Risedale Rest Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 8 August 2018 and was unannounced. This meant the provider and staff did not know we would be coming.

We previously inspected Risedale Rest Home Limited in May 2017, at which time the service was in breach of regulations 9 (person-centred care), 12 (safe care and treatment), 17 (well-led) and 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the previous inspection we rated the service as requires improvement. At this inspection, whilst there had been some improvements, the service remained requires improvement.

We found risk assessments were not managed appropriately, care plans were not person-centred, staffing levels were too low, training had lapsed, premises were not adequately maintained or cleaned and that there was a lack of management oversight.

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

Risedale Rest Home accommodates a maximum of 17 people across two floors. Nursing care is not provided. There were eight people using the service at the time of our inspection, some of whom were living with dementia.

The service did not have a registered manager in place at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The manager had applied to be registered with CQC and was registered as the manager after the inspection.

At this inspection we found the manager had made a range of improvements and addressed the majority of the areas where the service was previously in breach of the regulations.

We found there were still improvements required with regard to the planning of staffing levels, which were not always adequate to meet people's needs. Staffing levels were determined by a dependency tool which was not effective. We have made a recommendation about this.

People's social needs, for example activities and hobbies, could not always be supported because of the lack of appropriate staffing levels. On at least one day a week, the manager was required to assist the one member of care staff on duty. Care staff also had to complete cleaning duties as the provider had not ensured adequate levels of staffing cover in this regard.

Activities provision was not effective. There was no activities co-ordinator and the manager did the bulk of activities planning. Staff helped people with individual activities or played games with people, but none of this was planned in line with people's preferences. The provider had not ensured there was sufficient staffing in place to provide person-centred care. Subsequent to the inspection the provider confirmed they were seeking the help of a volunteer to help deliver activities.

There had been significant improvements in terms of cleanliness since our last inspection, with evidence of recent refurbishment and more planned. Infection control training had been delivered to staff and all visitors and people who used the service agreed the service was cleaner.

Medicines administration practices had improved and were now safe. Protocols for 'when required' were not yet in place.

Risk assessments were in place and described the factors which may put people at risk of harm, and what staff needed to do to minimise these risks. Documentation regarding risks, along with all aspects of care planning, were under review and would benefit from more detailed, person-centred information. Staff knowledge regarding how to keep people safe was good.

All staff were aware of their safeguarding responsibilities and the manager had done some work to ensure this was well understood.

Training and support for staff had improved since the last inspection. A range of mandatory and additional training had either been delivered or planned, whilst staff confirmed they now received supervision meetings. They told us they were now well supported.

Training was monitored via a training matrix, which did not always prove effective as it did not contain information regarding online courses staff had completed. The manager was aware of this and planned a new matrix.

People received a range of meal options and the mealtime experience we observed was a pleasant one. People's individual tastes and preferences were well catered for.

People were supported to have maximum choice and control of their lives in the least restrictive way possible. Staff had received training in the Mental Capacity Act (2005).

There were adequate bathing and toileting facilities. Some refurbishment work had been undertaken, mostly downstairs in communal areas. Further work was required upstairs to renovate one bathroom and refurbish remaining bedrooms.

Staff knowledge of people's needs was good and there were well documented interactions with external healthcare professionals.

People who used the service, their relatives and external professionals gave consistently strong feedback about how staff care for people who used the service.

There had been no complaints since our last inspection. The manager ensured the complaints process had been reviewed to ensure it was accessible and understood by people who used the service.

The manager demonstrated a keen desire to continue improving the service. Staff we spoke with and people

who used the service confirmed they had taken a proactive, 'hands-on' approach to making improvements. All confirmed they had involved staff and people in planning and making improvements.

The culture was one focussed on caring for people in a dignified way, in a homely environment. The impact the manager had been able to make had been limited by the lack of resources at their disposal, most significantly staffing levels. The manager had done well to make a range of improvements but needed more supernumerary time to make further improvements, rather than having to provide cover for when there was only one care assistant on duty.

We have identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

There were significant improvements to the cleanliness of the service. Some refurbishment work had yet to be completed.

Improvements had been made regarding medicines administration and auditing, although there were no protocols in place for people who were prescribed medicines 'when required.'

The dependency tool in place was not effective.

Is the service effective?

Good

The service was effective.

Staff had received a range of updated training and the manager had arranged more refresher training.

Staff supervisions and staff meetings were in place and staff confirmed they were well supported.

People enjoyed a range of meal options and staff understood their mealtime preferences well.

Is the service caring?

Good

The service was caring.

All people who used the service and relatives we spoke with complimented staff on their caring attitudes.

People confirmed they were treated with dignity and respect and we observed numerous instances of this.

People were involved in decisions about refurbishments to their home and were made to feel part of the homely, welcoming environment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always accurate or contemporaneous and only one had been fully updated since our last inspection.

Staff ensured people did have access to some in-house activities but the provider needed to do more to ensure people's preferences were reviewed and met.

External professionals provided positive feedback about how staff worked well with them to ensure people's needs could be met.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A new manager had made a range of improvements but there remained a number of improvements to make and sustain.

Staff, people who used the service and external professionals gave positive feedback about the impact of the new manager.

Improved auditing procedures were in place but the manager needed to ensure this was embedded within the culture.

Risedale Rest Home Limited

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.

We visited the service on 8 August 2018 and the inspection was unannounced. We do this to ensure the provider and staff do not know we are coming. The inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted professionals in local authority commissioning teams, safeguarding teams, the local infection control team and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

During the inspection we spent time speaking with five people who used the service. We did not use the Short Observational Framework for Inspection (SOFI) as people were able to tell us what they thought about the service. SOFI is a way of observing care to help us understand the experience of people who are unable to speak with us. We observed interactions between staff and people who used the service throughout the inspection, including at lunchtime. We spoke with three members of staff: the manager and two care workers. We also spoke with the owner. We looked at three people's care plans, risk assessments, medicines records, staff training and recruitment documentation, quality assurance systems, meeting minutes and maintenance records. Following the inspection we contacted another member of staff, two relatives and two health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found some bathrooms, toilets and other areas to be unclean. External agencies who visited in March 2018 also found this to be the case. At this inspection we found significant improvements in terms of the cleanliness of bathrooms, toilets, people's bedrooms and communal areas. New flooring had been laid in the entrance hall and corridors and the old carpet removed. One living room had been redecorated, as had the dining room, with plans to redecorate the second living room. The kitchen was tidy and clean and, during the inspection, received positive feedback from the Food Standards Agency. The kitchen was currently rated '5', meaning 'very good' in terms of cleanliness. Infection control training had been delivered and additional soap and hand sanitiser dispensers added. One person who used the service said, "It's always clean." One relative told us, "Overall the home seems better organised & more hygienic. I note the stair hand rail is no longer sticky and hand cleanser is provided alongside some decorative, more welcoming touches throughout the home and outdoor entrance."

There remained areas to improve with regard to infection control. The sluice room was still not adequate and recommendations from the Infection Control team had yet to be acted on regarding the lack of a hand washing sink. Cleaning rotas were in place but not always completed. The domestic assistant was not present at the time of inspection and had been off work for a number of weeks but the provider had not ensured adequate cover. Care staff and the manager confirmed they regularly completed cleaning duties in addition to their roles. Subsequent to the inspection the manager told us they were reviewing domestic hours and had arranged additional cover for when regular domestic staff were unable to attend.

Rooms on the first and second floor were being refurbished. Some had been completed, with new flooring and walls painted, although furnishings were basic. Some were in need of complete refurbishment and one room had a malodour that was noticeable in the corridor outside. The manager showed us this was part of their action plan and that these and other health and safety issues had been identified in the daily, weekly and monthly checks that they had introduced. They gave assurances that the floor in this room would be replaced as a priority. Subsequent to the inspection they confirmed this work had been completed.

There had been some improvements in relation to the storage and administration of medicines. At the previous inspection, and in recent visits by other agencies, concerns had been raised about the cleanliness of the medicines storage room. We found improvements had been made. Surfaces were clean and clear, opened medicines had a date marked on them, there were no loose or unaccounted for medicines and temperatures of the room and the medicines fridge were regularly recorded. We sampled medicines and medicines administration records (MARs) and found no errors.

New monthly auditing and daily stock checks had been introduced, as well as regular planned competency checks of staff. Staff we spoke with were confident in the administration of medicines and demonstrated a good knowledge of people' needs. They felt the new manager had improved the processes in place. The manager also planned to introduce a more comprehensive medicines competency assessment, which would be more challenging for staff and incorporate more areas of best practice.

The manager had yet to introduce specific protocols for the administration of 'when required' medicines. These are known as PRN protocols and should give staff clear instructions regarding when and why the medicines may be needed. We saw the manager had identified the need for these specific protocols and they agreed to make them more of a priority. When we reviewed people's needs, most people could verbally communicate their needs. This meant, whilst this was clearly still an area to improve, there had been no detrimental impact on people who used the service because staff knowledge of people's medicines was good. After the inspection the manager confirmed PRN plans were now in place.

People who used the service felt safe and content. They told us, "Generally it is very nice here, I feel safe," and, "I feel safe, I think it's very nice. I can talk about my problems with them." We observed staff interacting with people well and people acted calmly around staff.

When asked about whether there were sufficient staff, there was a consensus that staff were always attentive, though at times could be very busy. People said, for example, "The carers are busy all the time," and, "They come but sometimes the staff are busy." We reviewed the staffing dependency tool and found it was not specific. It determined the number of staff required based on a range of questions which were too ambiguous to be accurate. These questions then led to different dependency 'scores' which were factored in to establishing staff levels required, but the statements were not in any way significantly different. This meant staffing was planned based on analysis that was not specific about people's needs.

The dependency tool was also formulated based on establishing a total number of people who needed a certain level of help, rather than assessing each person's needs individually. The dependency tool also did not factor in any of the remedial and improvement work required to bring the service up to standards of compliance.

We reviewed recent rotas. On average, the service was staffed on one morning a week with just one care worker and the manager (as on the day of our inspection). This meant the manager did not have the time necessary to complete their managerial responsibilities on that day. It also meant, given one person at the service required two people to help them mobilise, there would be no staff available to help anyone else whilst they were being supported. We fed this back to the manager who agreed to review the tool. After the inspection the manager confirmed rotas had been amended to ensure they were not required to act as an additional member of care staff.

We found there were sufficient care staff to keep people safe and meet their basic needs but not to ensure staff had adequate time to ensure people had access to meaningful activities, such as leaving the service to go to local shops. This is discussed further in the Responsive key question. We fed this back to the manager who agreed to review the dependency tool and to request additional staffing from the owners as necessary.

We recommend that the service seek advice and guidance from a reputable source, about the review and implementation of a revised dependency tool.

After the inspection the manager confirmed they had sourced a new dependency tool, which would be regularly evaluated.

Pre-employment checks remained in place for new members of staff and all staff demonstrated an awareness of their safeguarding responsibilities. The safeguarding policy had recently been updated in line with external advice and was made available to staff, whilst posters encouraged staff and people who used the service to raise any concerns they may have.

Risk assessments were in place and detailed the actions required by staff to keep people safe.

Servicing and maintenance of utilities and safety equipment was in place, for example gas safe testing, portable appliance testing (PAT), legionella testing, fire safety equipment servicing and lifting equipment. A maintenance book had been introduced by the manager, which meant staff could document any repairs and the manager could identify when these had been completed by the handyman.

Personalised Emergency Evacuation Plans (PEEPs) had been introduced to help in the event of an emergency. The manager held meetings with people who used the service to ensure they were aware of the plans should there be an emergency. One person told us, for example, "We had a meeting and talked about what would happen in there was a fire."

Accidents and incidents were noted and documented in such a way that allowed for the manager to conduct analysis. Accidents were limited in number and minor.

Good

Is the service effective?

Our findings

At the previous inspection we found staff had not been appropriately trained in core topics such as the Mental Capacity Act 2005 (MCA). We found the manager had arranged MCA training for staff and the staff we spoke with were more confident in this area.

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 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 Deprivation of Liberty Safeguards (DoLS). We saw appropriate DoLS applications had been made and the manager's understanding of the system was sound. We observed instances of staff ensuring people consented to day to day choices such as meals and what activities to take part in.

Staff had access to a good range of training, both mandatory and additional, through a variety of e-learning and face to face learning. For instance, fire safety refresher training was planned, whilst the manager planned to roll out React to Red training they had received. React to Red is an NHS initiative aimed at carers and family members with a view to increasing awareness of the risk of pressure sores. Core training included safeguarding, moving and handling, fire safety, infection control and dementia awareness. Staff confirmed the manager's approach to training was a significant improvement. One said, "My training is up to date now – it wasn't for a while. We've done things like diabetic awareness, dementia awareness, fire and health and safety."

Training was planned on a matrix, although this was not fully effective as it was not aligned to the online training staff had also completed. It was at times difficult to establish which staff needed to refresh which training when, and the manager agreed to review the training matrix in place.

At the last inspection we found supervisions and appraisal were not happening. Supervisions are meetings between an employee and their manager whereby the staff member can talk about training or other needs they may have, and both can reflect on areas of good practice or areas for improvement. Appraisals are annual reviews of staff performance. At this inspection the manager had made improvements and staff supervisions were taking place and appraisals planned. One staff member told us, for example, "We are getting supervisions and we have the staff meetings too." Supervisions were planned for the year on a matrix.

People who used the service expressed confidence in the ability of staff who cared for them. They told us, "I think they know what they're doing," and, "Basically we are their priority. They look after us residents and they do it very well."

The manager had instigated some improvements to the premises in terms of their accessibility and

appropriateness for people who used the service. For instance, they had ensured newly painted areas contrasted with floors and handrails to help people more clearly orientate themselves. The dining room had been brightened and had new wall art specific to the local area. One person told us, "It's nice in here now, they have made some changes." Another person said, "They have done some decorating – it's good." One upstairs bathroom was out of order and awaiting refurbishment. When we spoke with people they confirmed there was ample bathing facilities for their needs. We acknowledged this bathroom was on a floor with far fewer people than if the service were full. The lift was serviced and in working order, with people using it during the inspection to access the top two floors of the building.

People had a choice of meals and gave generally positive feedback about the standard of meals. One person said, "The food is good. I get a choice. I like everything they give me." Another said, "I am happy with the food here." Another said, "I can have my breakfast in my room. This is ideal - I can have my favourite television programmes and a set breakfast, which is what I like." We saw the mealtime experience was a positive one, with people sensitively supported to make choices in a calm environment. Tables were set in advance and were brightened by flowers in vases.

Where people had specialised diets, either through medical need or religious belief, this was acted upon. For instance, people with diabetes were offered no sugar alternatives. One person whose religion meant they needed a specific type of ingredients had these needs catered for and they told us, "They always ask me what I would like. It's very important they get the right food for me." They were extremely pleased with how the service managed their needs.

The manager had reviewed the use of the Malnutrition Universal Scoring Tool (MUST) as it had evidently not been used consistently prior to their arrival. MUST is a tool which helps identify where people are at risk of poor nutrition and puts in place measures to help prevent this. The manager had ensured people were weighed regularly and the actions set out on the MUST tool followed. We saw they had recently referred a person to a dietitian to help identify ways to encourage them to eat meals. We observed refreshments being offered throughout the inspection and the manager had set up a drinks station in one living room for people to help themselves to drinks. This meant the manager had ensured people had access to a healthy, balanced diet.

Whilst the majority of care records would benefit from wholesale review, we found the documentation of visits and advice by external healthcare professionals to be good. People were clearly supported to access primary and secondary healthcare. One person told us, "I have a dental appointment and I get reading glasses. The district nurses come out to visit me and they change my medication when I need." Another said, "The manager organises my appointments and organises an ambulance to take me to hospital. A carer comes with me which is nice to have someone to talk to when waiting." Information from external healthcare professionals had been acted on by staff. Care plans we reviewed, whilst sometimes task-focussed, did contain sufficient evidence for staff to know people's basic needs and staff knowledge of people's needs was good. Plans lacked additional person-centred detail and this is discussed further in the Responsive key question.

Good

Is the service caring?

Our findings

People who used the service all agreed staff were caring and patient. One person told us, "The carers are pleasant enough, not nasty or anything like that." Another said, "The carers are all nice and deal with situations well. For example they make sure [person] is alright and in their wheelchair. They fuss [person]." Another said, "They really do care about us." One relative told us, "I have been delighted with the care my [person] has received from care staff at Risedale. I have found the ladies to be helpful patient and friendly."

The majority of staff had been at the service for a number of years. This meant they knew people's needs extremely well and people were comfortable around them. External professionals all agreed they had observed appropriate interactions between staff and people who used the service, and that staff genuinely cared for people.

People's individualities were understood and respected by staff. For instance, one person who previously enjoyed DIY was encouraged to informally oversee the recent refurbishment work. This meant they felt more a part of the work in their own home. It also gave them the opportunity to comment on and share their skills and life history. The manager told us all the recent refurbishments had been done in consultation with people who used the service. People confirmed they had been asked about colour schemes. People told us they were involved in their own care planning, with one person telling us, "I have a care plan in the office and they talk to me about my care."

People's religious beliefs were respected and supported. For instance through access to halal food or through having the option of visits from ministers of religion.

Staff communicated well with people, some of whom were particularly anxious or needed staff to vary their style of communication. One person had a mental health issue. We observed the manager calming them and discussing their concerns. The manager evidently understood their needs and was able to put them at ease and support them in remaining independent. Where one person at lunchtime nodded their head and moved a plate, staff promptly understood this as the person indicating they were not happy with the meal and they were offered more choices. The person was happy with an omelette. This meant staff communicated well with people and understood non-verbal prompts.

People's independence was respected and promoted. At times this independence was subject to staffing levels and the manager agreed the dependency tool needed to better consider people's social needs rather than basic care tasks. We found some good examples of people's independence being promoted however. One person told us, "I sometimes go for walks with staff but I am independent. They know this and let me do things for myself." Another said, "Staff walk with me to go and see my relative."

People were treated with dignity and respect and staff acted in line with the provider's values. People told us, "They always close the door if I'm getting changed," and "They treat me fine. They always knock before they come in." People were well presented and some chose to use a hairdresser who visited regularly, or have their nails done.

We saw the manager had put up posters with 'dignity dos' information for staff to continue encouraging a respectful approach to people who used the service. They also planned to have a dignity champion in place as well as putting a dignity tree up in the service.

We found the atmosphere was welcoming and relaxed and people told us they felt at home. People made use of both lounges, the dining room and the yard. People's rooms we saw were individually decorated and had been personalised with belongings and memorabilia. The manager had acquired new shelving for one person who had collected a range of memorabilia important to them. They confirmed they had been involved in the discussion about putting up a shelf to display their items and also to choose new colours for their room.

Requires Improvement

Is the service responsive?

Our findings

We found activities provision required improvement, particularly in terms of the resources needed to plan and deliver activities. Currently care staff and the manager were planning and delivering daytime in-house activities to help keep people stimulated but this was in addition to their caring and management responsibilities. There was no activities coordinator and no allocated time for anyone to plan activities, for instance by reviewing people's individual needs and preferences and factoring these into the planning of upcoming activities. This meant there was insufficient staffing to ensure people's preferences were met and that they had access to activities meaningful to them.

The impact on people had been lessened due to the proactive actions of staff and the new manager, but the provider needed to ensure people had access to in-house and external activities and hobbies of their choice. Currently staff played card games, bingo, armchair exercises, had one to one chats with people, whilst the manager had arranged a raffle and a hairdresser came once a week. Staff had completed a sponsored walk in order to raise funds for people who used the service and were planning a summer fete.

The manager was aware of the risk of social isolation and had already taken some steps to ensure the service and the people who used the service were able to better access their community (and vice versa). They held a summer fete and intended to hold other coffee mornings at the service's outdoor seating area for nearby residents.

Entertainment was intermittent and there were as yet no strong links with volunteers or local groups that could help bring activities into the home and help prevent the risk of social isolation. When we spoke with people who used the service and staff they agreed there was little to do by way of activities. One person said, "I stay in my room, nothing I can do," and another said, "I sometimes can't go out if there are no staff." A member of staff said, "We do activities when we can but we have to do it on top of everything else." One relative told us, "I hope improvements continue with a focus on activities/outings for residents with perhaps guest speakers/entertainers."

Records were not always person-centred. Person centred means that care is planned and delivered in a way that sees the people as equal partners in planning and puts their needs and individualities first. One person had a history of behaviours that could challenge. Staff were aware of these issues and it was apparent the person was supported by a team who knew them well. The care plan however did not include any positive strategies to help the person cope with their negative behaviours. Their care file contained a list of social interests from 2011 but there had been no recent review of these interests, nor an attempt to engage the person in them positively as a means of helping them to feel more fulfilled and improve their wellbeing.

One person walked with a stick and required the use of handrails to steady themselves. Their moving and handling risk assessment however, dated 6 July 2016, stated, "no problems walking". The plan had been reviewed on a monthly basis, but not meaningfully or effectively, as no changes had been documented. The combination of records lacking sufficient detail and the lack of provision for the planning and delivery of activities meant the provider was not providing person-centred care.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

The manager was aware of the issues regarding care files and had begun to take steps to improve these. They had audited all care files and identified that all needed significant reworking. They had completed one of the files themselves to demonstrate the standard they expected and we found this to be well ordered and with sufficient information. Senior carers told us they expected to be more involved in the review and updating of care plans. One said, "The manager has a different view of what we need in the care plans and is going through it with us seniors." The manager had begun to introduce a keyworker system, the intention being that staff would be responsible for designated care files and take responsibility for updating them.

The manager had made efforts to ensure the service became part of the wider community, for instance hosting a summer fete. They confirmed after the inspection that this had been well attended, improved community links, raised funds for residents' activities, and led to the planning of a MacMillan coffee morning.

The manager had regard to ensuring information was accessible to people who used the service and had displayed posters prominently regarding safeguarding awareness. They had also made up a pack for each person to keep in their room, which contained accessible information regarding how to complain, and the newsletter. They had introduced this bi-monthly newsletter as another means of keeping people informed of changes in the service and also to try and generate interest in upcoming events.

Whilst people's changing needs were not always well documented we found staff demonstrated a strong understanding of people's needs, including their mental health needs. Staff were able to describe what would constitute a good or bad day for people. We saw in care files that staff had liaised with other staff and external healthcare professionals when they felt someone's needs had changed. No one at the service was receiving end of life care. As part of the care file review process the manager planned to review whether anyone wanted to make advance care plans or talk about any plans they wanted to have in place should their health deteriorate.

With regard to complaints, we observed the manager acting in accordance with the 'open door' policy they told us they had. They engaged with people openly and encouraged them to talk about any concerns they had. Newly arranged resident meetings and surveys also gave people the opportunity to raise any concerns. The manager had also put a copy of the complaints process in a folder in each person's room. People told us, "If I had a problem I would talk to the boss. They are so understanding or I would talk to the carers and tell them. I think it's good like that." There had been no formal complaints since our last inspection for the manager to respond to.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in place at the time of inspection. The manager had however applied to be registered with CQC and attended their fit person interview with CQC the Monday after the inspection. They were subsequently registered by CQC. They had relevant experience and had brought across some examples of improved record keeping from their previous roles.

We found the manager had ensured improvements were made in the fabric of the building, cleanliness, staff training and supervision and auditing. We received a range of positive feedback about the impact the manager had made on the service. One relative told us, "I have noticed significant improvements at Risedale, particularly since [manager] arrived. I am confident they have excellent ideas. In my view they seem genuinely driven to achieve the best they can for the resident group with limited resources."

We found this comment to be representative of the opinions of external health and social care professionals we spoke with, who acknowledged the efforts of the manager. One professional said, "They're a very 'can-do' manager and have made a lot of improvements." Another told us how they liaised closely with the manager and had confidence in their ability to continue making improvements, provided they received the appropriate resources and support from the owner of the service.

Where we found evidence of clear improvements in the service, these were largely down to the drive of the new manager and they had made good progress in instilling a greater focus on ownerships of aspects of work within the staff team. For instance, staff we spoke with agreed the new keyworker system would benefit people who used the service and that, previously, they did not update care plans as the previous manager had completed all the paperwork. They agreed that the new manager wanted to increase their responsibilities and that this was a positive change.

We also found that the manager would benefit from more support during this time of transition and improvement. Administration support was limited to the owners completing stock taking and weekly orders of food supplies. At least one day per week, the manager was required to help with care tasks and helping a person mobilise until a second member of care staff arrived. They acknowledged they had not completed as many of the planned actions as they would have liked. There was a deputy manager but their hours were limited and they had been off work recently. The provider could have done more to ensure there was support in place for the manager at a time when they were attempting to make a range of significant improvements to the service.

The owners visited the service regularly and the manager confirmed they took an interest in their work.

We noted the manager was working on an action plan for the both the local authority and the infection control team when we arrived. We reiterated the urgency of this work and the manager confirmed they had completed these plans shortly after the inspection ended. We found the manager keen to make improvements and to seek advice from external sources. The manager also planned to have champions in place for specific subjects, for instance pressure sore awareness and dignity. They hoped this would again

help instil a greater sense of involvement on the part of care staff and ensure the culture was one focussed on continual improvement.

The manager demonstrated a good understanding of when they needed to notify CQC of specific incidents and had done so recently, promptly and with an appropriate level of information. Registered providers and managers must ensure they notify CQC of major events, such as serious injuries or stoppages in the service, so that CQC can monitor the service remotely.

The office was organised and auditing processes had been improved or, where they were previously lacking, implemented. These checks were still being embedded into processes and the manager was still trialling some of them to establish which would be most effective for the service. They did however demonstrate that they understood the need to continually assure themselves of the quality of the care provided, and that they had put, or planned to put, effective quality assurance systems in place.

Staff morale was generally good, with all staff we spoke with acknowledging improvements since the new manager's arrival. They confirmed they were approachable, accountable and listened to any concerns. One staff member told us, "The manager is very dedicated," whilst another said, "If you have a problem you know you can go to them as confidential means confidential with them."

We found the manager had successfully begun the process of changing the culture of the service from one which was reactive and inflexible, to one which focussed more on the needs and individualities of people who used the service. There were still a range of improvements to make and they needed to ensure improvements that had already been put in place were maintained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure records were sufficiently detailed and person-centred. The provider had failed to ensure there was adequate person-centred planning and delivery of activities.