Mrs Rishpal Singh

Riverview Residential Home

Inspection report

1 Heyfields Cottages, Tittensor Road
Tittensor
Stoke On Trent
Staffordshire
ST12 9HG

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We completed an unannounced inspection at Riverview Residential Home on 4 April 2017. At the last inspection on 25 August 2016, we found there was a breach in Regulation 17 and improvements were needed to the way the service was monitored and managed risk and governance. We received an action plan from the provider, which stated that the required improvements would be made by the 29 September 2016. At this inspection we found that the action plan had not been met and we identified further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Riverview Residential Home is registered to provide accommodation with personal care for up to eight people. People who use the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection the service supported seven people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service did not require a registered manager because they are registered as an 'individual'. 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. The provider was managing the service, and there was also an assistant manager and a deputy manager.

Risks to people's health and wellbeing were not consistently identified, managed or followed to keep people safe.

We found improvements were needed to ensure staff were deployed across the service effectively to ensure they were available to provide support when people needed it.

We found that medicines were not consistently managed in a safe way.

People were protected from the risks of abuse because swift action had not been taken by the provider to ensure people were protected from possible harm.

Staff told us they received training. However, we found that some of the training they had received was not effective. There were no systems in place to ensure that staff understood and were competent to support people safely and effectively.

People were not always supported in line with the requirements of the Mental Capacity Act 2005, because staff and management did not have a clear understanding of their responsibilities.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

Advice was not always sought from health professionals in a timely manner to ensure people's health needs were met effectively.

Improvements were needed to ensure that people were able to access hobbies and interests that were important to them.

People's care records did not contain an up to date and accurate record of people's individual needs and reviews that had been undertaken were not effective in identifying changes to people's care needs. This meant that people were at risk of receiving inconsistent care.

People were supported to eat and drink sufficient amount and staff understood people's nutritional risks.

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives.

People and staff told us that the registered manager was approachable and staff felt supported to carry out their role.

People told us they were treated in a caring way and staff promoted their dignity. People were supported to make choices about their day to day care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from the risk of harm because their risks were not planned, managed or monitored to keep them safe. Medicines were not always administered and managed safely and staff were not effectively deployed to consistently meet people's needs at a time people needed support.

Staff understood how to protect people from abuse and their responsibilities to report potential abuse. However, swift action had not always been taken to protect people from unsafe and inappropriate support.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed to ensure staff had sufficient knowledge and skills to carry out their role.

Health professionals' advice was not always sought to ensure people received effective care.

People were not always supported in line with the Mental Capacity Act 2005 and staff were not always aware whether people were subject to any restrictions to keep them safe.

People were supported to eat and drink sufficient amounts.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were caring, however we found that people did not always receive support that was caring because the provider had not taken steps to ensure that people received care that protected them from potential harm.

People's choices were respected by staff and their privacy and dignity was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not consistently supported to access hobbies and interests to meet their individual emotional wellbeing.

People were at risk of inconsistent care because care records did not reflect an accurate account of people's needs. Reviews of people's care were not always undertaken when people's needs had changed.

People knew how to complain and complaints were handled in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the manager and provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

People and staff felt that the management team were approachable.

Riverview Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 April 2017, and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we reviewed the information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries, safeguarding concerns and deaths that had occurred at the service. We also gained feedback about the service from local authority commissioners.

We spoke with three people who used the service, two staff and the deputy manager. We observed how staff supported people throughout the day and how staff interacted with people who used the service. 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 viewed five records about people's care and four people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, and staff recruitment and training records.

Inadequate

Is the service safe?

Our findings

At our inspection carried out on the 4 January 2016, we found that people's risks were not managed in a way that protected them from the risk of harm. We inspected the service on the 25 August 2016 and found that some improvements had been made. However the provider needed to make further improvements to ensure people received safe care. At this inspection we found people's risks were not managed and the improvements made had deteriorated, which meant people were not always protected from the risk of harm.

We found that people's risks were not always managed or mitigated to keep them safe. For example; we saw one person was unsteady on their feet when they mobilised. The incident records showed that this person had fallen on two occasions and had sustained an injury from one of the falls. The care records we viewed stated that this person was in a ground floor bedroom, they were restless during the night and they needed supervision when mobilising after sleeping. We saw that this person's room was not on the ground floor as stated but upstairs close to the stairway. The deputy manager told us that the person wanted an upstairs bedroom, but they had not considered that moving this person had placed them at risk and had not taken any action to lower their risk of falling. We found that there were no safety measures in place to alert staff that this person was mobilising when they were in their bedroom and the stairway was open with no equipment in place to safeguard the person from using the stairs unassisted. We spoke with staff who told us that this person needed supervision when using the stairs as they were unsteady and a visiting professional also confirmed that the person needed supervision to ensure they were safe when using the stairs, but we found that this had not been considered in this person's risk assessment. We asked staff how they could be assured that this person was safe at night if staff were supporting another person at the far end of the service. One staff member said, "We would hear them if we were in the lounge as their bedroom is directly above, but I agree we wouldn't hear them if we weren't in that area". We spoke with the deputy manager who told us that they had removed sensors from people's bedrooms because this could be seen as restricting people, but there had been no consideration of other methods that could be used to keep this person safe from harm. The deputy manager placed a sensor in this person's room during the inspection. This meant that this person had been placed at risk of harm because their risks had not been managed or mitigated to keep them safe from the risk of potential harm.

We found that one person had suffered regular bruising over a period of three months due to them attempting to get out of bed and they had injured themselves on the bed rails in place. The daily records we viewed recorded that this person had frequently attempted to get out of bed and injured themselves on numerous occasions. We did not see that action had been taken by the provider to prevent these accidents from reoccurring and further injuries had occurred. We found that there was no bed rail assessment in place to ensure that this person was safe to have bedrails in place. We were told by the deputy manager that the local authority safeguarding team had been involved and had visited the person. However, the deputy manager was not aware of the outcome of the investigation as the provider was unavailable and had been present at the investigation. We saw and the deputy manager told us that there had been no immediate changes to this person's care since the investigation had been carried out. Staff we spoke with gave inconsistent accounts of this person's risks and the support they needed to keep them safe from harm. One

staff member said, "They don't try and get out of bed, I've never seen them try". Another member of staff said, "The person does try to get out of bed sometimes and has bruised themselves. We just do our best". This meant that this person continued to be exposed to this risk because the provider had not taken action after accidents had occurred and this person continued to be exposed to the risk of harm and accidents continued to occur.

We found that staff were not always deployed effectively to ensure people's risks were mitigated to keep people safe from potential harm. For example; one person was at high risk of falls and their care plan stated that they needed supervision in the day when they were mobilising after they had been sleeping as this can affect their mobility. We saw this person awoke from sleeping and started to mobilise to the toilet, they were unsteady on their feet and they did not have a walking aid to assist them. We saw the person was grabbing onto the furniture and walls to steady themselves. There were no staff available in the lounge and they were unaware that this person had mobilised. Staff told us that this person needs monitoring at all times as they could be unsteady on their feet. However, we saw that they were left in the lounge unsupervised throughout the inspection for periods of 15 to 20 minutes. We saw that there were no sensors in place in the lounge to alert staff that this person was mobilising when staff were in another area of the home. This meant people's risks were not managed to keep them safe.

We checked the balance of stock that the home held against the balance recorded on the MARs for six people. We found that the stock did not balance for two people, which meant that we could not be assured that these people had received the medicines they needed. For example; one person's boxed medicine had been discontinued and a line had been put through the MAR to show this was no longer required. However, we found the box was stored in the medicine trolley and two tablets had been administered. We asked the deputy manager why this person had received medicine that they were no longer prescribed and they were unable to ascertain who had administered this medicine incorrectly. Another person's boxed medicine did not balance with the amount stated on the MAR. We found that there were two tablets extra than stated on the MAR. We asked the deputy manager why the stock did not balance and they were unable to give an explanation for this and were not able to identify if these people had received their medicine as prescribed. This meant people were at risk of harm because medicines were not managed in a safe way.

The above evidence shows that people's risks were not planned, monitored or mitigated in a way that kept them safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff we spoke with told us they felt there were enough staff available at the service. However, we found that improvements were needed to ensure that staff were available to people when they needed support. For example; one person spilt their drink over the table and floor in the lounge area. The person looked around for a staff member for help but there were no staff available in the lounge at the time and asked an inspector to help them. Staff we spoke with told us that they would normally ask the manager on duty to observe people in the lounge area when they were unavailable, but they had not asked the deputy manager on the day of the inspection because they were busy. This meant people did not always receive support when they needed because there was not a contingency plan in place to ensure that staff were deployed across the service effectively when the deputy manager was unavailable to assist them.

Staff we spoke with understood how to recognise and report some types of abuse. One staff member said, "I would not hesitate to report any concerns I had if I thought someone was not being treated right". Another member of staff said, "I would tell the manager if I had any concerns". However, we saw that where a person had sustained some unexplained bruising this had not been reported to the safeguarding authority by the provider. A visiting health professional had raised their concerns about the person and an investigation had

been undertaken by the local authority. This meant that staff and the provider had not recognised that unexplained bruising was potential abuse and required reporting to the local safeguarding team.

We found the provider had a recruitment procedure in place. Staff told us they had undergone checks to ensure they were suitable to provide care to people. We viewed seven staff files which showed that the manager had obtained references and staff had undergone criminal checks with the Disclosure and Barring Service (DBS). We also saw that there were details of staff's approval to work in the UK, which had been approved by the immigration service.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they had received training to carry out their role. We saw records that showed staff had received training in areas such as; safeguarding vulnerable adults, manual handling and the Mental Capacity Act 2005. However, staff we spoke with lacked a clear understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were unable to fully explain how they needed to support people who lacked capacity and they were unable to give sufficient explanations of why people may needs a DoLS. The deputy manager understood why people needed a DoLS in place but did not fully understand the actions they could put in place to keep people safe whilst they were waiting for the local authority to authorise restrictions that were in place. They said, "I was told we couldn't restrict anyone unless they had a DoLS in place". The provider had failed to ensure staff were adequately trained and action had not been taken to ensure people were supported by staff that had appropriate knowledge and skills to carry out their role.

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 saw that there were inconsistencies in the provider's approach to MCA. For example; we found that one person had a best interest decision that showed it was in their best interests for bed rails to be in place when they were in bed. However, another person who had bed rails in place had not had an assessment completed to ensure that this was the least restrictive option and whether this was in the person's best interests. This meant that the provider did not consistently act within the requirements of the MCA.

We saw that the registered manager had made referrals for a Deprivation of Liberty Safeguards (DoLS), where they felt people had restrictions in place to keep them safe. People can only be deprived of their liberty so that they can 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 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. Staff we spoke with were unsure of why people may need a DoLS in place and how they needed to support people in line with legal requirements. One staff member said, "I'm not sure who has a DoLS in place, I better go and check". The deputy manager told us they had been informed that they were not allowed to use motion sensors on people's doors until a DoLS had been authorised and had therefore removed these sensors, which had placed one person at serious risk of harm. This meant people there was a risk of people receiving inappropriate treatment because staff had inconsistent knowledge of the principles of the MCA and DoLS.

People told us that they were able to access health professionals when they needed to, such as doctors, chiropodists and opticians. We saw that some people had been referred to health professionals for advice and support when their health had deteriorated. For example; one person had developed pressure areas and the district nurses had been involved to ensure this person's skin was maintained. We saw that this

advice was followed and this person's skin had improved. However, we saw that advice was not always sought when people's needs had changed. For example; we were told by the deputy manager that they had requested a specialist low/high bed from the district nurses to keep one person safe from harm. We found there were no records that confirmed this had been requested and the professional we spoke with stated that they had not received a referral for a specialist bed. This meant that we could not be assured that the provider had requested support from health professionals to keep this person safe. We saw that one person had suffered a fall in 2015. The deputy manager told us this person could use the stairs independently. Staff and a visiting health professional told us this person was unsafe using the stairs. However, this person had not been referred to an occupational therapist or physiotherapist for an assessment to ensure this person was safe using the stairs independently. This meant that advice had not always been sought to maintain people's health, safety and wellbeing.

People were happy with the quality of the food. One person said, "The food is nice. I like all the food". Another person said, "We can choose what we want to have. It's fish today I really like fish". We saw that people were supported effectively with their nutritional needs. For example; we saw that where people had lost weight or were at risk of weight loss, staff regularly weighed and recorded people's weight to ensure they were eating sufficient amounts. We saw that some people had been prescribed nutritional supplements and records showed that people were receiving their supplements are required. We saw that people were offered drinks regularly throughout the day and with their meals. This meant that people were supported to eat and drink sufficient amounts to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

People told us and we saw that staff were caring towards people. We saw that staff treated people with care when they were supporting them. One person said, "The staff are very caring towards me, I have no problems at all". Another person said, "I am well looked after". However, we saw that staff were not always available to people when they needed help. For example; one person spilt their drink and shouted for help but staff were not available to make sure they were supported to clean their spilt drink to ensure they were comfortable. We also found staff were not always able to support people with the care they needed because the provider had not ensured that their current needs were recorded to ensure that staff provided the correct care. This meant that people were not always supported in a caring way because the provider had not ensured that people received care that met their needs and lowered the risks of potential harm.

People told us that they were given choices in how and when their care was carried out. One person said, "We can all choose things that we want, like the clothes we wear and the food we want to eat. It is small so we often choose the meals on the day, depending on what we fancy". Another person said, "I choose what I want to wear and staff help me with what I have chosen". We saw that people were given choices throughout the day by staff who were patient and listened to what people wanted. Staff told us they always made sure that people were given choices with everything that they supported them with. One staff member said, "I always ask what people what they want to wear and ask them before I support them with their personal care as some people's independence can change on a daily basis".

People told us that they were treated with dignity and respect when they were being supported by staff. One person said, "I can spend time in my room if I want and staff treat me in a nice way, they speak to me well". Another person said, "The staff and [provider's name] treat me in a nice way. I feel I am given privacy when I want it". We saw that staff spoke with people in a way that respected their dignity, for example; when they asked someone if they needed to use the toilet they asked the person quietly so their dignity was protected. Staff we spoke with were aware of the importance of dignity and were able to explain how they supported people to feel dignified. One member of staff said, "I always make sure I speak with people in a respectful way and I make sure people's dignity and privacy are protected when helping with their personal care".

Requires Improvement

Is the service responsive?

Our findings

We saw that reviews were ineffective and where people's needs had changed the records had not been updated to reflect this. We found that reviews of care plans had been completed and contained signature and dates to show these had been reviewed by the deputy manager. However, we found that care plans did not contain up to date information about people's needs which led to potential inconsistent and unsafe care being provided. For example; one person had suffered a fall in their room. We checked their care plan and risk assessments and found that although these had been reviewed there had been no updates in their care plan to ensure the risk of this person sustaining further falls was reduced. Another person's care records showed that they had been reviewed on a monthly basis, however, the information within the care plan regarding their mobility did not reflect what we saw at the inspection and the person continued to be placed at risk of receiving inconsistent and unsafe care.

People told us that there were some activities on offer such as; exercise to music, board games and trips to the local pub for a meal. However, on the day of the inspection and we saw people watching television and asleep in the lounge areas. We saw that one person was supported to be involved with a board game, but they told us that they would like to do more things in the day to keep them occupied. We did not see that there were any planned activities available for people to keep them occupied or to maintain their emotional wellbeing. Staff told us that they tried to spend time with people but they were not always able to give them their time as they were busy supporting people with their personal care needs. This meant that improvements were needed to enable people to access activities to maintain their emotional health and wellbeing.

We found that although staff knew some areas of people's care needs well, some improvements were needed to ensure there was an accurate record of how people were supported in a consistent way that met their individual needs. For example, staff told us how they needed to support a person at lunch time to alleviate their anxieties by ensuring they were provided with their lunch first. Staff stated that if this person was provided with their meal after other people they would get anxious because they thought they were been given someone else's food. This could lead to the person displaying signs of behaviour that may challenge and the person would not eat their meal. The records we viewed did not contain these important details of how to support this person in a way that met their needs. This meant there was a risk that staff working at the service who did not know this person well may not have the information they needed to support people in accordance with their individual needs and risks.

People told us they knew how to complain. One person said, "I would let staff know if I wasn't happy". We saw that there was an informal suggestions box in the reception areas of the home to encourage feedback from people. We saw that the provider had a complaints policy in place which was available to people and visitors. There was a system in place to log any complaints by the manager. The complaints we viewed had been investigated and acted on in line with the provider's policy and a response had been sent to the complainant.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that systems were not in place to monitor, manage and mitigate risks to people's safety. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had continued to fail to meet the requirements of the regulation.

Risks to service users were not managed and monitored effectively. We found that there were some systems in place to monitor the quality of the service provided. However, we found that the systems were not effective and had not identified the concerns we raised on our inspection. For example; we found that care plan audits had been completed on a monthly basis by the provider and these had not identified that people's care plans did not provide an accurate and up to date records of people's current needs. We found that care plans and risk assessments contained different information about people's needs. The records did not contain sufficient up to date information and staff gave us inconsistent accounts of how they needed to support people. For example; one person was receiving inconsistent support to safely mobilise because staff did not have up to date guidance on how to support this person safely, which had led to inconsistent and unsafe care. This meant that people received inconsistent and unsafe care because the systems in place to ensure care plans were up to date were not effective.

We saw that there was system in place to record incidents and accidents. However, we found that some incidents had not been recorded on an incident form or incident log to enable the manager to audit and analyse incidents. For example; we saw the daily records showed that one person had sustained five injuries and these had not been recorded as an accident and therefore this meant that the provider was unable to analyse the incidents and take actions to lower any further occurrences. The provider and deputy were aware of some of the incidents and they told us that they checked the daily records to ensure actions were taken where incidents were re-occurring, but we did not see that action had been taken to lower risks to people. For example; one person's care records had not been updated and action had not been taken to ensure further incidents were prevented. This meant that the system in place to record, analyse and act on incidents and accidents was not effective.

Staff told us they received supervision on a regular basis, where they discussed any concerns they had regarding the people they supported and their development. One member of staff said, "Supervision is good and I can raise any issues". However, we found that areas that had been discussed in supervisions had not always been acted on. For example; one action that had been recorded was for staff to ensure that records of health visits were recorded, We found that there were still issues with recording and no further action had been taken. We also saw that a development area to motivate people with activities was set. However, we saw a lack of motivation of staff members to encourage people's involvement during the day of the inspection and there were no systems in place for the provider to monitor that staff were undertaking the actions set by the provider. This meant that areas that had been raised in supervisions had not been acted on or followed up to make improvements to the quality of the service.

We found that the systems in place to ensure that staff had sufficient knowledge to carry out support to

people were not effective. For example; staff told us and we saw that they had received training. However, we found that staff and management did not have a clear understanding of how to support people in line with the principles of the Mental capacity Act 2005. We found that there were no systems to assess staff's competency after they had received training. This meant that the provider had failed to ensure staff were trained adequately and were assessed on their abilities to provide effective acre to people who used the service.

The provider forwarded an action plan from the previous inspection on 25 August 2016 and we found that the actions had not been met. The action plan stated that quality monitoring systems and audits were in place to ensure that governance systems would remain effective. We found these systems were not effective and the improvements seen at the inspection on 25 August 2016 had not been sustained and we found further breaches found in Regulations. We spoke with the provider after the inspection and feedback our concerns. The provider was unaware of their failings to meet the regulations and were unable to give a clear explanation as to why the required improvements had not been made. This shows that there is a history of failing to sustain improvements adequately to serious concerns raised by CQC

The above evidence shows that effective systems were not in place to monitor, manage and mitigate risks to people and protect them from harm. Improvements to the quality of the support provided had not been sustained to keep people safe from harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not notifying us of safeguarding concerns. We had been informed of safeguarding concerns from the local authority before the inspection. We noted that these had not been reported to us (CQC) by the provider as required by law. Reporting of incidents enables the commission to monitor the service and to ensure that the provider had taken appropriate action to lower any further incidents. The deputy manager told us they did not realise that they had a duty to report allegations of abuse and thought that this would be completed by the local authority. However, at the last inspection the provider told us that they understood their responsibilities to notify the commission of incidents of abuse but this had not been sustained.

The above evidence shows a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and staff we spoke with told us that the management team were approachable and they were available at the service on a daily basis. One person said, "[Provider's name] is lovely, they come and talk to us. I can tell them anything". Another person said, "The manager is nice and friendly". Staff we spoke with told us that the management were supportive and they could approach them if they had any concerns or needed advice. One staff member said, "[Provider's name] is approachable, things get sorted. The deputy manager is good too and all the management team will provide care if needed". Another member of staff said, "The deputy manager checks what we do and will tell us if we need to do something different. I can approach all the managers and they are all helpful". This meant that people and staff felt able to approach and raise any concerns to the registered manager.