Riva Limited

Alexandra Rose Residential Care Home

Inspection report

358 Havant Road
Farlington
Portsmouth
Hampshire
PO6 1NE

Tel: 02392382944
Website: www.alexandra-rose.co.uk

Date of inspection visit:
25 August 2017
30 August 2017

Date of publication:
03 October 2017

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 the 25 and 30 August 2017 and was unannounced.

Alexandra Rose Care Home is registered to provide accommodation and personal care services for up to 32 older people and people who may be living with dementia. At the time of our inspection there were 27 people living at the home. They were accommodated in an extended residential building providing spacious communal areas and access to enclosed rear gardens. The majority of bedrooms were for single occupancy and had ensuite facilities.

At the last inspection the service was rated Good. At this inspection we found the service remained Good.

The provider had arrangements in place to protect people from risks to their safety and welfare. Arrangements were also in place to store medicines safely and to administer them according to people's needs and preferences. People were supported to access healthcare services, such as GPs and community nursing teams.

Staffing levels enabled people to be supported safely and in a calm, professional manner. Recruitment processes were followed to make sure only workers who were suitable to work in a care setting were employed. Staff received appropriate training and supervision to make sure they had the skills and knowledge to support people to the required standard.

Staff were aware of the need to gain people's consent to their care and support. 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. The arrangements included processes and procedures to protect people from the risk of abuse.

People were supported to eat and drink enough to maintain their health and welfare. They were able to make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs.

People found staff to be kind and caring. They were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's individuality, privacy, dignity and independence.

Care and support were based on plans which took into account people's needs and conditions, as well as their abilities and preferences. Care plans were adapted as people's needs changed, and were reviewed regularly.

People were able to take part in leisure activities which reflected their interests and provided a high level of mental and physical stimulation. Group and individual activities were available if people wished to take

part.

The home had an open, friendly atmosphere in which people, visitors and staff were encouraged to make their views and opinions known.

Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided. The provider took action where these systems found improvements could be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Alexandra Rose Residential Care Home

Detailed findings

Background to this inspection

We carried out this comprehensive 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 inspection was unannounced and was carried out on 25 and 30 August 2017 by two inspectors. On the 25 August an expert by experience in the care of older people was also present. 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people who used the service and five family members. We also spoke with the registered manager, five care staff, the chef, housekeeping staff, the activities coordinator, administration and maintenance staff and two health care professionals. We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated records for five people using the service. We also looked at a range of records relating to the management of the home including four staff recruitment files, staff training records, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in June 2015 when no issues were identified.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe at Alexandra Rose Care Home. When asked if they felt safe one person said, "Yes I do, they [staff] come every night to check on you, they check in the morning as well". Another person said "Perfectly yes, so many carers are around, they keep an eye on you". Family members told us they did not have any concerns regarding their relatives' safety. One family member said, "I visit often and have no concerns about [person's name] safety". We saw that people appeared relaxed and happy in the presence of staff.

Staff protected people from the risk of abuse and were clear about their safeguarding responsibilities. Staff knew how to identify, prevent and report abuse and all staff, including those not providing direct care for people, had received appropriate training in safeguarding. One staff member told us "I would report any concerns first to [name of registered manager] I know they would take any necessary action but I could also report to you (CQC) or safeguarding". Another staff member said, "If I was concerned I would go to [name of the registered manager]". The registered manager explained the action they had taken following a safeguarding concern. The action taken had included seeking support from relevant external professionals, ensuring the ongoing safety of people concerned and reviewing some procedures within the home.

People were supported to receive their medicines safely. All medicines were stored securely although the keys to medicines storage were not kept securely being placed in an unlocked box accessible to people and visitors. The registered manager took immediate action to purchase a secure storage container for these and other keys. Appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Procedures were in place and followed to ensure that people had received medicines as prescribed and as recorded on medication administration records (MAR). Staff were aware of how and when to administer medicines to be given on an 'as required' (prn) basis for pain or to relieve anxiety or agitation. Should people be unable to explain they were experiencing pain staff described how they would determine the need for this; however, a recognised pain assessment tool was not in use. We discussed this with the registered manager who stated they would research formal pain assessment tools and determine which would be most suitable for use at the home. Where people had been prescribed prn medicines, a prn plan which explained when the medicine could be given was in place. Training records showed staff were suitably trained to administer medicines and had been assessed as competent to administer medicines. Staff administered medicines competently, explaining what the medicines were for and did not hurry people. Overall, the provider had good systems for the safe management of medicines in the home.

Individual risks for people were managed safely. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, nutrition, moving and handling and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm. Where people had fallen, comprehensive assessments were completed of all known risk factors and additional measures put in place to protect them where possible. Staff had been trained to support people to move safely and we observed equipment, such as walking frames, being used

in accordance with best practice guidance. People were assessed and supported to take risks where this promoted their independence. For example, one person was supported to continue to manage their own insulin injections and to make hot beverages within their bedroom. Staff explained the risks related to individual people and what action they needed to take to mitigate these risks.

Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. Following falls which may have resulted in a head injury the registered manager told us staff monitored people; however, specific records of this were not maintained. Following discussion the registered manager told us they would be introducing a specific recording tool to guide staff to possible indicators of complications and enable monitoring to be formally recorded.

There were sufficient numbers of staff on duty to meet people's needs. People told us staff were available when they needed them. One person said "Staff are obliging; anytime you want them they come, day or night". A visitor told us "There are always staff around". The registered manager told us that staffing levels were based on the needs of the people using the service. They described how the provider trusted them to use the staffing budget flexibly to provide more staff at times when these were required. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences, such as those due to staff sickness, to be managed through the use of overtime. Staff were not rushed and were able to respond to people's requests for assistance in a timely manner. Staff felt that the staffing levels were suitable to meet the needs of the people. Staff comments included, "There are enough staff" and "On most days there are enough staff, the manager or deputy will also help if needed".

The provider had a safe recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references, full employment history and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. A staff member confirmed that they were unable to start work at the home until their DBS had been completed and references from previous employers received.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. People had personal evacuation plans in place detailing the support they would need in an emergency. Staff had also undertaken first aid training and were able to correctly describe the action they would take in an emergency. An emergency call bell system was located within all bedrooms meaning staff could communicate with other staff and get support promptly if required in an emergency.

Good

Is the service effective?

Our findings

People, their families and healthcare professionals told us they felt the service was effective. People said that the staff knew their needs well. Relatives felt people received an effective service and health and personal care needs were being met. One visitor said "[Person's name] was quite poorly; since she's been here she looks 10 years younger. She enjoys the house, she is more mobile. She has put on weight; she is looked after very well". Another relative told us "They [staff] know what they are doing; they pick up [person's name] infections quickly". A healthcare professional said, "They [staff] seem very competent, they follow our guidance and know the patients here well".

People told us staff knew how to care for them and told us their needs were met. People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes of consultations were recorded in detail showing staff identified medical needs and sought appropriate treatment promptly.

Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. They monitored the weight of people each month or more frequently if required due to concerns about low weight or weight loss. However, we found one person was not receiving the high calorie milk shakes detailed in their care plan as being required due to a loss of weight identified the previous week. We informed the registered manager about this and they took immediate action to ensure the person received these. On the second day of the inspection we saw the person was receiving the high calorie milkshakes prepared by the home's chef.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. Where relatives had the legal authority to make decisions about finances or health on behalf of people copies of the documentation confirming this were obtained by the home. This helped ensure decisions were only made by people legally able to do so.

People told us that staff asked for their consent when they were supporting them. One person said, "They always ask". A relative told us "She gets up when she wants, goes to bed when she wants, she gets choices with meals". Daily records of care showed that where people declined care this was respected. Staff showed an understanding of the legislation in relation to people living with dementia. Before providing care we saw staff sought consent from people using simple questions and gave them time to respond before undertaking the required care or support. For example, they asked people if they would like to move to the dining room before they supported them to do so and they asked the person they were supporting, where they would

like to sit. Where people had capacity to make certain decisions, these were recorded and signed by the person. We saw a staff member ask a person if they would like a bath. The person said no. The staff member encouraged them but accepted their negative response. The staff member told us they would try again later and see it the person wanted a bath then.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether DoLs applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLs applications had been made and reviewed. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

Everyone was complimentary about the food. When asked about the meals one person said, "Very good, I eat it all, I enjoy it". Another person said "We have no problem about that at all". A visitor told us "Always nice choices, [person's name] seems to like it; it [food] smells lovely when you come here". Another visitor said "[person's name] eats more food now than when they were at home". People received appropriate support to eat and drink enough. Staff supporting people to eat their lunch did not rush them with their food and spoke with them gently during the whole process. People were encouraged to eat and staff provided appropriate support where needed, for example, by offering to help people cut up their food. Most people chose to eat in the dining room where they sat in small groups at tables for four to six people. Tables looked attractive and had been laid with tablecloths, serviettes, cutlery, glasses and placemats. This helped make the mealtime a pleasant and sociable experience.

People were offered varied and nutritious meals which were freshly prepared at the home prior to each meal. This included, if people wanted, a full cooked breakfast, a main lunchtime meal and a lighter meal in the evening. Alternatives were offered if people did not like the menu options of the day. Drinks were available throughout the day and staff prompted people to drink often. Special diets were available for people who required them and people received portion sizes suited to their individual appetites. The chef was aware of people's special dietary needs and described how they would meet these although they were unaware that some people should avoid certain foods due to medicines they were prescribed. The registered manager took action to ensure the chef was provided with this information.

People were supported by staff who had received all necessary training. All staff, including catering and housekeeping staff undertook the same basic training to meet the needs of people living with dementia. One housekeeper told us about dementia training they had undertaken and said this had "helped them understand what it must be like to have dementia". New staff received induction training which included at least two weeks shadowing experienced staff and undertaking the Care Certificate. This sets the standards people working in adult social care need to meet before they can safely work unsupervised. Records showed staff were up to date with essential training and this was refreshed regularly. One staff member said "We get lots of training and the training is really good". Another staff member told us how they had been supported by the provider to obtain a care qualification. Most staff had obtained vocational qualifications relevant to their role or were working towards these.

Staff were supported appropriately in their role. They received one-to-one sessions of supervision, observed practice and a yearly appraisal with the registered manager. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. An on call system provided staff with access to a member of the management team when one was not immediately available in the home. Staff said they felt able to approach the registered manager or the provider's representative if

they had any concerns or suggestions for the improvement of the service.

The environment was very well maintained and appropriate for the care of older people with specific adaptations such as passenger lifts to the first floor and ramped access or platform lifts to other areas. Bathrooms and toilets were tidy and safety measures such as hand rails and non-slip flooring were in place. Decoration had taken account of people's needs and included hand rails of contrasting colours to walls. People had access to the rear garden which was safe, fully enclosed and provided level access and various seating options.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People and family members agreed that staff were caring. One person said of the care staff "Very attentive, if anything happens, they are here in minutes". Another person said "They are absolutely caring. For example, always helping when needed, all the time" and a third person told us "Yes, they are very caring". Visitors also felt staff were caring. Their comments included "They [staff] all call her by her name, they ask her instead of telling her and all is done in a very respected manner. They take interest; they make eye contact, very courteous". These comments and others all reflected that staff were kind and caring.

People's privacy was usually respected. We received mixed views when we asked people if staff knocked on their doors before entering. For example, various people told us "They always knock the door"; "They just barge in they don't knock"; "They always knock before getting in"; "They knock before getting in" and "It varies, mostly they just come in, we expect that isn't it?" During the inspection we observed that with the exception of one occasion when a staff member entered a bedroom without knocking or announcing their intention before doing so, people's privacy was maintained. The registered manager told us they would remind staff about the need to respect people's privacy and knock or announce their intention before entering bedrooms. Staff told us they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, and keeping people covered as far as possible during personal care.

Alexandra Rose Care Home had two rooms which could be used to accommodate two people. The registered manager was clear that this would usually only occur if people specifically requested a shared room such as if a married or long term couple were admitted to the home. Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

People were cared for with dignity and respect. We saw staff kneeling down to people's eye level to communicate with them and heard good-natured conversations between people and staff. We observed that staff were kind, affectionate, knew each person well and responded promptly to people in a patient and attentive way. Staff spoke with people while they were providing care and support in ways that were respectful. Staff were aware of the individual actions they should take if people became distressed or upset. For example, one person was known to like dogs. A suitable lifelike model puppy was purchased for them. We saw that when they became distressed staff sat with the person and encouraged them to relax by stroking and grooming the model dog. The person visibly relaxed.

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and we observed that people were offered choices in what they preferred to eat, where they wanted to sit and if they wanted to take part in activities. A staff member said, "I always tell people what I'm going to do and give them the choice". One person said, "Yes, I choose my own clothes" and a second person told us, "If you don't like what they offer [food or drink], you can ask for something else". People were

provided with choice about their food. Some people were living with dementia which can make it harder for them to make choices when asked verbally. We discussed this with the registered manager during the first day of the inspection. On the second day of the inspection they showed us some pictures which could be used to help people make choices.

People were supported to be as independent as possible and staff understood people's abilities. One person said "You can do things by yourself; they [staff] are very helpful". A visitor told us they felt their relative was encouraged to be as independent as possible. They said "Here she is using her spoon to feed herself, she feels very happy". Care plans gave clear information about what people were able to do for themselves and when support was required. Comments in care plans included, '[Person's name] can wash their upper body but requires assistance with lower body' and '[Person's name] is able to clean own teeth'. People confirmed that the staff only helped when they need it. We observed staff encouraging people to be as independent as possible. One member of care staff monitored a person as they used their walking frame to walk to the toilet. They encouraged the person and reassured them that they were doing well.

People were supported to maintain friendships and important relationships and their care plans identified people who were important to them. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. One visitor told us they were able to bring in their pet dog. The registered manager had arranged an external experiential training session for relatives of people living with dementia. They explained that the training had previously been completed by care staff who had reported how this had helped them understand the communication and other difficulties people living with dementia experienced. This training for relatives would help them understand the experiences of people living with dementia and communicate better with their loved ones when visiting them.

Alexandra Rose Care Home had links with the local community and encouraged community involvement. The registered manager told us a local preschool nursery group visited the home twice a month so that the children and people at the home could enjoy some joint activities. The home was also supporting a local teenager to complete part of their Duke of Edinburgh Award by providing a volunteer opportunity linked to social activities with people. Activities staff supported people to attend local shops and services when appropriate.

People's spiritual needs were known and met. Activities staff supported some people to attend a local church group every Wednesday whilst local clergy visited the home monthly for a communion service. The registered manager was aware of how to contact other religious leaders and groups where necessary and understood that meeting spiritual needs was an important part of ensuring people lived the lifestyle of their choice.

Good

Is the service responsive?

Our findings

Opportunities for mental and physical stimulation were provided by activities staff 13 days per fortnight. Additionally external entertainers were provided five days each week. On the first day of the inspection external entertainers were seen providing positive activities for people during both the morning and afternoon. This also included a Pets as Therapy (PAT) dog who we saw people greatly enjoyed spending time with. People told us there were always activities available and that they enjoyed these. One person said "There is always activities I can join in with." Throughout the day various activities were provided. These were amended to meet the needs of people participating and provided people with worthwhile activities. For example, the activities organiser asked a person if they would like to help them by sorting sweets into bags for bingo prizes. Rummage boxes containing a range of specific items such as socks for pairing or buttons for sorting had been developed. This meant activities and care staff would be able to provide activities which people would enjoy and which would promote manual dexterity and mental concentration.

Group activities were also organised. For example, we observed a game of bingo and a quiz with suitable questions which encouraged everyone to join in. People were also encouraged to take part in interactive activities which included an element of physical exercise. For example, people were encouraged to throw bean bags as part of an interactive session provided by one of the external activities organisers. People who preferred or needed to spend more time in their bedrooms were also provided with some individual activities. Individual and group outings were also organised and we saw destinations for these had been discussed during resident meetings. For example, trips to local places of interest, pubs, restaurants and tea rooms as request by people had been organised.

Staff responded to people's needs. During the afternoon a person was distressed and stated they wanted to go home. Staff supported the person to move to a wheelchair and took them out for a short walk to the local shop. We saw when the person returned they were settled and happy. Another person liked to smoke a cigarette several times a day. We saw staff responded promptly when they requested support to exit the home to go outside. Staff remained with the person to ensure their safety. On numerous other occasions we saw all staff, including those not directly employed to provide a care service, responding to people. For example, an ancillary staff member noted a person trying to stand from a chair and assisted them to reposition their walking frame so they could use this safely once they were stood.

People were provided with personalised care. Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. Care plans contained information about people's life history, preferences, medical conditions and any individual needs. They each contained a detailed description of the individual care people required covering needs such as washing, dressing, bathing, continence and nutrition. These detailed what people could do for themselves and how they needed to be helped. This helped ensure people received consistent support and maintained skills and independence levels. Where able, people had signed care plans which demonstrated that they had been involved in the planning of their care. Where people lacked capacity relatives had been involved in care planning. Formal reviews of care including discussions about future plans were conducted every six months with the person or their families and a member of the homes

management team. A visitor said "I attended a review meeting, I am involved". As people's needs changed, care plans were developed to ensure they remained up to date and reflected people's current needs.

Staff used the information contained in people's care plans to ensure that care provided met the individual needs of the people. A health professional told us, "The staff seem to know the residents well". People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Care was individual and centred on each person and staff had a good awareness of people's needs. Care staff were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required with their personal care and when mobilising. This corresponded to information within the person's care plan.

Staff responded promptly when people's health needs changed. Care plans contained clear information for staff about the action they should take in various situations. For example, one person had a diagnosis of diabetes; their care plan detailed the specific action staff should take if monitoring of blood sugar levels showed these were higher or lower than usual for the person. When people became agitated, they were given extra support in accordance with pre-arranged plans, including the use of distraction techniques and being supported to a quiet area to relax. Staff identified when people were 'not their usual self' and acted to identify the possible reasons for this such as a urine or other infection.

People were provided with information about how to complain or make comments about the service through information in the 'residents' handbook' and information provided at the entrance of the home. When asked about making a complaint a person told us "I don't know because I don't have any. My window was faulty and as soon as I reported it, it was fixed". Another person said "We don't have a great deal to complain about, you have to be picky to find something to complain about". Relatives and people told us they had not had reason to complain, but knew how to if necessary. They said they would not hesitate to speak to the staff or the managers who they said they saw regularly and who were very approachable. The complaints records showed that when complaints were made these were investigated comprehensively. A full written response including, where necessary, an apology and information as to what would be done to resolve the issue had been provided.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members and healthcare professionals also said they would recommend the home to their families and friends. One person said "He [the registered manager] is very accessible". Other people named various members of the management team and said they could approach them if needed. One of the visitors told us the name of the registered manager and said "I will approach any senior management to address any matters. I am aware of the hierarchy". Where we identified minor areas for improvement the registered manager took prompt action to address these.

There was a registered manager in place. 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.

There was a clear management structure, which consisted of a registered manager, deputy manager, head of care, senior care staff, care staff and ancillary staff. Staff understood the role each played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. Staff member's comments included, "[Name of registered manager] is very approachable and listens to us" and "The home is well organised". Regular staff meetings were held providing an opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. The provider had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. The registered manager told us that they felt well supported by the provider.

Staff spoke positively about the positive open culture and management of the service. They said they were able to raise issues and make suggestions about the way the service was provided and their suggestions were taken seriously and discussed. A staff member said, "I really enjoy working here, the owner and manager have supported me to undertake training and develop my career". The home had a whistle-blowing and safeguarding policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the CQC of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.

People were given opportunities to express their views about the service. They said they were asked for their opinion and all felt they were listened to. One person told us about a recent residents meeting and said "Whatever complaint or grumble one has, they all take note of that". Another person said "Oh yes they [management] listen, if you have an issue they will sort it out". Activities staff undertook resident meetings

approximately every two months. Records of these showed people were encouraged to discuss various aspects of the service and that where suggestions were made staff acted to meet these. People and relatives were also able to express their views anonymously through an external organisation via the internet with information about this available in the entrance hall. The registered manager said they made a point of talking with people and visitors and felt this meant people could raise any issues in an informal way which could be quickly resolved.

The registered manager worked closely with other staff and was receptive to comments or suggestions made by staff or others. Over the past few years various parts of the home had been upgraded to improve the environment for the benefit of the people living there. The ethos of the provider and staff was one of continuous improvement for the benefit of people living at Alexandra Rose Care Home. For example, following feedback from families the services website had been developed to provide a 'residents hub'. This could only be accessed by relatives and provided information about activities and event at the home.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. Every month the registered manager provided a formal report to the provider detailing various aspects of the service such as new admissions and any accidents which may have occurred. The registered manager and provider carried out regular audits which included medicine management, infection control, the environment and care plans. These were based around a comprehensive quality monitoring tool which was overseen by an external quality auditor who assessed the home twice a year via a formal process. Where this had identified action was required we saw this had occurred. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety.

There was an extensive range of policies and procedures which had been adapted to the home and service provided. This ensured that staff had access to appropriate and up to date information about how the service should be run. Folders containing policies and procedures were available to all staff at all times in the reception office.