness of all equipment and this checklist was then reviewed a minimum of weekly by the registered manager.

More robust audits had been implemented following guidance from the Quality Assurance Improvement Team (QAiT). The QAiT team offers advice and support providers to meet the quality standards and requirements of regulators and local authority. Audits reviewed people's care plans and risk assessments, incidents and accidents and health and safety. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up. For example, care plans and risk assessments were more detailed and personalised.

There was a registered manager in post. 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 commented: "The manager is excellent. Always professional, yet friendly, approachable and helpful" and "The care home is well run."

Staff spoke positively about communication and how the registered manager worked well with them and encouraged an open culture. Staff felt able to raise concerns and were listened to. Staff meetings occurred on a regular basis. Staff confirmed they were kept up to date with things affecting the overall service via team meetings and conversations. Additional meetings took place as part of the service's handover system which occurred at each shift change.

People's views and suggestions were considered to improve the service. Resident meetings took place, with the last being on 5 September 2018. This meeting took into account people's views about the food, activities and any other issues. Surveys had also been completed by people using the service. The surveys asked specific questions about the standard of the service and the support it gave people. Where actions were required these had been followed up by the registered manager. For example, concerns were raised about clothing not being returned to the rightful owner. As a result, a laundry worker had been employed to remedy this problem. This showed that the provider recognised the importance of continually improving the service to meet people's individual needs.

People's equality, diversity and human rights were respected. The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value.

Our inspection found that the organisation's philosophy was embedded in Kent House. People were encouraged to actively access the community, such as the local church and clubs, for example.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP and community nurse. Medical reviews took place to ensure people's current and changing needs were being met. One professional commented: "Staff are helpful. They alert professionals in a timely manner."

The registered manager had notified CQC appropriately. We use this information to monitor the service and ensure they respond appropriately to keep people safe. The provider had displayed the rating of their previous inspection in the home, which is a legal requirement. However, although the rating was displayed on the provider website, it was not prominent, being further down the page. We fed this back to the registered manager who said they would ask the provider to amend this.