

Arthur Bunting

# Ryehill Country Lodge

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection was completed on 2 August 2018 and was unannounced.

Ryehill Country Lodge 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.

The service provides accommodation and care for a maximum 24 older people and up to four people attending day services each day. There were 22 people living at the service and one person attending day services at the time of the inspection.

The service had a manager who had registered with the Care Quality Commission. 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.

At our previous inspection in December 2015, this service was rated good overall. This is the first time the service has been rated requires improvement.

Notifications relating to safeguarding incidents had not always been made to the local safeguarding authority, or CQC as required by law. We reviewed the service's safeguarding records and found there were incidents of safeguarding which we should have been notified of.

Parts of the environment were not always safe. The laundry area was accessible to people and we found this contained substances which would be hazardous to people if ingested. There was no evidence that the fire alarm and detection system had been serviced by a competent person since December 2014. An upstairs toilet was dirty around the bottom, and a metal pedal bin had mould around the base. A landing window contained bird faeces on the sill.

The registered manager was able to demonstrate they had an understanding of Deprivation of Liberty Safeguards (DoLS) and the Court of Protection. However, we found that Mental Capacity Act (2005) guidelines were not always followed. We have made a recommendation about this.

The quality assurance system in place was not always effective. Checks carried out failed to identify and mitigate risks to people regarding infection control practices and the safety and maintenance of the premises. The system had failed to identify the MCA had not been applied consistently. The registered manager began to address some of the concerns we raised during the inspection.

People told us they felt safe living at the home and that they would tell someone if they were worried about

anything. Staff were able to demonstrate they knew the different types of abuse and how to report any safeguarding concerns and had access to training on how to safeguard people from abuse.

Risks to people had been identified and recorded in their care plans. Where people presented with behaviours that placed others and themselves at risk of harm, staff knew how to support them.

Recruitment practices were robust to ensure the suitability of people who worked in the service. There were sufficient numbers of suitably skilled and experienced staff positioned across the service to meet the needs of people and keep them safe.

Medicines were managed safely and staff had appropriate training.

We saw that staff completed an induction process and had regular training to equip them with the skills and knowledge to meet people's needs.

People's nutritional and hydration needs were assessed and planned for. People enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day. People's comments were positive about the provision of food and drink.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. The guidance contained in some care plans was not always sufficiently detailed on how staff were to support people during times of distress.

The approach to care planning for people was person centred and their care plans took account of the person's views and preferences about how their care was to be provided.

People were offered a variety of different activities to be involved in, and people told us they were well cared for. People were treated with dignity and respect and we observed staff communicated with people and gave encouragement.

People were supported to access healthcare services when they needed to, including their GP and dieticians. Electronic records were maintained for people, describing the contact and input from external healthcare professionals.

A complaints procedure was in place and complaints were addressed appropriately.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back 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?

The service was not always safe.

Not all areas of the service were safe, clean and well maintained.

Staff displayed a good understanding of the different types of abuse. However, information about safeguarding concerns had not always been submitted to the safeguarding team.

Individual risks to people had been assessed and measures put in place to reduce these risks.

There were sufficient numbers of safely recruited staff employed to ensure people received a safe and effective service.

There were arrangements in place to ensure medicines were safely managed.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards. However, we found the Mental Capacity Act (2005) guidelines had not been followed.

The premises required some repair and decoration.

Staff received an induction, supervision and training in key topics that enabled them to carry out their role.

People's health and dietary needs had been assessed and were recorded. People were supported to maintain good health and had access to appropriate healthcare services.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

People were treated with respect and staff were knowledgeable

**Good** ●

about people's care and support needs.

People were offered choices about their care, food, drink and daily routines where possible.

We observed caring interactions between people and staff throughout the inspection. Relatives spoke positively of the staff and the care they delivered.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People had their health and social care needs assessed and care plans were developed to guide staff in how to support people. Information needed to be improved to provide staff with guidance to follow when people became distressed.

People received care and support which was responsive to their needs.

People had access to activities.

The service had a complaints procedure and people knew how to make a complaint.

### **Is the service well-led?**

**Requires Improvement** ●

The service was not always well-led.

The service had failed to notify us of incidents of safeguarding, which they were required to by law.

The service's quality assurance system was not robust, and audits had failed to identify the associated risks we evidenced during our inspection.

The service provided an open culture. Staff and visitors to the service told us they found the registered manager to be supportive and felt able to approach them.

# Ryehill Country Lodge

## 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.

Inspection site visit activity started and ended on 2 August 2018 and was completed by an inspector and an assistant inspector. During the inspection we spoke with three people who used the service and two visitors. We also spoke with three members of staff, the registered and assistant manager.

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. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

We asked the local safeguarding and commissioning teams, and Healthwatch for their views of the service provided. Healthwatch is an independent consumer champion for health and social care. We used the feedback we received to inform the planning of our inspection.

During the inspection we reviewed records, which included three people's care plans, three staff recruitment and supervision files, staff duty rotas, medicines and training records. We looked at documents relating to the management of the service such as meeting minutes, quality assurance systems, servicing and maintenance records.

# Is the service safe?

## Our findings

Despite policies for general maintenance and infection control, and a cleaning rota in place, we observed areas of concern regarding infection control practice, maintenance of the premises and its safety. Substances which would be hazardous to people if ingested were found to be easily accessible in a laundry room cupboard. We raised these concerns with the registered manager and these items were removed and access to the laundry room secured.

We observed an upstairs toilet was dirty around the bottom, and a metal pedal bin had mould around the base. The boiler cupboard contained an old cup with mould in. An upstairs landing window sill was rotting and another landing window was open and contained bird faeces on the sill. We checked some people's bedrooms and found tiles coming away from the wall in one toilet, and a dirty net curtain that had brown deposits on it in another. The window in this room was very dirty. The deputy manager removed the net curtain straight away.

We found the fire detection system had not been maintained. The latest evidence of a fire detection and alarm system test carried out by a competent person was dated December 2014. Because of our feedback the registered manager updated us after this inspection with improvements they had begun to make, this included evidence a check of the fire detection system had been completed.

The above concerns were a breach of Regulation 12 (1) (2) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in safeguarding. Staff told us they understood their responsibilities for safeguarding people from abuse and knew how to report any concerns. We reviewed the safeguarding monitoring logs and saw a significant number of recorded incidents of alleged physical abuse. The registered manager had acted to ensure the person's safety. However, they had not reported potential safeguarding concerns to both the local safeguarding team and the Care Quality Commission (CQC). Following the inspection, we asked the registered manager to discuss these concerns with the local safeguarding team. This was a breach of regulation and has been addressed in the well-led section of this report.

Risks to people had been identified and recorded in people's care plans. These included for example, mobility, falls, eating and drinking and continence. Associated support plans were in place to mitigate the risks and to help staff deliver safe care and support. Where people presented with behaviours that placed others and themselves at risk of harm, staff were able to confidently speak to us about how they would support people.

We saw that a suitable fire risk assessment was in place and checks of fire extinguishers were carried out to ensure they were in safe working order. We saw regular fire drills took place to ensure staff knew how to respond in the event of an emergency. Documentation and certificates showed relevant checks had been carried out on the electrical circuits and lifting equipment.

Accidents and incidents which occurred at the service were recorded and reported by staff on the services electronic system. Such events were reviewed monthly in line with peoples care plans as a way of identifying any patterns or trends and how the risk of re-occurrence could be reduced.

People told us they felt safe at the service. One person said, "Yes, I feel safe. They're lovely girls I can't grumble." A relative told us, "Yes definitely [relative is safe] I am glad they are in this home." We asked people who used the service and relatives/visitors if they felt there were enough staff on duty. One person told us, "Oh yes, there are enough of them [staff] around if I need them."

People and their relatives we spoke with told us they had no concerns with the levels of staff. We asked staff if they felt levels were sufficient. Comments included, "Yes there are enough staff, sometimes it can be hectic so we don't get to spend as long as we would like to" and "Sometimes we don't [have enough staff] as we are really busy. Some days are not as bad so we do activities."

We observed there were sufficient numbers of staff on duty during the inspection to enable people's needs to be met. There was always a staff presence in the communal living and dining areas. We found people did not have to wait for attention. We checked the staff rotas and saw staffing levels had been consistently maintained. This meant that care staff were able to concentrate on supporting people who lived at the service.

We looked at the recruitment records for three staff members. We found application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured people were not exposed to staff that were barred from working with vulnerable adults. Staff were provided with job descriptions and a contract of employment. This helped to ensure staff knew what was expected of them.

There was a safe system and process in place for the ordering, storage, handling and disposal of medicines and this was in line with best practice. On each shift there was a designated senior staff member who had responsibility for the administration of medicines. All staff involved with the administration of medicines had received up to date training. The medicine trolley was secured to a wall in the communal lounge area. We observed two people being supported to take their medicines in a safe manner at lunchtime. The senior staff checked the medication administration record (MAR) to ensure the correct medicine was given, administered the medication and waited until the person had taken the medicine, before completing the MAR. MARs were accurately completed, and regular checks were carried out to monitor and control the medicine stocks at the service. This ensured that people received their medicines as prescribed.

## Is the service effective?

### Our findings

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.

We found examples where the MCA guidelines were not being followed. For example, five people did not have capacity to consent to the use of door alarms that were fitted on their bedroom doors, and two people were unable to consent to the use of bed rails which were in situ. There was no specific mental capacity assessment or best interest decision made about the use of these restrictions. The registered manager told us the bedrails were not used for one person and removed these during the inspection.

We saw closed circuit television cameras (CCTV) had been installed in the service in communal areas to ensure the safety and security of people. People's care plans did not reflect they had been consulted with and agreed to the use of these cameras prior to their installation. We discussed these concerns with the registered manager who told us that people and their families had been verbally consulted about the use and installation of CCTV. The registered manager began to implement clearer documentation around consent and consultation during this inspection.

We recommend the registered manager seek advice and support from a reputable source to ensure people's rights under the Mental Capacity Act 2005 are upheld and recorded appropriately.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 any conditions on authorisations to deprive a person of their liberty were being met. The registered manager worked in partnership with relevant authorities to ensure appropriate DoLS applications were made for people. We saw details of DoLS authorisations were included in care plans.

Most staff had attended training on MCA and DoLS and information on the MCA was displayed in the main lounge area of the service. In discussions, the registered manager and staff who we spoke with were aware of the principles of MCA and DoLS, how they impacted on people and how they were used to keep people safe. A staff member told us, "We always assume a person has capacity unless it's shown otherwise. We ensure we give people enough information to make a decision, and if they make an unwise decision it doesn't mean they don't have capacity."

The premises required repair and decoration in some areas. In addition to what we reported in the safe section of this report, we noted the paintwork throughout the building was marked and chipped. There was a hole in the conservatory ceiling, small holes in the stair carpet, and in one person's bedroom we saw the

wallpaper border was hanging off. We were shown the homes expenditure plan which evidenced the registered manager had a plan to update areas of the home. After this inspection the registered manager provided us with evidence to show some of this work had begun.

We saw some attention had been paid to supporting people living with dementia. For example, people's bedroom doors displayed a sign with their name, a picture of them and their named keyworker. There was accessible outside space and a quieter area with three chairs which was located in the entrance area. We noted a person who chose to sit in this area had a photograph personal to them on the wall.

People were supported with their nutritional and dietary requirements. We asked people what they thought of the food and drinks. Comments included, "It's very nice" and "It's up and down, sometimes it is cold but if I tell them it gets sorted." A relative told us, "Yes it's nice, [name] is a good eater. I have been invited for food before." We observed people were able to access drinks when they wanted. People had their own jugs of juice and were offered hot drinks and snacks throughout the day.

We observed lunchtime and saw tables in the dining area were set with cutlery, condiments and crockery. People were offered a choice of drinks with their main meal and following it. People were given choice of where they wanted to sit, some people stayed in the lounge and some people went through to the dining area. People who required assistance with eating and drinking received this in a dignified manner. The food was well presented, looked and smelled appetising. Vegetarian options were offered. There was a menu board in the entrance area of the building which had two options available, although, we did not see people being offered choices of the meals during the inspection. One person was asked if they would like an alternative when they did not eat the meal provided.

Records included provision to support people to maintain their health and wellbeing. A malnutrition screening tool (MUST) was used to identify people, who were malnourished, at risk of malnutrition or obese. This information was recorded in people's care plans. People had their weight monitored regularly. Where concerns had been identified about people losing weight the service had sought appropriate advice from relevant healthcare professionals.

People were supported by their GP and other healthcare professionals such as dentists and dieticians. One relative told us, "They [staff] ring a doctor if needed, and they have chiropody and opticians who come here [the service]." All contacts were recorded in people's care plans, to include any advice offered by healthcare professionals. We saw details of people's health conditions included in their care plan.

We looked at the induction and training files of staff to check their induction would give them the necessary skills and knowledge to care for people who lived at the service. We saw newly recruited members of staff were required to complete an induction covering service specific topics. Competencies were checked in areas such as attitude, communication skills, health and safety, personal care and hygiene and medicine administration. We saw the service considered essential training to include fire, infection control, food hygiene, moving and handling, safeguarding adults from abuse, MCA and DoLS, communication and dementia. Some staff had completed additional training in risk assessments, pressure care, diabetes, pain management and end of life care. Some staff were enrolled on the National Vocational Qualification (NVQ) in care at varying levels. NVQs are nationally recognised work based training courses. One member of staff told us, "I have completed my NVQ level two and I am now doing NVQ level three."

Staff confirmed they had regular supervision meetings with their line manager. The registered manager told us supervisions were completed every two months, records we looked at confirmed this.

## Is the service caring?

### Our findings

People who used the service told us staff were kind and caring. One said, "They [staff] are kindness itself. I cannot fault them." A relative told us, "They [staff] are a lovely bunch. I am very content that [name] is here." We saw a comment that had been given by a relative that said, "Staff are always friendly and welcoming."

People were able to move freely around the home; some required assistance and others were independently mobile. We saw people and staff had a good relationship with each other. Observations of people in the lounge, conservatory, dining room and around the service indicated people appeared safe and relaxed in the home.

People told us they were given a choice about how their care was provided. We saw people were given a choice of where they sat during the day and at mealtimes, and whom they spent their time with. One person told us, "I get up about 7.30 to 8.00am by choice. The home is kept clean and tidy. It's absolutely lovely."

Staff we spoke with showed concern for people's wellbeing in a caring and meaningful way. They gave us examples of how they ensured people were offered support appropriate to their needs and choices. One member of staff told us, "We always offer choice. We ask and don't just give. Like today [name of person] normally has a bath in a morning but they had a visitor coming so they said they wanted a bath in the afternoon."

We observed during the day that interactions between people and staff were calm, friendly and positive. For example, on the way to an activity in the garden one person began to feel tired. We saw the member of staff supported the person to sit down straight away and quietly enquired about how they were feeling. We observed the member of staff regularly came back into the home to check on the person's welfare.

The privacy and dignity of people was respected by staff. Our observations showed staff respected the fact bedrooms were people's private space. One person had their own key to their room. People told us that staff were always respectful towards them and took steps to promote their privacy and dignity. One person said, "They always knock on my door and they cover me up when I am getting washed." The staff team were able to give us examples of how they promoted and respected people's dignity and privacy.

The registered manager and staff we spoke with understood the importance of treating everyone at the service equally. This was demonstrated from discussions with staff and evidenced in people's care plans. Some staff had completed training in equality and diversity. A member of staff told us, "We don't assume we know what the person wants, we ask them what they want. It's about that person and we don't just treat everyone the same." Care plans reflected people's diversity and any protected characteristics under the Equality Act. For example, initial assessments of people's needs contained information on people's sexuality, social interests, culture and religion.

Reviews of people's need took place, which involved the person using the service (where possible), their family member and relevant healthcare professionals. One relative told us staff actively involved them by

seeking their views about their care. They said, "I am lasting power of attorney (LPA) for [name of person]. I come to reviews, and they ask for my consent. They tell me everything." A LPA is a legal process that lets a person appoint one or more people to help them make decisions or to make decisions on their behalf.

Relatives and visitors told us and our observations confirmed people were able to visit their loved ones without any restrictions. One relative said, "I can visit any time. I just pop in. I am made to feel welcome, they [staff] are very friendly."

The registered manager was aware of when to involve the use of advocacy support. At the time of our inspection one person had an advocate involved. An advocate can be used to help people to have information in a way they understand to help them with choice independence and control over their lives and associated decisions.

Staff confirmed they understood how to respect people's confidentiality. One staff member said, "I don't discuss anything with people outside of work. I would only share if it was safeguarding [concerns]. If someone wants to tell me something I would tell them I may have to tell someone else. We keep files locked away." We saw that any personal information relating to people or staff was stored securely. Some documents were stored on computers which were password protected. The registered manager was aware of the new General Data Protection Regulation (GDPR). GDPR is new legislation which came into effect in May 2018 and gives people more control over how their personal data is used.

## Is the service responsive?

### Our findings

People's needs were assessed prior to them moving into the service. A care plan was developed based on assessments carried out by the registered or assistant manager, and other assessments obtained from external health and social care professionals. A person-centred approach to care planning was present in the care plans we reviewed. The registered manager told us and we saw that since the last inspection people's care plans had been transferred and were now completed, maintained and regularly reviewed on an electronic system.

Care plans included sections about risks to be aware of for each person, each day's care delivery, likes and dislikes, medical history and allergies. Other areas of care and support included continence, death and dying, mobility and nutrition and hydration. Each section recorded the person's assessed current situation, care needs, outcome, description of care and any actions and reviews.

We tracked people's care to check they were receiving care and support in line with their care plan and found they were. For example, it was recorded that one person liked to sing, and had a particular favourite song. We observed the person was encouraged to sing this during the inspection. Some identified risks and the risk control measures were incorporated into care plans. For example, a person's assessment for moving and handling stated they required support from one member of staff and their walking aid when standing. We saw staff followed this in practice. Information needed to be improved to provide staff with guidance to follow when people displayed behaviour that may be of challenge.

People's initial assessments included their decisions about the care they wanted to receive at the end of their life, if they had chosen to discuss them. For example, where they would like to receive their end of life care, what their wishes were and any arrangements they had made for their funerals. At the time of the inspection no one was receiving end of life care. A 'Do Not Attempt Resuscitation' (DNAR) certificate was conspicuously displayed in the care plans of people who had expressed this wish. The certificates had been authorised by an appropriate medical professional.

Information regarding people's methods of communication was recorded in care plans. The plans contained details including how the person communicated. For example, one person's plan stated, 'Communicates through speech. Is quietly spoken.' Another person's said, 'I have a minor speech impairment. I need time to process information.'

Information about people's needs was communicated between relevant staff through the completion of 'changeover notes' inputted onto the electronic system and accessed through the use of a mobile handset. Some information was made available to people in different formats, for example, the service user guide was available in large print. The registered manager had an awareness of the accessible information standard and explained that information could be provided in alternative formats if required. People's communication needs were explored at assessment, and we saw one person had a clock that verbally told them the time.

People's views on opportunities to participate in activities were positive. One person said, "They do bowling and throwing hoops there's enough activities for me. Yes, I can get out into the garden, but I like to sit here [in chair]." Another person told us, "I think they do bingo." Relatives/visitors comments included, "They try their best with activities" and "They offer activities but [name of person] is past it really. They do fairs and stuff like they have today."

During the inspection we saw a barbecue and raffle held in the home's gardens. This was well attended. People were observed to be smiling, laughing and socialising with each other, whilst enjoying the sunshine, food and drinks.

We saw an activity board in the lounge which staff wrote on every day with what activity was on offer. Peoples participation in activity was monitored every month and we saw records confirmed recent activity had included crosswords, walking, music, watching films, games, singing, dominoes and reminiscence. There were notices including ideas people had given for fundraising and various photographs of people enjoying previous events at the service.

People and their relatives were provided with information about how to complain and the information was also displayed in the entrance area. People and their relatives told us they knew how to complain and would so if they needed to. Their comments included, "I have only ever told them my food is cold, and they sorted it" and "Never had to complain but would go to the manager. I think it would be responded to. I wouldn't let it drop." The registered manager maintained a record of complaints made, the records included details of the complaint, who made it and the response, and any actions taken.

Other opportunities were available for people to offer feedback on the service they were receiving. We saw 'Resident and family' meetings were held regularly and we reviewed the notes from recent meetings held each month from February to July 2018 (which had been attended by people using the service). Different topics were discussed, including privacy and dignity, menus, fundraising, recent purchases for the home and activities.

# Is the service well-led?

## Our findings

Ryehill Country Lodge was required to inform CQC of certain events that happened in the service. The registered manager had not informed CQC of a significant amount of notifications of abuse. This meant we could not check that appropriate action had been taken.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009. We are pursuing this outside of the inspection process.

We asked for a variety of records and documents during our inspection. These were easily accessible and stored securely. We were shown the folder which held the service's policies and procedures. We found the complaints policy did not contain the correct information for people if they wished to contact the CQC.

During the inspection we identified there was a failure to identify and mitigate risks to people. This included risks associated with the environment and infection control practice. Although we did not evidence any impact on people there was a risk to their health, safety and well-being.

Despite regular audits of areas of the service delivery we saw oversight was inconsistently maintained. For example, the last maintenance audit we reviewed in July 2018 indicated that electrical items tests were up to date. We were unable to see any evidence of this during the inspection. This audit also included checks of fire alarm tests. It did not identify that the fire detection and alarm system had not been tested by a competent person since December 2014. British Standard 5839 recommends that a fire alarm system should be inspected by a competent person at least every six months.

We found risks from access to hazardous substances and poor infection control practice. We also found that safeguarding concerns were not always submitted to either the safeguarding team or the CQC. Additionally, audits had failed to identify that the service was not always following the principles of the Mental Capacity Act 2005.

The above concerns were a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The assistant manager showed us audits they completed which included fire safety, care plans, bedroom/bathroom cleanliness, maintenance, nurse call systems, pressure care equipment and medicines. We saw that when these audits identified any areas for improvement, actions taken were recorded on the audit to rectify the problem. For example, we saw action had been taken to redecorate a person's bedroom and toilet area after a complaint had been received.

Relatives and visitors to the service told us they could approach the registered manager if needed. Comments included, "[Name of registered manager] is very approachable, she's nice and generally cares about her home. Nothing is too much trouble."

Additionally, surveys were distributed to stakeholders including people who lived at the service, relatives and staff. These had only recently been distributed so they had not yet had many returned. One person who used the service told us, "They [staff] come around and ask questions, if I'm happy, stuff like that, and they write any queries down."

Staff told us they had been consulted with, and we saw minutes of staff meetings recorded. Discussions included the use of personal protective equipment, medicines, falls, online training and on call arrangements. Staff told us they felt the meetings were a useful opportunity to participate in discussions about the home. One said, "We have staff meetings every few months. if people bring things up they are sorted straight away."

All of the staff we spoke with told us they were happy with the management and found them to be approachable and supportive. Comments included, "As a manager [Name] is very open and approachable. She is someone that we have all been to for support and advice at some point, both in a professional and personal capacity. She is always available, even for small things that may be causing worry" and "We have a manager and assistant manager so it's a good balance. There is always someone to go to."

We discussed the culture of the service with the staff. They told us, "It is open [culture]. If I made a mistake I would be open and honest. We have good team work", "It's like a family" and "[Name of registered manager] often brings treats in [for staff]. Most recently bringing iced lollies for the staff on duty when the weather was particularly hot. She organises a Christmas party each year and everyone is given a present, and she organises a Christmas 'didlum' [saving] for staff to join if they want to save up throughout the year."

The registered manager and staff worked in partnership with others to meet people's needs. This included working with health and social care professionals such as GPs, commissioners of packages of care and relevant others such as people's relatives.

Providers are legally required to display their CQC rating. The ratings from the last inspection were prominently displayed in the entrance area at the service.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered manager had not always ensured the premises were safe, assessed the risks to the safety of service users so these could be appropriately mitigated, nor done everything that was reasonably practicable to mitigate risks to people.</p> <p>Regulation 12 (1) (2) (a) (b) (d) (h)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems in place to assess, monitor and improve the quality of service that people received were not always effective.</p> <p>Regulation 17 (1) (2) (a) (b)</p>