Redhouse Nursing Home (UK) Limited

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Inspection report

55 Redhouse Street
Walsall
West Midlands
WS1 4BQ

Tel: 01922616364
Website: www.redhousenursinghome.com

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 15 May 2017. At our last inspection on 23 and 24 November 2015 we rated the provider as 'requires improvement' overall. Redhouse Nursing Home provides accommodation for up to 34 people who may have nursing needs. At the time of our inspection there were 31 people living at the home.

At the time of our inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although people told us they felt safe living at Redhouse, people were not always protected from harm because risks to their health and safety were not always managed safely. People did not always receive their medicines as prescribed. The registered manager had failed to take appropriate action when potential safeguarding incidents occurred. People told us there were times when there were insufficient staff to meet their needs. The provider had a safe recruitment system which meant staff employed at Redhouse were safe to work with vulnerable people.

People's rights were protected as the registered manager had applied the principles of The Mental Capacity Act, however people told us and we saw staff did not always seek consent before providing care. People had mixed views whether staff had received training to support them. We saw some of the training staff received was not effective.

People told us they were happy with the food at Redhouse and they got choices in their diet. People and their relatives told us and we saw people had access to other healthcare professionals to help them maintain good health.

Staff did not always have the time to spend with people but people told us when they did staff were kind and caring. Staff did not always support people in a dignified way. People told us staff encouraged them where possible to remain independent.

People did not always receive care which was responsive to their individual needs. People did not have access to activities because staff did not have the time to spend with them. There was a system in place should people wish to make a complaint.

The quality assurance system in place was not effective and failed to identify and act on issues that were on-going. Some of the issues that had not been acted on placed people at risk. The systems in place had failed to identify when issues identified at previous inspections remained unresolved. People and their relatives told us they knew the registered manager well and were happy at Redhouse. Staff told us they were

supported by the registered manager and felt there was a positive culture within the home.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's health and safety were not always managed safely. People did not always get their medicines as prescribed. Staff understood how to protect people from harm but the registered manager did not always report potential safeguarding incidents to the local authority. People told us there were times when there were insufficient staff to meet their needs. The provider operated a safe recruitment system.

Is the service effective?

Requires Improvement

The service was not always effective.

Training staff received had not embedded into their practice. People's rights were protected through the effective use of the Mental Capacity Act. People's nutritional needs were met. People had access to other healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us and we saw staff did not have the time to spend with people. People were supported by staff who did not always respect their dignity. People told us staff were kind and caring. People were supported by staff who encouraged their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have access to meaningful activities. People's individual needs were not always met. The provider had a system in place should people and their relatives wish to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance system operated by the provider was ineffective. Issues noted and identified at previous inspections and some issues noted by the registered manager had not been acted on to ensure people received safe care and support. People and their relatives spoke positively about the registered manager and how they managed the home. Staff felt supported and involved in the running of the service.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 May 2017 and was unannounced. The inspection team consisted of one inspector, one expert by experience and one specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of medicine management and working with older people and people living with dementia.

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.

As part of the inspection we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We asked for feedback from the Commissioners of people's care to find out their views on the quality of the service. We also contacted the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection we spoke with five people who used the service and three relatives. We spoke with the registered manager and six members of staff and a visiting health professional. We carried out observations throughout the day to help us understand the experiences of the people who lived there. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care and medicine records for four people.

We looked at other records relating to the management of the home. These included staff files, accident reports, complaint logs and audits carried out by the registered manager.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in November 2015 we rated the provider as 'requires improvement' under the key question 'Is the service safe?' This was because there was not always sufficient staff to meet people's needs. At this inspection we found the required improvements had not been made in this area and in other areas the provider was not now meeting the requirements of the law.

Although people told us they felt safe living at Redhouse we saw people's risks were not always managed safely. Staff explained to us how they managed risks to people's safety. However we saw they did not consistently provide care to people in the way which they described. For example, we saw one person who was at risk of choking and staff had to thicken fluids to reduce the risk to the person. We saw staff gave this person fluids which appeared not to be the correct consistency which resulted in the person coughing and going red in the face. We asked staff what quantity of thickener had been added to the person's drink to ensure it was safe for them. Staff were unable to give us consistent answers about the quantity of thickener needed to ensure the drink was of the correct consistency to prevent the person from choking. The registered manager was unable to confirm the amount of thickener added to this person's drink as it was not recorded after it had been given. The registered manager told us all the people who have their fluids thickened were on 'syrup thick' fluids should have one scoop to 200mls of fluid, some staff told us they use half a scoop which would mean the fluid was not thick enough and would increase the person's risk of choking. Following our discussions with staff we then observed a member of staff attempt to give the person their thickened fluid using a syringe which may have caused harm. The member of staff told us this was because they could not drink the liquid from the drinking cup because the liquid was too thick. We spoke with the registered manager about this who was not able to give us a reason why staff were unaware of the correct consistency. The registered manager told us there were drinking cups available to staff for people to use when their fluids were thickened and could not explain why staff were not using them. The registered manager told us they would address this with further training for all staff.

People were not protected from the risk of harm because we found one person had sustained bruises when they had bed rails to keep them safe. Staff told us this person had always had bumpers to protect them and they should be the full length of the rail so as they don't harm themselves. We checked the person's risk assessment that had not been fully completed by staff but did confirm full bumpers should be fitted. The registered manager documented on the accident record following the incident they had applied bumpers to the rails. The registered manager could not give us an explanation as to why there were no bumpers in place when the person sustained the injury. They continued to tell us all people living at Redhouse should have full length bumpers fitted to their bed to protect them from injury. On the day of our inspection we saw short bedrail bumpers were still in place in four people's rooms. We made the registered manager aware of our findings and although they could not offer an explanation about the reason for the failing they told us this would be addressed immediately.

Although people told us they received their medicines as prescribed, we saw the administration was not always consistent. One person told us, "They give it [medicine] to me on time. They never miss it". Staff told us only the trained nurses gave people their medicines. We saw people were not always given their

medicines as prescribed. For example, we saw the nurse on duty take one person's blood sugar level and then administer their medicine after having their breakfast. Records we saw confirmed this person's medicine and blood sugar level should be taken prior to food. We spoke to the nurse who told us, "I don't normally do that. The manager told me blood sugars should always be done pre meals". They were unable to offer an explanation as to why they had administered it different on this occasion. Records confirmed this person's blood sugar level should be taken pre meals. From records we saw that on occasions their blood sugar level had been taken at a time which indicated they were taken after meals. We saw on nine occasions this person's blood sugar levels were higher than their recommended levels. We looked at the guidance in place for staff to follow in this person's care plan. It stated if their blood sugar level exceeded a certain level further medical advice should be sought. We saw on the nine occasions it recorded that it was above the recommended level for this person and we could not be assured further medical advice specifically regarding their blood sugar levels had been sought. Whilst we saw this person was well, we saw that staff did not following guidance in the person's care plan and poor practices had being adopted by staff.

We saw another member of staff signed people's medicine records to say they had been given their medicine prior to administering it. The member of staff told us they recognised this was not procedure but did not want to forget to sign the record afterwards. This meant people's medicine records may not always be an accurate reflection of the medicines they had been administered. The registered manager acknowledged that this was incorrect and advised that they would speak with the nurse about their practice.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Although staff knew how to protect people from harm by reporting concerns to the registered manager we found on two separate occasions the registered manager had failed to protect people by making a referral to the local safeguarding authority.

At our last inspection in November 2015 we found there were times when there were insufficient staff numbers on duty to support people. At this inspection we found the required improvements had not been made. People told us there were times when there was insufficient staff to support them. One person said, "If I want to go to the toilet I have to wait for someone to take me". Another person commented they had to wait for longer periods for staff in their room when they used the nurse call system (buzzer) but in the lounge staff were more available to them. Relatives told us they didn't think there were sufficient staff to support their family members. One commented, "Sometimes they do seem short staffed". We saw people spent long periods of time with no interaction from staff. For example, we saw one person sat alone in a lounge for most of the day and the only interaction from staff was to support them with food or drink. We discussed this with the registered manager who told us staff did usually have more time to spend with this person but on the day of our inspection a member of staff had called in sick. We asked a member of staff how staffing levels were calculated. They told us they didn't have a formal method of calculating staffing levels but they looked at the dependency levels of the people living at Redhouse. There was no formal processes in place to ensure people were supported by a sufficient number of staff.

We looked at the recruitment system operated by the provider to ensure people were supported by staff who were suitable to work with vulnerable people. Most staff we spoke with had worked at the service a number of years. One more recently recruited member of staff told us they had brought in documents and had to wait for legal checks to be completed before they commenced their role. We looked at two staff files which confirmed the provider had a safe recruitment system in place. We saw Disclosure and Barring Checks

(DBS) had been obtained prior to staff commencing their role. We saw references had been sought and documents to prove their identification were present. We saw evidence staff had been interviewed for their position. This meant the provider had a safe recruitment system in place which meant staff were safe to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2015 we rated the provider as 'requires improvement' under the key question 'Is the service effective?' This was because the principles of the Mental Capacity Act had not been embedded into the practice into the home. At this inspection we found the required improvements had been made in this area but in other areas improvements were still required.

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. At this inspection we found staff had received training and were able to tell us how the principles of the Act affected peoples care. One member of staff told us, "It's about people not being able to make decisions for themselves and how other people make it in their best interests". Staff explained to us how they knew people who could make decisions themselves and how some people sometimes required more encouragement but ultimately made choices about their care themselves. We saw when people lacked capacity to make a decision for themselves the registered manager had consulted others involved in their care to ensure any decisions were made in their best interest. For example, the registered manager had involved family members in the decision for one person who lacked capacity to make a decision about their safety due to an increased amount of falls. The decision was made with family members to care for the person in bed for their own safety.

We received mixed views from people if staff sought their consent before providing any care. One person told us, "Oh yes, most times they ask". Another person commented, "No they don't explain what they are going to do". Although staff told us they sought permission from people before providing any care we saw occasions when staff did not seek people's consent before providing care. For example, we saw a member of staff putting aprons on people to protect their clothing at mealtimes. We saw no consent or agreement was sought from people. The registered manager had not ensured that all staff had the knowledge and skills to understand the need to gain consent from people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty so they remain safe. Staff were aware some applications had been made and understood how the authorisation affected people's care. The registered manager had applied to the supervisory body to deprive 15 people of their liberty. Only two of the applications have been authorised by the supervisory body at the time of our inspection. We looked at the records and saw staff were working within the guidelines of the authorisations.

We received mixed views from people about whether staff had the knowledge to provide effective support which met their needs. One person commented, "Sometimes I need two people to help me". Another person told us they didn't think staff had the right training to meet their needs. Staff we spoke to told us they had

received training which enabled them to provide support to meet individual's needs. One member of staff told us, "The training helps me do my job". Another member of staff told us the registered manager encouraged them to take further training courses such as wound care and catheter care to help them support people living in Redhouse. They told us they had applied to go on further training to develop their knowledge and received support from the registered manager. However whilst we saw some of the training was effective to help support people with the care they needed we saw this was not consistent across all staff. The registered manager told us staff had received training from the company who supplied the thickener prescribed by their doctor. This training had not been effective as staff had mixed opinions on how to thicken people's fluids so as to reduce the risk of choking. The registered manager told us they would organise further training so all staff were clear about thickening people's fluids. The registered manager had not ensured that all the training the staff received was effective in providing people with good care. One recently recruited member of staff told us they received a thorough induction before commencing their role. This involved shadowing [working alongside] senior members of staff up to the point they felt confident in supporting people themselves. They told us because they had not worked in a care environment prior to Redhouse they had been allowed time to develop their confidence before working alone.

People told us they were happy with the food they received at Redhouse and that they had choices in their daily menus. One person told us "I can have what I want to eat". Another person told us they had followed a particular diet before coming to live at Redhouse and staff had respected their choice and ensured they still had choices in their diet. One person who chose to eat in their bedroom told us although there was a choice it took staff a long time to deliver their food. We spoke to the cook who knew people's dietary needs well and was able to share with us who was on special diets and how they ensured their dietary requirements were met. We saw the cook mixed with people at mealtimes chatting and asking what they required. Records we looked at demonstrated where people had any nutritional risks these were documented and action taken to ensure the risks were managed. People told us and we saw drinks were available throughout the day. One person commented, "You get plenty to drink". People were supported by staff to meet their nutritional needs.

People and their relatives told us they were supported to access other health professionals when they required further support. One person said, "When I had a chesty cold they got the doctor out. They always do if you need one". Relatives told us staff supported their family members to stay healthy but sought other healthcare professionals if needed. One relative told us staff monitored their family member's weight as they were losing too much and staff had sought advice from healthcare professionals resulting in the person's weight improving. We spoke with one visiting professional who attended the home on a regular basis. They praised the staff at Redhouse and told us when they gave staff guidance on how to manage a health condition staff followed their instructions which meant people's health improved. People were supported to maintain their health and when required were supported to access healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2015 we rated the provider as 'requires improvement' under the key question 'Is the service caring?' This was because staff did not have the time to spend with people. At this inspection we saw the required improvements had not been made and in other areas improvements were now required.

People raised concerns at our previous inspection about the lack of time staff had to spend with people. At this inspection despite our previous inspection the registered manager had failed to ensure there were staff available to spend time with people. One person told us, "There's always someone off sick". Another person told us, "They would know more about me if they had the time [to spend with me]". We saw people spent long periods of time with little interaction from staff. We saw staff only had time to speak to people in passing but not to spend time with them because they were busy supporting other people. Whilst people shared with us when staff did have the time to speak to them they were kind and caring. We saw there were missed opportunities for staff to enhance their interaction with people when staff were focussed on completing a task. For example, we saw staff had the time to ask one person how they were and to offer a drink. The person responded with a happy smile however the member of staff left without spending any time with the person to chat about their day or anything of interest to the person. We saw some examples of staff being caring but this practice was not consistently demonstrated by all the staff on duty. For example, we saw one member of staff went to get a blanket to ensure one person was comfortable. However another member of staff appeared not to acknowledge a person who was sitting in their chair un-comfortably whilst being supported to eat and the staff member took no action to adjust the person's posture.

People told us they were offered choices about the care they received. One person said, "Yes I have choices, I have a shower on a Wednesday, but I could have it when I want". Staff gave us examples of how they offered people choices in their daily care. For example, we saw staff offered people choices of where they would like to sit or what they would like to drink.

People told us staff respected their privacy and dignity. One person said, "Oh yes they make sure they shut the door". Another person told us staff respected their dignity by always calling them the name they preferred. Relatives confirmed what their family members had told us. Staff gave us examples of how they respected people's privacy and dignity. For example, asking them quietly if they needed support with their personal care. However, this was not consistent across all staff. . For example, we saw one person supporting a person to eat and instead of concentrating on them they spoke with the registered manager over them and at the same time. We saw a member of staff not treating a person with respect or in a dignified manner. We noted the person was not taking an interest in eating and the member of staff called to another member of staff across the dining room, "They [referring to the person they were supporting]are having me on here". The registered manager had not ensured all the staff had the skills to respect people's dignity in Redhouse.

People told us staff encouraged them to remain independent. One person told us they had been given an adapted cup which meant they could pick it up with both hands which promoted their independence. Staff

gave us examples of how they encouraged people to remain independent, such as not completing all their personal care and encouraging people who were able to do so themselves. People were encouraged to maintain independent living skills where possible.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2015 we rated the provider as 'requires improvement' under the key question 'Is the service responsive?' This was because people did not have access to activities to spend their time. At this inspection whilst we saw some improvements had taken place we saw improvements were still required to ensure people received care which was responsive to their individual needs.

People and their relatives told us there weren't many opportunities for them to spend their time doing activities that interested them. One person told us they used to attend painting classes and would prefer to do this rather than sit in front of the television all day. They continued by telling us, "Sometimes I just go to sleep because I am bored". A relative told us, "There used to be entertainment but you don't see much of that anymore". Staff told us because there were always staff shortages they didn't have the time to do activities with people. We saw some people joined in with an organised activity, during the morning of our inspection. However, we saw people spent most of their time sitting down with no interaction from staff. We spoke with the activity co-ordinator about how they planned activities which were meaningful for people to enjoy. Although we saw a list offering activities we saw the staff did not have the time to spend with people. The registered manager told us the activity coordinator had been asked to provide cover for a member of care staff who had called in sick during the afternoon. The registered manager had failed to ensure people had support and access to meaningful activities to spend their time.

People and their relatives told us they were involved in making decisions related to their care and routines. One person told us they were involved in decisions about their care and this was reviewed on a regular basis. They told us they could decide when they got up and when they went to bed each day. Another person commented they had choices about their care and could choose when they wanted to have a shower and staff respected their choice.

Relatives told us staff knew their family members well and they felt involved in their care. Because most staff had worked at Redhouse for a number of years they knew people well and were able to explain to us how they provided care which met peoples individual needs. However, we saw not all staff delivered care which was consistent with people's choices. For example, we saw one person drank out of a mug at breakfast. Later in the day we saw a member of staff gave this person a drinking cup with handles and a spout. The person told us it wasn't their normal choice but added that they didn't mind. Another member of staff saw this and gave the person a drink in the cup of their choice. We saw one person who wasn't able to make their own choices about their care needs was left for the majority of the day in a room by themselves. Staff told us this was because they shouted a lot and upset other people living in Redhouse. We spoke with the registered manager about this person who told us they liked staff to sit with them and hold their hand and speak to them. However on the day of our inspection we saw no staff were available to spend any time with this person and support them as described by the manager. This person spent the majority of our inspection alone and shouting out. People were not consistently supported to meet the individual needs of people.

We saw records contained information about people's likes, dislikes and preferences. Although some of the records we viewed did reflect people's current needs we saw this was not consistent. For example, staff told

us they cared for one person in bed. We looked at this person's care plan which detailed how the person was supported by two members of staff to mobilise around the home; the care plan was incorrect. The registered manager told us following our inspection they would ensure people's records were reflective of the current needs of people living in the home. We saw staff that shared information about people's needs at the end of each shift to the staff who were just coming onto shift. We saw that the information shared between staff enabled them to have details of any changes in people's care or specific areas that staff needed to be aware of. This meant staff had up to date information when caring for people in Redhouse.

Everyone we spoke to told us they had not had a reason to complain but felt confident if they did they would be listened to. One person said, "I would complain if I needed to: to the person in charge". Relatives echoed what their family members had told us and repeated they had never had a reason to complain because they were happy with the care provided. We looked at the system the provider had in place should people wish to complain. We saw there had been a complaint made by a person living in Redhouse about a member of staff and the registered manager had investigated the complaint. We saw the provider had a system in place should people wish to complain about the care they received.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2015 we rated the provider as 'requires improvement' under the key question 'Is the service well led?' This was because the registered manager had failed to take action when concerns were highlighted. At this inspection we saw the required improvements had not been made which meant the provider was not complying with the regulations.

At our previous two inspections we have rated the provider as requires improvement overall. The provider had failed to ensure the required improvements had been made to meet the needs of people in the home. We saw there was a quality assurance system in place operated by the provider and we saw the registered manager carried out audits on a regular basis and highlighted where improvements were needed. However we saw these audits were not always effective as no action had been taken by the registered manager to ensure that improvements identified as necessary were made.

At our previous inspection in November 2015 we highlighted that audits had been completed but the registered manager had failed to take any action to improve people's care. At this inspection we found the same concerns. For example, we saw the registered manager completed a monthly audit of people's medicines which highlighted some staff had repeatedly missed signing people's medicine records to confirm they had taken their medicine as prescribed. We saw two staff had been highlighted on three separate months as not completing records correctly and sometimes medicine counts meant people had not received their medicine. The registered manager had taken no action to prevent this reoccurring and we saw one of these staff was not following nursing guidelines in documenting when people had been given their medicine. Also at our previous inspection we highlighted there were times when there was insufficient staff to meet people's needs and staff did not have the time to spend with people. At this inspection we found improvements had not been made and people spent long periods of time with no interaction from staff.

At the previous two inspections we highlighted improvements needed to be made so that people had access to activities they enjoyed doing. At this inspection we found people still did not have access to sufficient activities they enjoyed. We saw the quality assurance system operated by the provider had not ensured the training staff received for managing and serving thickening fluid was embedded into the practice in the home and this failed to help keep people safe. We saw there were occasions where the registered manager had not ensured that staff cared for with dignity and respect.

The lack of effective systems to drive improvements and identify and take action to manage risks is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

People and their relatives told us they thought the home was well led and knew the registered manager well. One person said, "It's nice and comfortable here and I can speak with [name of registered manager] if I wanted to". Another person told us they had chosen to live at Redhouse because they had enjoyed the respite care they received at the home. Relatives told us they were all happy with the care their family

members received and no improvements were needed in the home. We saw people and relatives speaking with the registered manager throughout our inspection and good relationships had developed. Staff told us they were supported in their role and had regular supervisions and team meetings which helped them to provide care to people living in Redhouse. One member of staff said, "The management is good. [registered manager] is supportive. They help us". The staff told us the culture in the home was positive and felt they could talk to management openly if they had a concern. One member of staff said, " I would be happy to live here". Another member of staff did tell us they didn't always feel supported due to the lack of staff and this happened a lot and gave an example of staff calling in sick.

The registered manager told us they involved people, their relatives and staff in the running of the home by sending out questionnaires. We saw these were positive comments from most of the questionnaires. Where a negative comment had been made we saw the registered manager had taken action to address this. For example, we saw a member of staff had commented about the outside space needed developing. The registered manager told us they had now started to develop some of the areas in the garden. We also saw that the provider had ensured information about the service's inspection rating was displayed as required by the law.