Red Oaks Healthcare Limited

Red Oaks Care Community

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 took place on 6 and 7 December 2016 and was unannounced.

Accommodation for up to 40 people is provided in the service over two floors. The service is designed to meet the needs of older people living with or without dementia. There were 33 people using the service at the time of our inspection. This location was registered for this provider by the CQC in April 2016.

A registered manager was in post but she was on extended leave. An acting manager was in place and was available throughout the inspection. 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 knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Risks were generally well managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were safely managed.

Staff received appropriate induction, training and supervision. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. The environment had been adapted to support people living with dementia.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though care plans could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the management team and that appropriate action would be taken.

The provider was meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of 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?

Good

The service was safe.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Risks were generally well managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training and supervision. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. The environment had been adapted to support people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though care plans could be

further improved.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the management team and that appropriate action would be taken.

The provider was meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided.

Red Oaks Care Community

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 6 and 7 December 2016 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with five people who used the service, three visiting relatives, a kitchen assistant, a domestic staff member, a laundry staff member, a senior housekeeper, an activities coordinator, two care staff, a nurse, the acting manager and a representative of the provider. We looked at the relevant parts of the care records of 11 people who used the service, three staff files and other records relating to the management of the home.

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.

Good

Is the service safe?

Our findings

People we spoke with told us that they felt safe living in the home. A person said, "I feel very safe. I could talk to any of the [staff] if I saw anything that scared me." Visitors felt that their family member was safe. A visitor said, "[My family member]'s quite safe here. We've got peace of mind when we go."

Staff were aware of safeguarding procedures and the signs of abuse. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. Appropriate safeguarding records were kept by the service of any safeguarding referrals they made and appropriate action had been taken to reduce further risks.

People told us that they were not unnecessarily restricted. A person said, "I can go where I like and they [staff] don't mind. We don't have to worry about rules and restraints." Another person said, "I can go where I want but don't go off outside now."

People told us that staff supported them to move safely. A person said, "They're nice and gentle when they move me." We observed people being assisted to move safely and staff used moving and handling equipment safely. Staff told us they had sufficient equipment to meet people's needs and if they required any additional equipment they could raise this with the management team and it would be provided.

Individual risk assessments had been completed to assess people's risk of developing pressure ulcers and nutritional risk. When bedrails were in use to prevent people falling out of bed risk assessments had been completed to ensure they could be used safely. Risk assessments were mostly reviewed monthly though one person's risk assessments had not been reviewed for four months and did not fully reflect the person's current needs and risks. We raised this with the acting manager.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals. Accidents and incidents were analysed to identify any trends or themes so that actions could be taken to reduce any risks of them happening again. However, the service's incident records indicated a person had fallen the previous month. We did not see evidence of the incident form or any actions following the fall within their care records. Another person had a risk assessment which indicated they were at high risk of falls and required supervision when mobilising but there was no falls care plan and their safety care plan did not mention they were at risk of falls. This meant that there was a greater risk that appropriate actions had not been taken to reduce the possibility of these two people falling in the future.

Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. However, they were not always set according to the weight of the person using them and there were no formal checks of the mattresses on a regular basis. The pressure mattress for one person was set for a person of 140Kg and over when they weighed less than 80Kg. This meant the mattress would not be effective in preventing the development of pressure ulcers. The

management team ensured that all pressure mattresses were set to the correct level following the first day of our inspection and implemented a system to check that mattresses remained at the correct setting.

A visitor said, "We know [my family member] gets checked and moved regularly in bed." People's repositioning charts had mostly been completed to show that staff had supported people to change their position in line with the instructions in their care plan. A person who was in bed was checked hourly by staff and this was documented consistently. They required assistance to re-position themselves to prevent pressure ulcers developing. Their care plan stated the person required re-positioning every two to three hours and we saw this was mostly completed in line with the care plan but there were some four hour intervals between re-positioning.

We saw that the premises were well maintained and checks of the equipment and premises were taking place. We saw that action was taken promptly when issues were identified from premises and equipment checks. There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place and available for staff to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People and visitors gave mixed feedback of whether there were enough staff to meet people's needs. A person said, "They always seem rushed off their feet, especially in evenings." Another person said, "I have to wait longer for help [at night]." However, a third person said, "I've not really noticed a problem myself." A visitor said, "No, there aren't enough staff. They don't have time to talk with people." Another visitor told us, "What worries me is the staffing levels." However, a third visitor said, "Compared to other homes we visit, it's better staffed here."

A staff member told us they felt there were generally enough staff on duty to provide the care people required. They said, "It can be stressful, and there is a lot to do, but on the whole it is ok." Care, domestic, laundry, maintenance and kitchen staff all felt that they had sufficient time to complete their work effectively. During the inspection we generally observed staff promptly attending to people's needs and call bells were responded to within a reasonable time.

Systems were in place to identify the levels of staff required to meet people's needs safely. The acting manager explained that they considered people's dependencies when setting staffing levels and monitored them closely to ensure that staffing levels remained at the correct level. The acting manager told us that they worked alongside care staff in the event of short notice staff absence. We looked at staffing rotas which showed that the provider's identified staffing levels were not always met. The acting manager and a representative of the provider told us that they were currently recruiting staff to improve cover in the event of short notice absence. They had also identified that an additional staff member was required on the night shift and had recently recruited staff to meet this need.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People were happy with how their medicines were managed, however two people told us that staff did not always wait with them to check that they had taken their medicines. These people's care records stated that they should be supervised when taking their medicines. A person said, "Some of the younger [staff] wait with me as they've been told to. Other [staff] leave them for me to take and don't pop back later." Visitors were

happy with how medicines were managed. A visitor told us, "I'm happy with the way they manage [my family member]'s tablets. They were on sedatives in hospital, but not here."

We observed the administration of medicine; staff checked against the medicines administration record (MAR) for each person and stayed with the person until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines. We found two gaps in the administration record for one person and when we carried out checks of the medicines we found they had been administered but the record had not been signed. The nurse told us they would follow this up with the individual staff member concerned.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability. Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines.

Staff administering medicines told us and we saw documentation indicating they had received competency checks for medicines administration. They told us they had completed training in medicines administration and records confirmed this.

Good

Is the service effective?

Our findings

Most people told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "They seem very well trained." Another person said, "They're wonderful people, such patience." A visitor said, "[My family member] can be very stubborn and the staff are very patient. They seem confident in what they do." However, another visitor said, "The younger [staff] don't seem dementia experienced. I see them struggle with their approach sometimes." We observed that staff competently supported people.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to a wide range of training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. Most of the training was provided face to face by a trainer and staff told us that they much preferred this to previous online training that they had received.

Staff told us they received regular supervision. Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training.

People told us that staff checked with them before providing care. A person said, "They always ask and say things like 'Would you like?'" A visitor said, "I always hear them explain first [before providing care]."

People told us that they were encouraged to make choices. A person said, "It's nice to be able to choose things in life. I plan my bedtimes and where I go and when." Another person said, "They always let me choose what to wear and my meals."

We saw that most staff asked permission before assisting people and gave them choices. However we observed at lunchtime that a staff member put a clothing protector on a number of people who used the service without explanation or asking the person whether they wanted one or not. Where people expressed a preference staff respected them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were being followed. We found mental capacity assessments had been completed for people for decisions about their care and best interest decisions recorded. When people were

being restricted, DoLS applications had been made. Staff had an appropriate awareness of MCA and DoLS.

Care records contained guidance for staff on how to effectively support people with behaviours that might challenge others. Staff were able to explain how they supported people with periods of high anxiety. Staff told us they also had access to the community dementia outreach team who were quick to respond when they identified a concern or required advice.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had mostly been fully completed, however, staff agreed to contact the GP to review one DNACPR form that was not properly completed.

People spoke positively about the food choices available and told us that they received meals that met their needs. A person said, "It's good food. We get some choice or we can ask for anything different. We can sit where we want for meals. I get a bedtime drink and sandwich too." Another person told us, "It's really nice food. I can't remember a single meal to complain about. They'd definitely make me a snack if I wanted one."

People told us that they had sufficient to drink. A person said, "I get plenty of drinks with meals and the tea trolley in between. It's a good service." Another person told us, "I never get thirsty." A visitor said, "[My family member]'s always got drinks and gets encouraged." We saw that people were offered drinks throughout the inspection.

We observed the lunchtime meal. Tables were nicely set and staff clearly explained the main meal choices to people. Food was appetising, a good portion size and hot. Staff supported people if they needed assistance when eating their meal. However, the meal service was slow. Some people had started sitting in the dining room from 12.30pm and desserts were not served until 1.50pm when all people had finished their main course. This meant that some people were sitting in the dining room for one and a half hours over lunchtime.

People were weighed regularly and appropriate action taken if people lost a significant amount of weight. Food and fluid charts were in place for people where appropriate and were well completed.

Care plans did not always fully reflect changes to the person's nutrition and their support needs. One person's care plan stated they required a plate guard to enable them to eat independently, but we observed a plate guard was not used. We asked staff about it and they said they did not use a plate guard. When we observed the person eating we saw that a plate guard may not have been suitable for their needs.

Another person had lost a considerable amount of weight between March and September 2016, but there were no further weights recorded in their care record following this and their care plan review for September 2016 stated they had a normal appetite, were encouraged to eat when necessary and there were no changes to their care plan. There was no mention of their weight loss. However, we saw the record of contact with other professionals stated the GP had been consulted about the person's weight loss and the person should continue to be monitored. When we talked with the nurse about this they checked a weight record book and we found a weight had been recorded for November 2016 and the person had gained weight. Therefore staff had taken some action and the person had started to gain weight but their care plans were not reflective of the issues the person had experienced.

People told us they were supported with their health care needs. A person said, "I've just had new hearing aids from the hospital and the optician was here a few months ago. My own chiropodist comes in to do me every six weeks." A visitor said, "[My family member] has a regular check on [their] pacemaker and sees the

optician and chiropodist when they come in. [Their] own hairdresser still visits."

Care records contained records of the involvement of other professionals in the person's care, including the GP, dementia outreach team, speech and language therapist, dietician, optician and chiropodist. We saw there were prompt referrals to people's GPs or other appropriate professionals when concerns were raised about their health. On the first day of the inspection staff contacted a person's GP to ask for a visit that day, as they were concerned about a person's health. We saw the GP visited and prescribed treatment for the person.

Adaptations had been made to the design of the home to support people living with dementia. Bedrooms, bathrooms, toilets and communal areas were clearly identified. Toilet seats and handrails in bathrooms were differently coloured to their surroundings so that people with visual difficulties could distinguish them.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and considerate. A person said, "They're all very kind and I can't imagine any not being approachable." Another person told us, "I find them so sweet to us." A visitor said, "They're very kind and cheerful and are always welcoming to us." Another visitor said, "The current team are kind and understanding but should be allowed more chance to interact with [people who use the service]. They don't laugh and joke with them now."

Staff had a good knowledge of the people they cared for and their individual preferences. We saw good interactions between staff and the people they cared for. These interactions indicated empathy for people and a caring approach by staff. We saw staff respond appropriately and promptly to people showing signs of distress.

People felt listened to. A person said, "They definitely listen if I ask something." Another person said, "My family come in and we talk about all the care things with staff." Visitors told us they had been involved in discussions about their family member's care. A visitor said, "We had a review a while back and I saw the care plan. I tell them to ring me with anything that changes or happens with [my family member]. Another visitor said, "We've got a review coming up. I was involved in [my family member]'s admission and have seen [their] care plan."

We saw that care records contained information which showed that people and their relatives had been involved in their care planning. Care plans contained information regarding people's life history and their preferences.

Advocacy information was available for people if they required support or advice from an independent person. We saw an advocate had been involved in the DNACPR decision of a person who lacked capacity to make the decision for themselves.

Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us. One person's care record identified they preferred a female carer to provide personal care. The person was unable to communicate verbally and this had been identified as a result of staff observing their reactions to male staff.

People felt that their privacy and dignity were respected. A person said, "They [staff] knock and come in, which is fine. My curtains get closed when we're dressing." However a visitor said, "My bugbear is they don't rearrange [my family member]'s clothing after they've hoisted [them] into the lounge chair. [Their] trouser legs are often rucked up and they don't pull them down." We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. The home had a number of areas where people could have privacy if they wanted it.

Staff were able to describe the actions they took when providing care to protect people's privacy and dignity. We observed most staff maintaining people's dignity. However, we observed two staff assisting a

person to move using a hoist. The staff did not speak with the person when they were in the hoist and spoke with each other without involving the person. This did not respect the person's dignity.

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

Staff encouraged people to be independent where possible. A person said, "They're encouraging me to do what I can for myself." A visitor said, "[My family member] has special cutlery at meals." We observed that people were supported to eat their meals independently, using adapted cutlery and plates, where appropriate. Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service. A visitor told us, "We're not tied to timings. We come every day to suit us."

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. A person said, "They [staff] don't mind how late we stay up. They bring me a cup of tea if I fancy it at bedtime. They're very flexible and kind." Another person said, "I can have a bath when I want one."

Feedback from visitors was mixed. Visitors told us of good examples of person-centered care but also some examples where care was more task-centered. A visitor said, "[My family member]'s room is personalised and they have their own bedding still. I like [my family member] dressed appropriately as they've always liked being smart. But [staff] just don't think and will dress [my family member] in summer clothes at this time of year, even though they feel the cold."

People felt that call bells were generally promptly responded to. A person said, "Normally it's okay and they [staff] come quite quickly." Another person said, "I use it quite often. They come to me fairly quickly." However, a third person said, "It can vary. Mornings are very busy for them so we wait."

People's views were mixed of the activities that were provided. A person said, "I like all sorts of things and I join in whatever they're doing. I do some knitting and sewing when I can. We get a regular church service here which I like." Another person told us, "I like to read a lot. If I feel sociable I can always sit in the lounge and chat." However, a third person said, "They don't have something on every day that I can do. I read a lot if I get bored." A visitor said, "I came in and saw [my family member] doing a giant jigsaw the other day which I'd not thought they'd ever manage. And today they joined in a balloon game. Most days they plan something." However another visitor said, "They put a bit of music on in the lounge and there's often a weekly entertainer. I still don't feel [my family member] gets enough attention. I know it's not easy with their dementia. I feel the activities lady doesn't have time now for one to one activities."

We observed group activities and some one to one activities took place during our inspection. Social or activities care plans contained information about people's interests and preferences. Although activities records were in place these had not been consistently completed. A staff member told us that there were activities on a regular basis. They said, "It is one of the better homes for activities." However, they said, "It would be nice to do more outdoor things and for residents to go on more outings although they did have some day trips in the summer."

Pre-admission and admission assessments had been undertaken and care plans were in place for people's care and support needs. Care plans had been reviewed monthly and were generally reflective of people's current needs. A life story had been completed to provide information about people's previous life, important relationships and their interests. We looked at the care records for a person who was unable to communicate verbally and had no relatives or friends who could provide information about their life. In this instance a member of staff had tried to complete the document by interpreting the person's gestures and body language.

However, a care plan for a person with diabetes did not provide any information on the signs of

hypoglycaemia or hyperglycaemia to enable care staff to recognise those signs. A care plan for a person with epilepsy did not provide guidance for staff on how to identify the signs of deterioration in the person's condition. The management team agreed to review these care plans to add further detail.

Some people told us they had not been asked whether they had a preference regarding the gender of the staff member that supported them. A person said, "I've not been asked but I don't mind who." Another person said, "No, they didn't ask me. I had a male today which surprised me. He didn't ask if it was ok." Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences.

People who used the service did not raise any concerns regarding the management of complaints. A visitor said, "We had an issue with a staff member. Our complaint was dealt with and it's all calmed down now." However another visitor said, "We've mentioned a number of times about how basic the care function is now and being understaffed. I just get fobbed off."

We found records showed that complaints were responded to appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed throughout the home. There was a clear procedure for staff to follow should a concern be raised.

A staff member told us that if a person wanted to make a complaint or identified a concern they would encourage them to talk about it so they could rectify the issues quickly if possible. They would also explain to the person that they could put the complaint in writing and it would be dealt with by the manager. They said they would report any concerns raised with them to the acting manager.

Good

Is the service well-led?

Our findings

Some people recalled giving customer feedback or attending meetings, but not necessarily with the new service provider. A person said, "I filled in a card once a long while ago." A visitor said, "I did one not so long back." Another visitor said, "I've had the odd one over the years." We saw surveys had been completed by relatives and visitors. Actions had been taken where appropriate. An accessible survey to gather people's views on the quality of the service was also used where appropriate.

A person said, "We have had a meeting sometimes and say what we like or don't like. They [staff] take on board what we say." Another person said, "I remember a residents' meeting a long while ago, often it was about the food. It'd be good if it happened more and if residents were encouraged to chat to each other more." A visitor said, "They had a meeting a few months back. It was supposed to be a welcome meeting and a lot came to the first session. There was no real outcome from the meeting, nothing's changed." We saw that meetings for people who used the service and visitors took place where comments and suggestions on the quality of the service were made. Actions had been taken where appropriate.

A whistleblowing policy was in place and staff told us they would be prepared to raise issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service. Staff were observed to act in line with them during our inspection.

Most people felt that the home had a good atmosphere. A person said, "It's relaxed and friendly." A visitor said, "I feel it's welcoming, pleasant and fresh." Staff were positive about their work and told us they worked well as a team. A staff member said, "The staff are a good team and they genuinely care for the residents."

People told us that the acting manager was visible but not as approachable as the registered manager. A person said, "I see [the acting manager] now and then. She's nice enough." Another person said, "[The acting manager]'s a nice lady and always available if you knock on the office door." A third person said, "I see [the acting manager] a bit more often now. She's a bit standoffish." A visitor said, "I can see the office when I'm here. [The acting manager] is not offhand but there's a bit of a barrier. [The registered manager] is more easy going."

Staff told us the acting manager was approachable and they felt able to talk freely with them about issues. They said, "She is always available for you. When she is not here you can text her." A staff member said they had meetings and 'catch ups' whenever they could. They told us there were staff meetings and care staff meetings. Another staff member told us they had lost quite a few staff when the new provider took over the service. They told us that this was as a result of changes made by management which had improved the quality of care provided.

Staff told us staff meetings were held regularly and they were encouraged to raise issues at the meetings. We saw that staff meetings took place and the management team had clearly set out their expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post but she was on extended leave. An acting manager was in place and was available throughout the inspection. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required.

The provider had a system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the acting manager and other staff. Audits were carried out in a range of areas including infection control, medicines, health and safety, dining experience, kitchen, laundry and care records. Actions had been taken where issues had been identified by audits.

A representative of the provider visited the service a number of times each month. They told us they spoke with staff, visitors and people who used the service. The documentation they completed for each visit did not provide this level of detail. They agreed to review this documentation to better reflect their visits.