The Orders Of St. John Care Trust

OSJCT Wyatt House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 21 and 22 March 2017 .

Wyatt House provides nursing, residential, and respite care for up to 30 people living with dementia and some day care places. At the time of our inspection 26 people were living there. The home is purpose built over two floors. There is a small day centre which people from outside the home can access four days a week and join in with activities there.

There had been no registered manager in post for six months and a new manager had not been appointed that the provider had applied to register with CQC. 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. A peripatetic interim manager was currently managing the service until a new registered manager was appointed.

There were three breaches of legal requirements at the last inspection in October 2015. At our comprehensive inspection on 21 and 22 March 2017 the provider had followed their action plan which they told us would be completed on 30 June 2016 with regard to referring people to healthcare professionals when required, staff completing regular training updates and notifying the Care Quality Commission about all incidents.

Improvements could be made to the care plans we looked at to ensure they were more responsive to people's needs and we have made a recommendation about the care plan information. Staff knew how to keep people safe and were trained to report any concerns. The home was well maintained and safety checks had been completed. People had their medicines administered by the staff and they were safely managed.

People were able to make some choices and decisions and staff supported them to do this. External healthcare professionals supported people when required and they were supported regularly by their GP.

People were supported by staff that were well trained and had access to training to develop their knowledge. There was a choice of meals. We observed one meal time and people's experience could be improved with regard to waiting for their food to be served. People were treated with kindness and compassion. We observed staff engaged with people in a positive way and they were caring when they supported them. Relatives felt welcomed in the home and told us the staff were kind.

People had a range of activities to choose from which included cookery, quizzes, ball games, arts and crafts and musical entertainment. Community links included people being part of the local 'memory walks' in Stratford Park and Stroud Christian Fellowship provided a weekly service in the home.

The provider's representative and the manager monitored the quality of the service with regular checks and

when necessary action was taken. Staff felt well supported by the management team. Staff meetings and resident/relative meetings were held and they were able to contribute to the running of the home. All complaints we looked at from relatives had been investigated robustly by the manager and responded to within the required timescales.

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

People needs were met by sufficient staff who had been thoroughly checked during their recruitment.

People were safeguarded as staff were trained to recognise potential abuse and to report any abuse.

People were protected against the risks of harm and injury as accidents and incidents were closely monitored and action was taken to minimise any further risks.

People's medicines were managed safely to ensure treatment was effective.

Is the service effective?

Good

The service was mostly effective.

People's dietary requirements and food preferences were met for their well-being. Their mealtime experience could be improved with regard to timing.

People were supported by staff who had completed their training and regular updates were planned. Individual staff meetings had not been completed regularly to monitor staff progress and plan additional training.

People had access to social and healthcare professionals and their health and welfare was monitored by them.

Where people were unable to make decisions they were protected by the Mental Capacity Act and decisions were made in their best interests.

Is the service caring?

Good

The service was Caring

People were treated with compassion, dignity and respect.

Staff treated people as individuals and interacted with them positively.

People were supported and encouraged to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans did not provide sufficient detail. There was not always enough guidance for staff to support people living with dementia.

People took part in activities and had some individual engagement with staff. Improvements to activities could be made.

Complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been no registered manager in post for six months.

People and staff were well supported.

Regular quality checks ensured that people were safe and improvements were made.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

OSJCT Wyatt House

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 21 and 22 March 2017 and was unannounced. The inspection team consisted of one adult social care inspector, a nurse specialist dementia care adviser and an inspection manager.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We received 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 peripatetic interim manager, the operations manager representing the provider, two nurses, the deputy manager, one care leader and three care staff, a chef, the training co-ordinator and the activity organiser. We spoke with three people who use the service and three relatives. We looked at information in seven people's care records, five staff recruitment records, staff training information, the duty rosters and quality assurance records. We checked some procedures which included medicines and safeguarding adults. We also contacted social and healthcare professionals that visited the service to obtain their view of the service.

Good

Is the service safe?

Our findings

There were sufficient staff to meet people's care needs. The recommendation we made at the last inspection in October 2015 to regularly assess staffing levels using a recognised method had been completed using the provider's assessment tool. Quarterly reviews had been completed to assess people's dependency and monitor staffing levels. The manager told us they looked at the total hours of staff needed almost every day to ensure people's needs were met. One person told us "There is plenty of staff, they are always there if I need someone". A staff member responsible for completing the staff rosters told us how staff were deployed. Deployment of staff was printed and gave staff responsibility to meet the needs of individual people. One member of staff told us, "I think the staffing levels are adequate."

One staff member told us people need to go out more but there was insufficient staff to escort people out. However five staff had recently volunteered to take people out in their own time. Another staff member told us the provider's representative usually listened to them when they needed more staff. The staff member told us an additional member of staff on the evening shift would assist the staff as there were no ancillary staff that during the day communicated with people and were an asset to the home. Currently dependency levels were high as several people were cared for in bed. We discussed this with the manager who agreed to look into the deployment of staff in the evening. There were two nurses on the early shift each day. The service regularly used agency nurses weekly and they usually knew people well. The recruitment of additional nursing staff was in progress.

Recruitment procedures were followed and correct checks had been made. People were cared for by suitable staff because, in the main, satisfactory recruitment processes were in place. There were checks of staff criminal record histories using the disclosure and barring service (DBS). People's employment history had been explored and risk assessments were in place where required. However one staff member had gaps in their employment history which had not been explored and another only had a reference from a previous work colleague and not the employer. This was discussed with the manager at the time and we were assured this would be addressed.

People were protected against the risks of potential abuse. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. People told us they felt safe in the home. Staff understood their safeguarding responsibilities and completed annual safeguarding training. They explained what they would do to safeguard people by reporting any incidents to the manager or the local authority safeguarding team. One person told us "I feel safe". One relative told us, "Yes my partner is very safe here." Another relative said the service was safe and one person told us, "I am safe, the staff are kind." There were clear policies and procedures for safeguarding people which included 'whistle blowing'. Whistle blowing is a term used when staff report an allegation of abuse by another staff member.

Incidents and accidents were well recorded and audited monthly. Trends were identified and action taken when required. People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. Any unexplained bruises were investigated and possible causes recorded. The manager looked at preventative measure after each accident and whether the actions taken

were preventing further occurrences.

Medicines were safely managed and audited. There were safe medicine administration systems in place and people received their medicines when required. Topical cream charts were completed. There were protocols for staff to follow when medicine was prescribed 'as required'. This enabled all staff to make the correct judgement of when to administer them. Medicines were safely stored. Dates of when medicines not on the monitored dosage system were opened were recorded on the items inspected. This enabled staff to discard them within the appropriate time for their efficiency. All minor medicine errors had been investigated and reflective practice recorded to improve administration. People usually had a six monthly medicines review by their GP and additional reviews when required. The service had a 'Medication champion' nurse and they and the manager checked all nursing staff medicine competency every three years. There was no record of agency staff, used by the service, medicine competency. We discussed this with the manager at the time and they agreed to find out when agency nurse's had medicine competency checked.

People were protected against the risks associated with infection control. There were infection control procedures for staff to follow and we observed staff using personal protective equipment to prevent cross infection. The home was clean and people and their relatives told us it was always clean. The recent infectious diseases at the home had been managed correctly and reported to Public Health England. The home had been closed to visitors when required.

People had individual risk assessments for their personal safety in the care plans. Individual risks were identified and minimised to maintain people's freedom and independence. The care plans had clear risk assessments for people, for example; falls, moving and handling and skin deterioration from pressure. The risks were reviewed monthly and any changes were noted and action taken to minimise risks and deterioration in health and wellbeing. Risk Assessments in the records we looked at were up to date and followed through into care plans. An occupational therapist had assessed one person who was a high risk from falling and various interventions were in place to help keep them safe and maintain their wellbeing. We observed staff complete a number of chair to wheelchair or chair to standing transfers with people which were safe and effective.

There was a comprehensive maintenance programme to help ensure the service was safe.
Safety issues were identified by staff and the maintenance person was there daily to ensure they were completed. Other more major improvements were scheduled and completed. The maintenance staff had completed a monthly health and safety compliance check list which included all areas and installations.

We looked at the certificate checklist completed by maintenance staff and all areas had been checked and the last certificate date of when equipment and systems were serviced was added. Additional monthly checks by the maintenance staff included the safe storage of substances, fire safety, emergency lighting , window restrictors and Legionella disease checks of the water systems. Both the manager and the maintenance staff had completed Legionella training and an outside company was used to check the water status. All hoist slings used by people were checked every six months and were tagged as suitable for use. Each person had their own hoist sling which had been measured for their personal use and kept in their bedroom.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed business continuity plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

Good

Is the service effective?

Our findings

At our comprehensive inspection on 13 and 14 of October 2015 the registered person had not ensured people were referred to a healthcare professional soon enough and were monitored to protect them against the risks associated with safe care and treatment. This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our comprehensive inspection on 21 and 22 March 2017 this requirement had been met. People had been referred to healthcare professionals. People had access to health and social care professionals and their visits were usually recorded. Healthcare professionals included for example chiropodists, occupational therapists and the mental health care team. GP visits were regular and staff ensured people who required their assessment and intervention were seen by them. One GP told us the home organised which people they had to see prior to their visit and made sure a nurse was available to assist them when they visited. The GP told us this provided a better service for people when they visited.

The Speech and Language Therapist (SALT) had been consulted for one person who was at risk from choking. A soft diet had been advised and staff had intervened when the person was choking on their food. The use of suction equipment which may cause further reflex vomiting was discussed with the manager. The manager told us the diabetic nurse specialist had visited a person with Type 1 diabetes. We were unable to find a record of what the diabetic nurse specialist had advised in the care plan. However staff had informed the GP when blood glucose results were low and the GP reduced their insulin.

At our comprehensive inspection on 13 and 14 of October 2015 the registered person had not ensured staff had completed regular training updates to ensure they had sufficient knowledge to carry out their roles. This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our comprehensive inspection on 21 and 22 March 2017 this requirement had been met.
Ensuring staff had regular updates to their training was progressing and a clear system was emerging which had been completed by the new training coordinator. A programme of training to maintain and update staff knowledge and skills was in place and staff were informed when their training was due. Some of the training was completed on computer and assessed. The training coordinator told us they were moving away from e-learning on a computer and had completed some competency checks, knowledge quizzes and had given staff scenarios to provide answers to, for example with regard to safeguarding people. Staff had completed a range of training to include dignity and respect, health and safety, moving and handling, infection control, fire safety, first aid and food hygiene. There had recently been workshop training about the Mental Capacity Act from the provider's Admiral nurse who is a dementia care specialist.

Staff told us they also had the training they needed when they started working at the home, and were supported to refresh their training. One staff member told us, "Induction has been pretty good." Another staff member told us they had just completed the new Care Certificate induction programme having worked at the home for seven weeks. New staff also have a named mentor who they can ask for help during the completion of the Care Certificate induction training and at other times.

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us they had the training and skills they needed to meet people's needs. Comments included: "All my training is up to date" and "I have done loads of dementia care training and just finished NVQ level three". Thirty two percent of the staff had completed NVQ level two or the equivalent qualification

We were able to look at one staff members training record where they had completed an annual personal development review and had set objectives and the target dates for completion.
The provider had recently introduced a 'Trust in conversation' format for all staff to have with senior staff to replace the individual 'supervision' meetings. This was led by the individual and how they felt about their progress and what they wanted to achieve. The aim was to complete the conversations four times during a year.

People had a choice of meals and their dietary needs were met but their dining experience could be improved. There was some waiting for people at lunch time in the dining room. We noted some people were sat in the dining room up to 40 minutes before their food was served. We discussed this with the manager who agreed this was not acceptable and it would be addressed. The meal we observed was calm and relaxed. We heard staff asking people where they would like to have their meal. There were no menus available but the chef told us they were being changed. People seemed to be enjoying their food. Where people needed assistance with eating staff helped them in a dignified way. They sat down with the person and engaged with them throughout.

The chef was knowledgeable about the needs of the people and showed us how she ensured new people were asked about their likes and dislikes. The chef kept a clear record of which people required a special diet for example, diabetic diet or gluten free. Where people declined the meals on offer the chef would prepare whatever the person wanted, as long as it was available.
Snacks were available for people on request and were offered by staff. Snacks were no longer left out accessible to all people because there had been some concerns about the risk management for people with diabetes. A relative told us "The food here is really nice".

People had care plans for Eating, Drinking and Nutrition and were regularly weighed to monitor their weight and assess this in relation to their risk of malnutrition taking into account additional health factors.

One person living with diabetes was supported by the diabetic specialist nurse who visited them.
The GP had been informed when the person's blood glucose levels were low and their insulin was reduced. The person had lost more than 6 kilogrammes in four months since admission and was weighed weekly to monitor their weight. One nurse told us the person had fortified foods but they were careful with these as the person's blood glucose levels had to be maintained within a normal range. The person's nutrition care plan referred to their skin condition care plan as the person was admitted with pressure ulcers and was prone to urinary tract infections. This indicated staff were aware of the connection and the need to ensure adequate nutrition.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005 (MCA). Staff had completed training on the MCA which 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's mental capacity assessments and 'best interest' records had been completed where required. An example seen of the provider's 'Best Interest Core Care Plan' booklet

which had been used to record the assessment of a person's mental capacity. The 'best interest' was for the person to remain at Wyatt House for treatment and accommodation. Where appropriate relatives or supporters were included in the 'best interest' record. We looked at three examples where people living with dementia had a mental capacity assessment completed by the Admiral nurse and a 'best interest' record to remain at the service to receive care and treatment. People who required their medicine to be given covertly had a 'best interest' record completed by their GP. Their mental capacity had been assessed and there was clear actions about how to give their medicine covertly.

The manager had identified people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. We checked whether the service was working within the principles of the MCA to complete Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The DoLS applications authorised by the supervisory body we looked at did not have any conditions for the service to fulfil. We could see that standard authorisations were sought when the previous authorisations were about to expire after one year. We identified that several people required a DoLS application and the manager completed these immediately. Most people had a DoLS application completed and a care plan which outlined their need for care and treatment in their best interest when they were living with dementia.

Good

Is the service caring?

Our findings

People had positive interactions with staff and their privacy and dignity were respected. Staff knocked on doors before entering and ensured there was privacy when people received personal care. People and relatives told us the staff were caring. We saw several thank you letters from relatives. One relative had written, "The professionalism and sincerity of staff… is very much appreciated". One relative told us "The staff here are wonderful and very kind". One healthcare professional told us the staff were, "Very caring and made tremendous efforts to care for a very challenging group of people with dignity and kindness, especially at the end of their life ".

Staff supported people with kindness and compassion. One care staff member told us how a person had been aggressive towards them when they first started as they didn't know them Gradually they built a relationship with the person by talking to them every day and now they are more relaxed in the staff members company. A daily activity record described how a twenty minute interaction with a member of staff helped a person who was shouting a lot. The staff member gave them a soft toy cat to hold. They talked about cats being good company as the staff knew the person liked cats. The person reacted by singing a nursery rhyme about a cat and knew all the words. The person then fell asleep holding the cat.

Another record described how a volunteer had put nail polish on a person and the person said, "I can't believe, she is still at school, she did such a good job". The volunteer also talked to the person about wanting to become a doctor one day. The person's wellbeing was recorded as good for the rest of the day. One record of a six monthly review with the person and their daughter recorded the person said, "All staff are kind and helpful", "and I feel safe". The person's daughter had told staff the home was just the right place, homely and a bit old fashioned and retro.

We observed a person calling out many times saying "What do I do with this." A care staff member asked if they were alright and if they wanted a drink. A drink was put in front of the person and the care staff member said, "Take my hand" and they guided the person's hand. The person responded and told the staff they didn't want a drink they had just had one. The person then asked to go to the toilet and the staff member took them straight away. The same person asked to go to the toilet again twice and each time the staff responded in the same kind way not once mentioning they had just been to the toilet.

Staff were observed to be really patient and kind towards people. We observed a number of hoist manoeuvres used to transfer people from chair to wheelchair and back again. Staff correctly spoke with people taking time and encouraging them to hold on and ensure their dignity as much as possible. Staff spoke to people and not to each other. They made sure each person was comfortably seated and had a drink to hand before leaving them. One person said, "They [staff] ask me what I want and will knock on the door to my room. I help with washing up too."

People had 'cloud' shaped records on their bedroom walls which told their story "All about Me". One person liked trains and knew all about them, they also liked music. The clouds said the person liked to wear polished shoes and enjoyed a beer. There was a picture of their keyworker who made sure they had

everything they needed. One person had a copy of a Daily Chat News with three records in February 2017 and two in March. The record said how the person had responded by smiling and chatting to staff. Information of people's interaction with staff was also recorded in the care plan daily record.

Requires Improvement

Is the service responsive?

Our findings

People received mostly personalised care but not all care plans had person centred information. There was no mention in one care plan for example of how the person liked to look and what clothes they preferred. One person's care plan required additional clear and informed records to determine what was causing their agitation. What was not recorded was what situations, if any, led to the behaviours and was 'as required' medicine given as a 'last resort' when the person became agitated. The possibility of pain was not explored as a cause of the person's agitation even though the admission records stated the person had 'arthritic knees'. The care plan for pain was blank with a 'post-it note ' saying 'no signs of pain or discomfort at present' The care staff member we spoke with told us the person had, "Never shown any signs of pain." We discussed this with the manager as there was no evidence of a pain assessment tool being used and they agreed to ensure this was corrected. One staff member we spoke with was unsure if the same person was living with dementia. The staff member knew the person did not have full mental capacity but they said the person understood and could talk. The person's care plan told staff to use 'low arousal approaches' but did not say what they should do.

We recommend that the service follows advice and guidance from a reputable source to ensure people's care plans are responsive to their needs.

One person's pressure ulcers were gradually healing and they had a clear 'person centred' wound care plan. Topical cream was applied regularly by staff. The care plan advised staff to call the tissue viability nurse if the wound deteriorated. The person was able to move themselves in bed to prevent further skin deterioration. The care plan told staff to prompt the person to eat as their appetite was poor which could affect the healing process. Some people had change position charts which were generally correctly completed to help prevent pressure ulcers. One relative told us they felt involved in any decisions made about the care their partner received. One healthcare professional told us the service had improved with regard to providing them with information about people before they visited to ensure their time there was effective and they were able to discuss people's individual needs.

A person at risk of falling had a low bed and a 'crash mat' by the bed to prevent injury. They also had a bean bag to help themselves up. They were assessed as being a very high risk of developing a pressure ulcer and sat in a special chair to relieve sacral pressure.

There was good use of acute care plans when required. For example when a head wound had a dressing to remain in situ for ten days to minimise the risk of infection. The GP had been contacted for advice. Another acute care plan described where a person had 'red areas' on their feet when they were admitted and described how staff should monitor this.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Information was recoded on a handover sheet and included the assistance people would need in the event of an emergency evacuation. One staff member told us the handover had changed for the better and there was a

'conversation book' for care leaders to leave messages to improve continuity of peoples care. Daily records had three entries for each shift and recorded what people had been doing, their general mood and the food and fluids they had taken. This helped to ensure each shift knew how people were feeling and whether they may need additional support and encouragement.

There was a programme of activities provided during the week. Improvements could be made with additional one to one interactions, weekend activities and supporting people to go out more often. One person told us they loved to walk they said, "I most miss walks in the fresh air. I was going to go but (name of activities co-ordinator) was busy and it was cold. I can go into the garden but I have to have someone with me." Generally few individual activities were recorded and there was no evidence of activities during most weekends. The activity organiser told us a lot of individual activities took place but more care staff involved in activities would improve the service for people. Two staff told us individual interactions with people were constantly provided. One member of staff told us people need to go out more and five care staff had recently volunteered in their own time to take people out.

The part time activities organiser currently had only one volunteer to assist them with the activities. There were "grab bags" and memory boxes in the lounge which contained individual activities to enable care staff to interact with people who were isolated in their bedrooms. There was also other activity equipment available in the lounge where people could use household items and look after 'toddler' dolls. A new outside activity group called ' The making of me" were providing eight weeks of entertainment which included dance, poetry and theatre. Activities for people who were living with less advanced dementia were completed in the day centre every week and included cookery, quizzes and ball games and people were assisted to join in there.

The activity organiser said that activities were aimed to be in line with people's life history and the record "All about me" in their care plan. A fortnightly singing activity called 'Mindsong' was a popular activity for people to join in with. One person told us, 'I love (name of activities co-ordinator) they organise sing-a-longs. It's smashing, I enjoy them". The activity organiser had recently attended a workshop to learn how to lead a percussion group activity for people.

We looked at the record of group activities for February 2017 and eight people had taken part in group activities Mindsong and dance. People's individual reaction to an activity had been recorded, for example their response of clapping and smiling. There were daily records where people had enjoyed some individual activities for example, the application of nail varnish and talking about a classical music radio station and the garden.

The activity organiser had forged community links and community memory walks had taken place in Stratford Park. The Museum in the Park made people very welcome and refreshments were provided. Stroud Christian Fellowship provided a service in the home every week. There were plans to purchase IPad computers where people could play musical instruments on them, listen to individual play lists and see reminiscence pictures of places they remembered.

Complaints were investigated and responded to. The service had received three complaints this year. The manager discussed with us one of the complaints that was waiting for a response and explained what actions were being taken. All other complaints appeared to have been robustly investigated and responded to in a timely way.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 13 and 14 of October 2015 the registered person had not fully protected people against the risks associated with abuse and allegations of abuse as The Care Quality Commission was not notified of all incidents. This was a breach of Regulation 18 CQC (Registration) Regulations 2009.

At our comprehensive inspection on 21 and 22 March 2017 this requirement had been met. There was a daily manager's report of important incidents and accidents completed by the nurses. We checked the safeguarding records and all incidents had been reported to CQC.

The recommendation we made at the last inspection in October 2015 had been addressed and quality assurance systems were in place and included regular audits. The quality of the service was monitored by a variety of audits including medicines management, infection control and care planning. Care plans had been audited monthly until December 2016 but since then few had been audited due mainly to management changes.

There had been no registered manager in post for six months and a new manager had not been appointed that the provider had applied to register with CQC. The provider was not complying with the registration condition with regard to having a registered manager in post.

Individual formal meeting with each member of staff (supervisions) had not always been completed but staff had attended regular staff meetings and felt able to contribute in the meetings. The lack of individual conversations was due to the change of managers during the last twelve months but there was now a formal plan to reinstate the regular individual meetings with all staff.

Some audit tools had been designed around the CQC areas of safe, effective, caring, responsive and well led. These audits had been completed regularly. Whilst it was not always clear from the way it was recorded if and when actions had been taken for some identified issues, such as the service's last infection control audit, there was evidence for the majority of audits that action had been taken. The manager told us that a recent full compliance audit of the service had taken place to allow her to have a detailed overview of where improvements were needed. She said they would extract the actions from this audit and work through them.

One relative told us they found the manager to be very approachable and open. A member of staff told us, "The provider is very supportive. I think they have their values right. When you get staff travelling long distances to go to work you must have done something right".

The service had a variety of regular meetings, including resident meetings, nurse meetings and senior care staff meetings. Within the meeting minutes we could clearly see what ideas had been generated and what actions had been taken. Although some appeared not to have taken place yet for example, the resident's idea for a fish and chip supper in January 2017.

Peoples, relatives and supporters were able to comment at meetings and told us they were pleased with the

service. One relative had requested a handrail in the corridor was lengthened to avoid their mother holding onto the door jam and her fingers being at risk of injury, this had been completed. People had commented about staff at a meeting in October 2016 and the minutes recorded their comments for example, "Helpful and pleasant, you can't fault them" and "You couldn't get a better set of staff."

The monthly review visits recorded by the provider's area operations manager looked at various aspects of the service. They included health and safety, accidents, care plans and peoples and relatives comments. The November 2016 and February 2017 reviews had identified actions for
Completion and we found they had been dated when completed. For example the staff training list was up to date.

The website called Carehomes where people and their relatives send information reviews about services had a score for the number of positive reviews at Wyatt House of five out of five from 8 positive reviews in the last 12 months. Relatives had commented on the service as follows; "In the four years that my mother resided at Wyatt House, I have never had any cause for complaint. All of the staff are very caring and professional and sensitive to the needs of the residents but also to the demands of the families of residents too" and "I would like to give great thanks to all the staff at this site for the encouragement, care and compassion each and every day my mum was here".