Autumn Days Care Limited

Rosedale Retirement Home

Inspection report

Ashfield Crescent
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29 November 2018

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

The inspection took place on 27 and 29 November 2018. The first day of our inspection visit was unannounced.

Rosedale Retirement Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide accommodation and personal care for a maximum of 24 older people, some of whom are living with dementia, within one large adapted building. At the time of our inspection there were 16 people living at the home.

At the time of our inspection, the registered manager had been away from the home for about one month. In their absence, we met with the directors, one of whom was overseeing the day-to-day management of the service, with the support of a registered manager from an associated 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.

Staff did not always handle and administer people's medicines in line with good practice. Medicine expiry dates were not consistently monitored. Staff did not always follow the provider's risk assessments to minimise risks associated with people's access to the home's laundry. The provider completed pre-employment checks on prospective staff to ensure they were safe to work with people. However, they had not carried out a risk assessment in relation to the renewal of staff members' DBS checks.

The provider had assessed, reviewed and put plans in place to manage the risks associated with people's individual care and support needs, including the risk of falls or skin breakdown. People felt safe living at the home, and understood how to raise any concerns about their own or others' safety with staff and management. Staff recognised their individual responsibilities to protect people from abuse and discrimination. They understood the different forms and potential signs of abuse to look out for. The provider monitored staffing levels in line with people's care and support needs. The provider had taken steps to protect people, staff and visitors from the risk of infections. This included providing staff with appropriate personal protective equipment for their use.

Prior to people moving into the home, the registered manager or a senior care staff member met with them to assess their individual care and support needs. Staff had received training in, and understood, the need to avoid any form of discrimination when assessing or meeting people's care needs. Staff and management worked with a range of community health and social care professionals to promote people's health and wellbeing. On starting work for the provider, staff completed the provider's induction training to help them

settle into their new roles and understand people's individual needs. After their induction, staff received further training to give them the skills and knowledge needed to succeed in their roles.

Staff supported people to have a balanced diet, and helped them choose what they wanted to eat and drink each day. Any specific needs or risks associated with people's eating and drinking were assessed, reviewed and plans put in place to manage these. Staff and management helped people access professional medical advice and treatment when they were unwell. The home environment provided people with sufficient communal space to eat in comfort, participate in activities and receive visitors. The provider had plans in place to create a more dementia-friendly environment. Staff understood the need to respect people's rights under the Mental Capacity Act 2005, and to support their day-to-day decision-making.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff treated people in a kind and caring manner, and took the time to get to know them as individuals. They supported people in an unrushed manner and listened to what they had to say. People were encouraged to participate in decision-making that affected them with appropriate support. Staff understood and promoted people's right to privacy and dignity, and addressed them in a polite, professional manner.

People received person-centred care and support that took into account their individual needs and requirements. They had individualised care plans which were kept under regular review. People's communication and information needs had been assessed to promote effective communication. People had support to participate in recreational activities, and the provider had plans in place to improve activities provision. People knew how to complain about the care and support they received. The provider had a complaints procedure in place to ensure complaints were dealt with fairly. The provider had processes in place to establish people's wishes and choices for their end-of-life care.

People's relatives benefitted from open communication with staff and management, who kept them up to date with any changes in their loved ones' health or wellbeing. Staff felt well-supported by the registered manager, and could seek advice from senior colleagues and the directors in her absence. The provider had developed quality assurance processes to enable them to assess, monitor and improve the service provided.

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

The service was not always safe.

Staff did not always handle and administer people's medicines in line with good practice or follow risk assessments.

The risks associated with people's individual care and support needs had been assessed.

Staff understood the need to remain alert to and report any abuse involving the people who lived at the home.

Is the service effective?

Good

The service was effective.

People had enough to eat and drink, and received the support they needed to do this safely.

People had support to access professional medical advice and treatment if they were unwell.

Staff understood the need to respect people's wishes and decisions.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and who had taken the time to get to know them well.

People's involvement in decisions that affected them was encouraged.

Staff protected people's rights to privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Individualised care plans had been developed for people to ensure their individual care and support needs were met.

People's relatives were encouraged to participate in assessments and decision-making about their loved ones' care.

People were clear how to raise any concerns or complaints with the provider.

Is the service well-led?

Good

The service was well-led.

Staff and management promoted open communication with people and their relatives.

Staff felt well-supported by an approachable registered manager, and had effective management support in her absence.

The provider carried out quality assurance activities to monitor and improve the quality of the care people received.

Rosedale Retirement 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 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.

The inspection took place on 27 and 29 November 2018. The first day of the inspection visit was unannounced. The inspection team consisted of two inspectors and an Expert by Experience on the first day of our inspection, 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 this type of care service.

Prior to our 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 took this information into account during the planning of our inspection of the service.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority and Healthwatch for their views on the service.

During our inspection, we spoke with five people who used the service, four relatives, and four community health and social care professionals. We also spoke with the directors, two senior care staff members and three care staff.

We looked at a range of documentation, including four people's care and assessment records, medicines records, incident and accident reports, six staff recruitment records, staff training records, selected policies , certification related to the safety of the premises and records associated with the provider's quality assurance.

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.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in May 2016 we rated this key question as 'Good'. At this inspection, we found shortfalls in relation to the safe handling of people's medicines and staff adherence to risk assessments. This key question is now rated as 'Requires Improvement'.

Whilst the provider had systems and procedures in place designed to ensure people received their medicines safely and as prescribed, these were not always sufficiently robust or effective. People's medicines were handled and administered by staff who received medicines training and who underwent periodic medication administration competency checks. Written guidance had been produced to ensure staff understood when to administer people's 'when required' (PRN) medicines. We saw staff maintained an accurate and up-to-date record of the medicines they administered on people's medicines administration records (MARs) and topical medication application charts.

However, we found medicine expiry dates were not consistently monitored. Staff had not always recorded the date of opening on people's liquid medicines in current use to enable them to monitor expiry dates. In addition, we found one person's eye drops were still being used over a month after their expiry date had passed. We brought this to the attention of staff, who took immediate action to remove this medicine. We discussed these issues with the directors, who assured us they would remind staff of their responsibilities to ensure people's medicines were managed in line with good practice at all times.

We looked at how the provider assessed, monitored and managed the broader risks to people to keep them safe. We saw staff had been provided with a range of training designed to give them the knowledge and skills to work safely and in line with the provider's procedures. This included moving and handling, health and safety and food safety training. Documented risk assessments had been completed in relation to the risks associated with people's individual care and support needs. This included an assessment of people's risk of falls, any risks associated with their nutrition and hydration, and their vulnerability to pressure sores. Plans had been put in place to manage identified risks, including, for example, the use of height-adjustable beds and crash mats where people were at risk of falling out of bed. People described to us how staff managed risks to help them stay safe. One person told us, "I was prone to falls but they [staff] follow me around supporting behind me. This prevents me falling and also makes me feel safe here."

The provider had also carried out documented risk assessments, and completed a range of ongoing safety checks, to manage the risks connected with the premises and equipment. This included regular checks on the home's fire alarm system. However, we were not assured staff consistently followed these risk assessments to ensure people stayed safe. On two occasions, we found the home's laundry room unlocked, when the provider's risk assessment stated this room must be locked when not in use. The laundry room contained a number of potential hazards, including trip hazards, and opened out onto an internal courtyard which, again, contained potential trip hazards at the time of our inspection. We did not see anyone attempting to enter the laundry room unaccompanied during our inspection. We discussed this issue with the directors who assured us they would immediately address the security of the laundry room with the care staff and contractors on site.

The provider carried out pre-employment checks on prospective staff to ensure they were safe to work with people. This included requesting employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions. However, we found the provider had not carried out risk assessment in relation to the renewal of staff members' DBS checks, and were unclear what their arrangements for re-checking their staff's DBS status were. The directors assured us they would carry out the necessary risk assessment, and review the need to renew the DBS checks of any current staff as a matter of priority.

All the people we spoke with felt safe living at the home, and were clear how to raise any concerns about their own or others' safety with staff and management. One person told us, "I feel very safe and happy here. They [staff] look after me ok and the home is safe with a door entry you have to press to get in." People's relatives also had confidence their loved ones received safe care and support at the home. One relative said, "[Person] is quite safe here; I have no safety concerns at all. They [staff] are always checking on them and making sure they are comfortable. [If I had] any concerns, I would speak to [senior care staff member]."

The provider gave staff training and support to help them understand their individual responsibilities to protect people from abuse and discrimination. Staff showed insight into the different forms and potential signs or abuse, and told us they would immediately report any concerns of this nature to senior care staff or the management team. The provider had safeguarding procedures in place to ensure any allegations of abuse were reported to appropriate external agencies and investigated.

People expressed mixed views about whether there were enough staff on duty, on a day-to-day basis, to meet their needs. One person told us, "There certainly are [enough staff]. They are always about and around." Another person said, "No, there are not enough staff; they need more in my opinion." People's relatives were satisfied staffing levels enabled staff to safely meet their loved ones' needs. One relative explained, "They have had changes, but now there appears to me enough [staff] to cover the amount of people they have in here at this time." During our inspection, we saw there were enough staff on duty to respond to people's needs and requests without unreasonable delay, and to monitor people's safety and wellbeing. The directors explained they monitored staffing requirements in line with people's individual care needs, and took into account feedback from people, their relatives and staff themselves. They covered any shortfalls in staffing through offering staff overtime, as opposed to bringing in agency staff, to maintain continuity of care. They were actively seeking to recruit care staff to fill their current staff vacancies.

Most of the people and relatives we spoke with were satisfied with the overall standard of cleanliness maintained at the home. One relative told us, "Yes, I am quite happy with it [cleanliness of home]. There are no smells when you come in and they keep it clean and tidy." The provider had taken steps to protect people, staff and visitors from the risk of infection. During our inspection visit, we found the home to be generally clean, well-maintained and free from unpleasant odours. Refurbishment work was taking place in an upstairs bathroom, and in the home's laundry room where a hand-washing sink was being installed. The provider employed a domestic staff member to support the nurses and care staff in ensuring the premises and equipment remained clean and hygienic. Staff had access to, and made use of, personal protective equipment, which comprised of disposable aprons and gloves.

Good

Is the service effective?

Our findings

At our previous inspection in May 2016 we rated this key question as 'Good'. At this inspection, we found people continued to receive care and support that achieved effective outcomes. The rating for this key question remains 'Good'.

Before people moved into the home, the registered manager or a senior care staff member met with them and, where appropriate, their relatives to assess their individual care and support needs. This enabled the provider to determine whether they were able to meet people's needs and, if so, use the information gathered to develop initial care plans. Staff and management understood the need to avoid any form of discrimination in planning or delivering people's care. Staff had received equality and diversity training to raise their awareness of people's protected characteristics under the Equality Act 2010 in the context of their work.

Once people moved into the home, staff and management worked with a range of community health and social care professionals, including people's GPs, occupational therapists and the local district nursing team. This collaboration promoted people's health and wellbeing, and enabled the provider to identify the care equipment needed to deliver effective care. 'Transfer forms' had been completed to provide hospital staff with key information about people's individual needs, in the event of a hospital admission.

Most people and all of the relatives we spoke with had confidence in the competence of staff. One person told us, "They [staff] are very good and look after me well. The staff have the right skills. [They] all seem to know what they are doing and know what I like to do." Upon starting work for the provider, staff completed the provider's induction training to help them understand and settle into their new roles. This included the opportunity to work alongside, or 'shadow', more experienced staff and participate in initial training. One member of staff raised a concern regarding the limited moving and handling training they had received during the induction period. We discussed their comments with the directors who assured us all staff were provided with sufficient training on how to move and handle people safely as part of their induction. We saw care staff had recently been provided with additional moving and handling training and hoisting training. The directors confirmed their staff induction programme took into account the requirements of the Care Certificate. The Care Certificate is a set of minimum standards that should be covered in the induction of all new care staff.

Following induction, staff received further training to help them work safely and effectively, with periodic updates to refresh their skills and knowledge. This included training on health and safety, first aid and food safety. Two members of staff spoke about the value of their dementia training in helping them better understand the impact of the condition upon people's lives, and how to support them effectively.

Overall, people and their relatives were satisfied with the quality and amount of food and drink served at the home. One person told us, "I will say they [staff] always ask if you want more [food] and don't skimp with it." A relative said, "They [person] love the food here; we can tell you that!" At the time of our inspection, a member of senior care staff was cooking people's meals, whilst the provider was seeking to recruit a new

cook. We saw staff helped people choose what they wanted for their main meals the day before these were prepared, and that people could have an alternative if they did not like what was on the menu. People's food and drink preferences had been recorded in their care files to ensure these were taken into account by staff.

The provider had systems in place to ensure any specific needs or risks associated with people's eating and drinking were assessed, recorded and managed. One person explained, "I am frail and they [staff] will help me cutting anything up and assisting me to eat, as I do struggle with my one hand in lifting." We saw the lunchtime meal was a relaxed, flexible event during which people could choose where they wanted to have their meals. One person told us, "I am able to feed myself. I have it [my meal] in front of me on a tray. That is my choice to eat in this way here in my chair." We saw there were sufficient staff available during the lunchtime meal to check people had enough to eat and drink, and to respond to any requests for assistance.

People told us, and we saw, staff and management helped them seek professional medical advice and treatment when they were unwell. One person said, "If I need to see anyone [medical professionals], the carers [staff] will get them in for me." Another person explained, "For any appointments, I ask the carer [staff] and they sort them out for me. They will take me if I need them to." People's care files included information about their medical histories and long-term health conditions to help staff understand this aspect of their care needs.

We looked at how the provider had adapted the home's environment to meet people's needs. We saw a lift and stair-lift had been installed to help people move safely between the home's floors. People had sufficient space in communal areas to eat in comfort, participate in activities and receive visitors. At the time of our inspection, the home's paved inner courtyard area was cluttered and not safe for use by the people living at the home. In addition, the efforts made to create a dementia-friendly environment were limited, although some pictorial signage was visible on people's bedroom doors. We discussed these issues with the directors who assured us plans were in place to further adapt the premises and courtyard to the needs of people with dementia. This included the planned development of a sensory garden in the inner courtyard. The directors explained they had recently had areas of the home repainted in calmer colours in response to people's needs. They assured us the inner courtyard would be cleared, as a matter of priority, to make this a more useable space. We will follow-up on the efforts made to create a more dementia-friendly environment at our next inspection.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. Staff understood the need to respect people's right to make their own decisions, and the role of best-interests decision-making. The provider had procedures in place for recording people's consent to aspects of their care and assessing their ability to make their own decisions. We saw examples of formal mental capacity assessments and best-interests decision records in people's care files. Applications for DoLS authorisations had been made based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, the provider had reviewed any

associated conditions, in order to comply with these.

Good

Is the service caring?

Our findings

At our previous inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found people continued to be treated with kindness and compassion. The rating for this key question remains 'Good'.

People told us staff treated them in a kind and caring manner, and took the time to get to know them as individuals. One person said, "The staff here and all nice and kind to me. Even though I choose to stay in my room, they always pop in to see me and have a natter." Another person said, "All the staff here are lovely, caring and kind to me. They do come and chat to me when they come past me." The staff we spoke with showed good insight into people's individual needs, preferences and personalities. They spoke about the people they supported with affection and respect. One staff member told us, "People are not a number; they are a person. These are my extended family." We saw staff were attentive to people's needs and requests, and took the time to check people were comfortable and whether they needed anything.

During our inspection, we saw staffing levels enabled staff to support people in an unrushed manner and to listen to what they had to say. People confirmed they felt valued by staff and management. The staff we spoke with understood people's right to express their views and be involved in decisions that affected them, with the support of their relatives and friends where appropriate. The management team confirmed they would support people to access independent advocacy services, where necessary, to promote their involvement in decisions about their care.

People felt staff promoted their privacy and dignity, and spoke to them in a respectful manner. One person explained, "They [staff] always close the door when coming to wash or move me, are gentle and always close the curtains as well." Although there were restrictions upon people receiving visitors at the home to avoid interruptions during mealtimes, people and their relatives did not feel these were unreasonable. We saw staff took steps to protect people's personal information, which was not left out where it could be accessed by unauthorised persons. Staff also met people's intimate care needs in a discreet and sensitive manner to protect their dignity. A community professional praised staff's awareness of people's right to privacy, and the support they gave people to be assessed in the privacy of their bedrooms. People's care plans included information about what they were able to do for themselves. We saw staff promoted people's independence in practice through, for example, encouraging them to move around their home independently.

Good

Is the service responsive?

Our findings

At our previous inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found people continued to receive personalised care that was responsive to their needs. The rating for this key question remains 'Good'.

The care and support people received at the home took into account their individual needs and requirements. People told us there was flexibility in daily routines at the service, and that their views were respected as to how they wished to spend their time. One person explained, "If I need something I tell them [staff] and, yes, I can get up when I want …" A relative told us, "It is more personal here, not like a big place, and they [staff] all know [person] well. [Person] is happy here and well looked after." During our inspection, we saw staff adapted their communication and the nature of the support provided to suit individual needs. One person described to us how staff had adapted to their changing mobility needs. They told us, "I am a bit less mobile now so they [staff] support me when I am walking around with my frame to lean and walk on."

People's care plans were individual to them, covered key aspects of their care and were reviewed on a regular basis. We saw evidence of people's relatives' involvement in care review meetings and discussions about their loved ones' care in people's care files. Alongside guidance for staff on how to meet people's needs, care plans included information about their life histories and preferences to promote a person-centred approach. The directors discussed their plans to transfer over to an electronic care management system in coming weeks, to further improve the overall standard of assessment and care planning.

We checked how the provider was meeting the requirements of the Accessible Information Standard. The Accessible Information Standard tells organisation what they need to do make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need. We found people's communication needs, including any sensory impairments and support needed with communication aids, had been considered as part of the care planning process. The directors explained that no one living at the home currently required information to be provided in alternative, accessible formats. However, they had the facility to provide information in alternative formats, such as large-print or pictorial materials, to support people's understanding, as required.

We looked at the support people received to follow their interests and take part in social activities to avoid boredom and isolation. One person explained how staff took into account their interest and working background in science. They told us, "The staff and the people here are all great. I worked on [project] and they have had lots of chats to me about it. I was a scientist there." This person expressed excitement over the recent Mars landing, and we saw staff helped them access a video about this event online.

However, other people commented on the limited range of activities on offer at the home, and felt these needed to improve. One person explained, "Everyone is just sitting around with a television on up the top end [main lounge]. This is why I wonder off to my room to read and watch my television on my own." During our inspection, we saw people singing with staff, listening to music and participating in a fun quiz. People's

activities records demonstrated activities were taking place in the form of, for example, chair exercises, ball games and reminiscence sessions.
We discussed people's comments with the directors. They explained that a member of staff had been trained as an activities champion, and that additional staff had attended training on how to provide meaningful activities for people with dementia. They acknowledged regular visits from two external entertainers had stopped, because people were no longer enjoying these. They assured us they were seeking to replace these activities and would continue to review how the support people had with activities could be improved.

None of the people or relatives we spoke with said they had ever had cause to make a formal complaint to the provider. They told us they would approach a member of staff if they were concerned about, or dissatisfied with, the service provided at any point. We saw the provider had a complaints procedure in place to ensure any complaints received were dealt with in a fair and consistent manner.

The provider had processes in place to identify people's preferences and choices for their end-of-life care, and we saw some evidence of discussions with people in this regard. At the time of our inspection, no one living at the home was currently receiving end-of-life care.

Good

Is the service well-led?

Our findings

At our previous inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found the overall leadership and management of the home remained effective. The rating for this key question remains 'Good'.

At the time of our inspection, the registered manager had not been at work for about a month. The provider had notified us of their temporary absence. The directors explained the registered manager were expected to return to work in January 2019. 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.

During the registered manager's absence, the day-to-day management of the service was being undertaken by the one of the directors, who was on site three to four times each week. They were being assisted, on a temporary basis, by a registered manager from another care home operated by the directors.

Most people and all the relatives we spoke with were satisfied with the overall service provided and the management of the home. One person told us, "[I am] happy with the care and [have] no complaints." A relative said, "It is well run and the care for [person] is excellent. We are kept well informed and [person] has settled and is happy here, so that makes us happy." People's relatives described open communication with staff and management, who ensured they were kept up to date with any changes in their loved ones' health or wellbeing. We saw people and visitors were relaxed in the presence of the directors, who clearly knew people well and took the time to speak with them and ensure they were comfortable.

Staff spoke about their work at the home with enthusiasm. One staff member told us, "I love coming to work." Staff described a positive working relationship with, and confidence in, the registered manager who they found approachable and supportive. One staff member explained, "[Registered manager] is very good at her job … If you need anything, you can go to her and she will help you and listen. She is not someone you are afraid to go to. She will 'muck in' and help as well." Staff felt the provider had taken appropriate steps to ensure the home was effectively managed during the registered manager's temporary absence. One staff member said, "We [staff] are under no more pressure. If I've got a problem, they [directors] are at the end of the phone and will answer any questions." The provider had a whistleblowing policy in place. Staff understood the role of whistleblowing, and felt able to challenge any practices or decisions taken by the provider which they disagreed with.

The provider took steps to involve people, their relatives and staff in the running of the home and seek their feedback on how it might be improved. As part of this, they sent out annual feedback questionnaires to people and their relatives requesting their views on key aspects of the service. We looked at the results of the survey completed in June 2018, and saw people and their relatives had commented positively on the care provided.

Staff and management liaised with a range of external health and social care professionals to promote people's health and wellbeing. The health and social care professionals we talked to generally spoke positively about their recent dealings with staff and management. One professional told us, "They [staff] are absolutely fabulous and caring. There are staff we have had a really good relationship with for a long time … I think they [provider] have taken note of what we have said to them." Another professional said, "[Registered manager] and [senior care staff member] both seem quite competent, caring and appropriate."

The provider had quality assurance systems and processes in place enable them to assess, monitor and improve the safety and quality of the service. These included the ongoing monitoring of any accident, incidents or complaints, routine in-house health and safety checks, and audits on key aspects of the service, including infection control practices and medicines management. We saw the registered manager had produced a rolling action plan to help them maintain and, where necessary, improve standards of care provided.

Registered providers must display their current CQC rating in their main place of business and on their website. The purpose of this is to provide the people who use the service and the public with a clear statement about the quality and safety of the care provided. At the time of our inspection, the provider did not have a website, but we found their current CQC rating was clearly displayed at the home.