

Mencap in Kirklees

# Castle Hall Residential Care Home

## Inspection report

33 Lee Road  
Ravensthorpe  
Dewsbury  
West Yorkshire  
WF13 3BE

Tel: 01924520270

Website: [www.mencapinkirklees.wordpress.com](http://www.mencapinkirklees.wordpress.com)

Date of inspection visit:

28 June 2018

03 July 2018

Date of publication:

23 August 2018

## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

This inspection took place on 28 June and 3 July 2018 and was unannounced. The service was last inspected on 13 February 2017 was not meeting the regulations related to consent to care and treatment. The registered provider had not always acted in accordance with the MCA (2005) and associated guidance.

After the last inspection in February 2017, the registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. At this inspection we checked to see if improvements had been made and found the registered provider had acted to ensure the requirement improvements had been made and sustained.

Castle Hall Residential Care 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. Castle Hall Residential Care Home accommodates 16 people in one adapted building and there were 16 people living at the home.

Within the constraints of the existing building, the provider had developed and designed the service in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post who had been registered since June 2017. 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.

Medicines management was safe and we observed medicines were administered appropriately during our inspection. There were some minor issues with how medicines were stored which we raised with the registered provider who agreed to address this immediately.

We found all the areas of the home we inspected were clean which ensured the risk of infection was minimised. The registered provider continued to upgrade the environment internally, with new carpets, furniture and décor.

We found decision specific capacity assessments had been carried out for people who lacked mental capacity to consent to aspects of their care delivery. These were compliant with the Mental Capacity Act 2005 (MCA). Staff understood the principles of the MCA and how to ensure people's human rights were respected when making decisions on their behalf.

People had been referred to other health professionals when the need arose and we saw this had positively

affected people's wellbeing.

We observed staff were very kind and caring when they were supporting people with care. People at the home who could verbalise their views, told us how kind and 'brilliant' staff were and how they treated people with dignity and respect.

Positive relationships between staff and people were evident. People's independence was promoted well by staff who understood how to maximise their independence.

There was clear evidence of person-centred care and records contained information detailing people's life histories, preferences and choices. Care plans were complicated due to the amount of information they contained. Plans were in place to make these more user friendly to provide the guidance staff required to support person centred care.

People were involved in activities based upon their established routines and preferences.

Management was visible in the service and communication was open, honest and transparent. Staff had clear direction and were sure about their roles and responsibilities. Systems and processes for ensuring the quality of the service had been updated to ensure improvements were sustained. New systems ensured the service continued to improve against nationally recognised evidence based standards of care for people living with a learning disability.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Systems were in place for recording and managing risk, safeguarding concerns, whistleblowing and incidents and accidents.

The service used positive risk management to ensure risk was assessed and managed without overly restricting people's freedoms.

The service had systems in place to ensure the safe administration of medicines. There were minor issues with the storage of medicines.

### Is the service effective?

Good ●

The service was effective.

Staff received a thorough induction and training to ensure they had the skills and knowledge to meet people's needs.

The service was working to the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People enjoyed their meals and the home was prioritising healthy eating choices in their new menu plans, which would also be produced in easy read formats.

### Is the service caring?

Good ●

The service was caring.

People told us they were happy living there and were complimentary about the staff who cared for them.

People were supported by staff who knew them well and were keen to enhance people's well-being and independence.

We saw people were treated with dignity, respect and their human rights were respected.

### Is the service responsive?

Good ●

The service was responsive

People were involved in activities based upon their established routines and preferences

People were involved in their care planning when appropriate and families consulted with where appropriate to ensure preferences and views were considered when devising support plans.

People's care needs were regularly reviewed to ensure changing needs were identified and responded to.

### Is the service well-led?

Good ●

The service was well-led.

Staff were engaged with the changes at the service to drive up improvement to provide a quality service for the people living there.

The quality assurance systems showed effective analysis and oversight to promote change and improvement.

Partnership working was evident in relation to external health and social care services alongside the local community.

# Castle Hall Residential Care 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 28 June and 3 July 2018 and was unannounced on the first day. This inspection was undertaken by one adult social care inspector.

We reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider. We contacted the local authority commissioning and monitoring team, the fire service, the infection control teams and reviewed all the safeguarding information regarding the service.

Before the inspection, we asked the provider to complete 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 spoke with the Chief Executive officer (CEO), the group operations manager, two care staff, the chef and a housekeeper. We spoke with five people using the service. We reviewed four care records, three recruitment records and checked several medicine administration records. We looked at the quality assurance systems and records in relation to maintenance at the home.

# Is the service safe?

## Our findings

Those people who were able to verbalise told us they felt safe at the home. We received comments such as, "Safe," "Happy", "Brilliant staff."

We asked staff about their understanding of safeguarding. They demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff told us how they had supported a person using the service to raise a concern about a member of staff. This led to a positive outcome for the person using the service. The staff member said in relation to the action taken by the provider, "It was the right decision. The staff member no longer works here." There were posters in the building to direct people to a telephone number to contact if they had information and they wanted to 'whistle blow.' A whistle blower is someone who reports concerns about unsafe or illegal practices in the work place.

People had dependency level assessments in their care records and we found there were enough staff on duty to meet people's needs and keep them safe. Staffing levels were assessed daily and allowed for flexibility to support people to go on trips and with appointments. Staffing levels had increased during the night following advice from the fire service, which demonstrated the registered provider acted responsibly. Night staffing levels were under review, to ensure sustainability of the service.

The registered provider used a positive approach to risk, where this was appropriate. This recognised risk taking can have positive benefits for individuals, enabling them to do things which most people take for granted such as going out to the shops. The registered provider minimised other risks such as choking, medication and moving and handling by assessing the risk and minimising it by putting in measures to protect people. We found standardised risk assessments to assess the risk of a person developing a pressure ulcer and the risk of malnutrition were in place where required. Staff could explain to us how they assessed and managed risks daily for one person with complex needs. This showed us they understood the importance of managing risks to people and how this keeps them safe from harm. Risk assessments were recorded in people's care plans and were evaluated regularly. We did find one person's risk assessments required updating following some recent changes to their health and this had been completed by the second day of inspection.

We asked the operational manager how they investigated accidents and incidents to learn lessons and make improvements to people's safety. Accident and incidents were recorded and analysed and the registered provider had a system in place for sharing learning across the organisation through management meetings. Information was shared with staff at team meetings to ensure incidents were discussed and to raise awareness to prevent recurrence.

Fire alarms were tested regularly and equipment such as extinguishers were checked by an external contractor. We found systems and processes were in place to ensure people's safety in the event of a fire. People had a personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. These were detailed and contained information

on how to support people and which zone to evacuate to, if the need arose. As part of our planning of this inspection we contacted the fire service who told us the provider's chief executive officer had contacted them in 2017 to request a visit to their service. When the fire service visited they found issues with staff training, drills and risk assessment. They told us the provider had acted responsively and rectified all the issues and when they revisited the provider was compliant with all the fire regulations. This meant the provider had proactively sought advice to ensure people were safe from the risk associated with fire.

Equipment and premises checks were in place including electrical and gas safety checks. The through floor lift between floors and moving and handling equipment had been checked as required under the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998. Work was due to commence to remove asbestos in the boiler room which meant there would be no hot water from the boiler. Contingency arrangements had been put in place to minimise the disruption to people at the home, although it was appreciated, preferences in relation to baths would not be met for the short period the boiler was out of action.

We looked to see how the service was managing people's medicines including the ordering, storing, administering and disposal of medicines. Medicines were safely administered and the systems in place to manage this were effective, although there were some minor areas which required improving. For example, there was an issue with the key code lock into the medicines room and not all creams had been dated upon opening. At a previous inspection we found staff had not always recorded the opening dates on creams and although this had improved at our last inspection, it was concerning this remained an issue. We raised this with the group operational manager who acted upon this immediately.

Some prescription medicines contain drugs (Controlled Drugs) that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We checked the controlled medicines register with the senior administering medicines and found all medicines were accurately recorded.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) check, reviews of people's employment history and two references had been received for each candidate. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. People living at the home had been involved in the interview process for new staff which demonstrated people were involved in the running of the home.

Cleaning schedules and records showed regular cleaning took place at defined intervals and we observed the housekeeper's systematic approach to infection prevention and control. Staff wore personal protective equipment (PPE), such as disposable aprons and gloves, and there were readily available for staff to access.



# 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. 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our inspection in February 2017 we found there was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The provider had not always acted in accordance with the MCA (2005) and guidance. They had failed to apply for DoLS when previous authorisations had expired, and they had not always ensured conditions of DoLS had been met. As a response the provider completed a log of DoLS applications, authorisations or reasons for declining the authorisation, dates of expiry and any conditions applied to ensure the above issues did not happen again. At this inspection we checked for improvements. We found the registered manager had appropriately applied for new DoLS before the expiry dates and they were waiting for the outcome of these decisions. Shortly after the inspection they notified us of six authorisations. One authorisation had a condition attached, which the provider had met.

We found decision specific assessments around medication, personal care and consent to day care. Restrictions to liberty was also considered such as lap belts and bed rails. Staff could describe the principles of the Act and understood the importance of assessing mental capacity to ensure they were providing care lawfully. Staff also understood the importance of helping people to make their own decisions including what to wear by showing them suitable items of clothing for the current weather.

Staff were provided with training and support to ensure they could meet people's needs effectively. The group operational manager told us they had recently trialled and reviewed all the training provided for staff to check its appropriateness. As a result, they had determined some courses were not appropriate and they had purchased more suitable courses to ensure staff gained the right level of skills and knowledge for their roles. This included changing some online courses to classroom based courses because of their analysis. They had tried a new way of inducting new staff by providing a full fortnight of training every six weeks to ensure new staff received all their training before starting work in the home so "We know they have all had the training." They had opened up the sessions to existing staff to do the parts of the training they required refreshing. Staff received regular supervision to help them to develop in their roles, and staff appraisals were planned to take place. Developing staff was one of the priorities of the new group operations manager as they recognised the importance of good training, supervision, and appraisal on providing a motivated, challenged, aspiring workforce.

Staff could tell us which people were at risk of malnutrition and what actions they were to take to ensure this was well managed. One said, "Weekly weights, fortified diet and a referral to the dietician." We observed staff supporting several people with their meal which they undertook with patience to ensure the person

was given time to eat in accordance with guidance provided. There was a picture menu book in the dining area and staff placed pictures next to the menu board outside the dining room to assist choice. We observed people's lunchtime experience in the communal dining area and could see people were enjoying their meals with an option of a hot meal and salad. They had the choice of going up to the counter for their meals or being served at the table. People were offered choice and one person was offered a different meal when it was noted they were not eating. People told us they liked the food on offer. One person said, "Nice and tasty," and we saw they ate a second helping. Another person told us, "The food is very nice. Lovely." People enjoyed ice cream for dessert and there was fresh fruit available. Plans were in place to review the menus to ensure they were more seasonal, with photos menus of the new meals put on the table and on the board outside the dining area.

The CEO used evidence based guidance when developing and updating policies and procedures. They also kept up to date with current guidance, by subscribing to relevant magazines, providing practical information and downloads to support best practice. The CEO was a member of the Skills for Care network, and attended Skills for Care events. They utilised CQC website and email alerts to gather information and they attended local networks and fora to share good practice to assist them to continuously improve their service.

We saw evidence staff had involved a multitude of professionals to care for people at the service. For example, the community learning disability team, dietician, speech and language therapists, occupational therapists, podiatrists, and opticians. Several people at the home had recently been assessed for more suitable seating and as part of the process, visited the local factory to see where these were made. People showed us their chairs with pride, clearly delighted by these new purchases. Where people required specialist equipment we saw referrals had been made to ensure the registered provider continued to meet their health and wellbeing

People had been supported to change bedrooms, when their disability progressed to allow improved access and more space for hoisting and wheelchair accessibility. Bedroom sizes were generous although without en-suite facilities. The service is in a large two storey building, which needed some modernisation. Plans had been in place to fully adapt the building and to make it more fit for purpose as a home for people with a varying degree of physical and learning disability. However, the owner of the building had decided not to progress with these plans and instead the registered provider was in discussions with local commissioners about a new purpose-built scheme. This would provide a more supported living arrangement for some people and to provide services in line with Registering the Right Support.

## Is the service caring?

### Our findings

We observed staff were very kind and caring when they were supporting people with care. People at the home told us how kind and helpful staff were and how they treated people with dignity and respect. One person said, "Staff are spot on. They listen to us. All staff are patient." Another person told us, "All the staff here are beautiful. Every one of them. They all help me getting dressed."

People said staff respected their privacy and treated them with respect. Staff told us they protected people's privacy for example, by protecting people's modesty when providing personal care. Ensuring they asked people discreetly if they needed to use the toilet and always knocking on people's doors before entering. Interactions between staff and the people living in the home were warm, friendly and caring. Everybody was addressed by their first name, although we did witness one member of staff refer to people in a way which was not person-centred. This was an isolated incident. People talked about staff in a friendly way, and were keen to tell us about a well-liked member of staff who was due on shift that afternoon. A member of staff had previously been a dignity champion but they had left the service "a few months ago." A senior member of staff told us they were trying to recruit a new dignity champion from the current staff.

A senior member of staff told us they ensured staff provided person centred care through discussions about care. They said, "We talk about these things in handover. If I saw anything that wasn't quite right, I'd speak with the person in a quiet place, straight away." Most people had personalised their rooms and created a very personal, comfortable space for themselves. Staff had supported people to identify their rooms with a picture of something they liked on their door, such as a picture of a watch or picture of singing. One person who had only just moved in had a very sparse room, and we raised our concerns with the management team, who said they had identified this and would ensure it was personalised to their taste.

Staff supported people to express their views and be actively involved in making decisions about their care and support. For example, one person had a "suitable bag of objects" following advice from the Learning Disability Team to help them understand the task or activity involved. We asked staff about this and we were shown these objects. For example, a roll of toilet paper indicated personal care, a bowl represented mealtimes. One member of staff told us they showed picture cards to a person who could nod and point to let staff know their preference. This showed the provider was considering the best way to communicate with people whose cues were not verbal communication.

People were supported to remain independent and gain new skills. This included one person who supported the kitchen staff to prepare meals and clean up afterwards. We were told, "This has given them a real sense of purpose and self-worth and their whole demeanour changed." Their long-term goal was to move to supported living and this type of involvement, ensured they gained confidence in independent living skills.

People's equality, diversity and human rights were maintained and our discussions with staff confirmed they understood the importance of respecting these rights. Spiritual needs were recorded in people's care plans and consideration was given to supporting people to practice their religion.

## Is the service responsive?

### Our findings

People had access to a lovely outdoor garden with seating areas, lighting and planters. Their involvement in developing the garden was evident and they had great pleasure in showing us the areas they had planted. The service had recently won an award from Kirklees Driving Quality programme for their gardening project. They had used old furniture to create planters, which they also sold to raise funds. One person told us proudly, "We won a gardening competition last week."

The provider supported people to have meaningful occupation throughout the day, which involved supporting people to day care or providing activities within the home. We asked people about the activities on offer. One said, "They are good here. They come from Branches (day centre) to do quizzes, games and bingo. Another person told us, "I do jigsaws and puzzle books. We observed some activities taking place on the day of our inspection, including indoor ball games. The group operations manager told us the focus for some people now was organising holidays. Two people had arranged a trip to the seaside for the following week and would be accompanied by staff. They had been involved in choosing their holiday. Planning for two other people to go on holiday was in consideration.

We checked to see how the service ensured a person's care plan fully reflected their physical, mental, emotional and social needs. We found evidence to support people's preferences, interests and aspirations were reflected in their care plans to ensure staff could offer them as much choice and control as feasible. However, the care plans were complicated with many sections, which mirrored other sections. The operational manager told us since taking up post they recognised care plans were complicated for staff to read and had commenced plans to simplify these. They had initiated a one-page profile to give staff an easy read summary of essential guidance to enable them to care for the person. Records were written in a way which reflected the person's preferences such as how they would like their care to be provided. These were evaluated and where changes were made, these had been added to the care plan although out of date information had not always been removed.

One person's whose needs had changed significantly had a care plan which had not been updated. However, between our two assessment dates, this had been completely updated and out of date information removed. We found a gap in one person's pressure ulcer prevention checklist kept in their bedroom. All the other care plans we looked were up to date. Simplifying the care plans in line with the expectations of the new regional group manager would ensure updating in between reviews was made easier for staff ensuring consistency in the different sections.

People who could tell us, said they had been involved in the care planning process, and were continuously involved in decisions about their care and how these needs were met. This showed they received care that was responsive to their needs and preferences. Staff told us they went through care plans with people and we could see some people had signed their care plans.

We asked the operations manager how they were implementing the requirements of the Accessible Information Standard. This requires them to ask, record, flag and share information about people's

communication needs and take steps to ensure that people receive information, which they can access and understand, and receive communication support if they need it. Although they were unaware of the requirements of the standard they told us and we saw a person's communication needs were recorded in their care plan with detailed instructions on how best to communicate with the person. We saw documents which would accompany people to hospital such as Hospital Passports. A hospital passport provides useful information about any communication, anxieties, likes and dislikes. Staff were aware of people's individual communication methods and could explain these to us in detail. Information was provided to people in easy read formats to ensure accessibility.

We talked with the management team on how they were using technology to support people at the service. They told us they had in the past used "Just checking" which enabled them to build a picture of a person's day through electronic monitoring. We saw one person at risk of falls had a pendant alarm to alert staff if they required assistance. Staff used a "tablet" to help some people do their Christmas shopping. The CEO recognised this was an ever-changing landscape and they needed to keep abreast of the changes to ensure they maximised technology to support people at their home

There was a complaints policy in place and there were signs up throughout the building on how people could complain. We asked people if they were confident to speak up if they had any complaints or concerns about the service and how they would do this. One person said, "They have slips. I've never used one. We can't complain." They told us how responsive the provider was to their views. They said, "We have a residents meeting to air our views. We brought up all residents need new chair. They bought them."

We found Do Not Attempt Cardiac Pulmonary Resuscitation forms in place for people. This means in the event of a cardiac arrest staff should not attempt to resuscitate them. We also saw recorded evidence of people's wishes regarding their end of life care including funeral arrangements. Recording this information helps staff to follow people's wishes once they reach this stage of life. The CEO spoke genuinely with us about the home being a home for life for those people who had reached the end of their lives and where it was possible to do so they accommodated people's wishes to remain in their home throughout their lives.

# Is the service well-led?

## Our findings

There was a registered manager in post at the time of the inspection, but they were absent whilst we were onsite at the home. The group operational manager and the CEO provided information during our onsite inspection. They discussed their ongoing plans to develop the home and evidenced how they were encouraging continuous improvement through quality assurance processes. The group operational manager had changed the way they were monitoring the home and were auditing against CQC key lines of enquiries as a benchmark. They talked with us about their plans to arrange an away day for senior staff to facilitate improved supervision, return to work discussions, managing difficult staff and around leadership. They used coaching principles to develop staff. They had challenged the existing culture at the home, involved staff in discussions about change and were promoting a positive culture that was person-centred, open, inclusive and empowering. The CEO of the organisation said the management team worked well together and with the enthusiasm of the registered manager, positive change was happening. This was impacting positively on people at the home.

Our discussions with the CEO confirmed they were considering improving outcomes for people in line with 'Registering the Right Support' for people with learning disabilities and they were in talks with commissioners about providing an extra care/supported living service where people with the abilities to live more independently were offered this opportunity. However, they also recognised the importance of providing a "home for life" supporting people they cared for as they developed disabilities associated with ageing. This provided the service with challenges supporting people with a wide range of physical and learning disabilities.

Staff told us how approachable the management team were. One member of staff told us there had been many managers but they now felt settled with the registered manager. They said the operational group manager has, "Some new ideas," which they saw in a positive light to develop the home. Another member of staff said the registered manager had, "helped to organise things better to make things more simple. She has made some of the paperwork easier. She has cleared the home out and made the activities room." We asked staff what they would change if they could, and one member of staff said, "Less paperwork" whilst another said, "More staff." The group operations manager had plans in place in respect of both these suggestions and gave us examples of other actions they had put in place from staff suggestions.

We inspected records of lift, hoist and sling servicing and testing which recorded all maintenance checks had taken place. We also reviewed audits which confirmed electrical hard wiring and gas services had recently taken place and testing was up to date. We saw audits were maintained in relation to premises and equipment. Mattress audits were undertaken weekly and were thorough. We did see some gaps in other checks records which had not been picked up through daily checks by senior staff such as a gap in bath water temperature records. We also found a shower chair had slight rust close to the castors, although it wasn't clear what action had been taken to rectify this. In addition, one of the upstairs windows was wide open. On further examination, we found the restrictor had been bypassed and the group operational manager determined this had been done by one person living there (although it was difficult to work out how they had done this). The group operational manager told us they would ensure these were added to the

seniors daily walk around to ensure all risks to people were minimised by effective controls.

We looked at the arrangements that were in place for managing accidents and incidents and preventing the risk of re-occurrence, the registered provider was accredited to a nationally recognised quality management system which means they must demonstrate they learn and continuously improve and this is checked through an external audit. The CEO told us every month they held a management meeting and managers send a service report which included accidents, incidents and near misses. Through this forum, lessons are shared to help managers throughout the organisation provide safe care.

The provider worked in partnership with the local community and other organisations. For example, during the recent learning disability week they opened their gardens to the local community for the annual garden party. As well as people from other Mencap in Kirklees services attending, they were joined by people who use the local authority day services in the area. They also attended the Registered Managers Network in Huddersfield to share good practice to continuously improve their service. They also regularly attended the Kirklees Council Good Practice events. The most recent was relation to infection prevention and control. They attended the Learning Disability Provider Forum where local providers meet the local authority commissioner and contracts manager every month and they also attended the Learning Disability Partnership Board monthly. The Group Manager was a member of the Board of Trustees of the Local Healthwatch as a partner organisation.

The provider sought feedback from people in an annual survey. They sent us the most recent one following our inspection which showed this information had been presented to people in an easy read format. People were positive about the service and the staff providing their care.

The previous inspection ratings were displayed on the registered provider's website and at the service. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.