Minster Care Management Limited

Rydal Care Home

Inspection report

Rydal Road
Darlington
County Durham
DL1 4BH

Tel: 02084227365

Date of inspection visit:
06 December 2017
12 December 2017

Date of publication:
31 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 and 12 December 2017 and was unannounced. This meant staff and the provider did not know that we would be visiting.

This was the first inspection since the new provider registered to operate this service.

Rydal Care Home is a 'care home'. People in care homes receive accommodation and 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. Rydal Care Home accommodates up to 60 people across three separate units, each of which have separate adapted facilities. Two of the units specialise in providing care to people living with dementia. At the time of this inspection 50 people were in receipt of care from the service.

No registered manager had been in post since April 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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 new manager had been in post since September 2017 and had recently submitted an application to the Commission to become the registered manager.

The regional manager had been in post since July 2017 and when they had taken on oversight of the service they had found a number of issues had arisen following the departure of the previous registered manager. They found staff morale had been low and a number of staff were looking to leave. Within a few weeks they had ensured the service stabilised and since then had worked hard to make improvements to the service.

We found the quality assurance procedures in place lacked 'rigour'. Although some auditing and analysis was carried out, this was not always effective. For instance, the tool the provider had supplied for monitoring care records did not assist staff to look at wider issues, so they had not considered if the current process of using care plans to assess people's needs and dependencies was effective.

On the whole people and staff felt there were sufficient staff on duty each day to meet people's needs but we observed that at times staff were stretched. We found the way staff completed the dependency tool would benefit from review, as they were judging people who required one-to-one support as 'medium dependency', which was incorrect. Using this information could lead to the provider's dependency tool calculating that less staff were needed than was actually the case. The quality assurance checks to monitor and improve standards at the service had not picked up that the staff were not completing accurate dependency assessments.

Appropriate recruitment checks were carried out. Staff were supported to constantly develop in their roles and all the staff discussed the wide range of training they had been able to complete. However, staff had not

received training around how to support people who may become anxious and display behaviour that challenges others. The manager and regional manager were aware of this gap and were sourcing courses for staff.

The provider ensured maintenance checks were completed for the equipment and premises. They completed health and safety checks and adhered to fire safety guidance. However, we found that one of the two lifts had been broken since before the providers had taken over the service but this had not been repaired. The regional manager told us action was being taken but the previous provider had initially told them they would deal with this issue but had not. We found that effective quality monitoring processes would have identified the impact the lack of a lift was having for the management of the downstairs unit on the general nursing unit and resolved this in a timely manner.

People were happy and told us they felt safe. The relatives we spoke with felt the service delivered safe care but at times the communication between staff and themselves could be improved. The staff had a clear understanding of safeguarding procedures and ensured that action was taken if any concerns arose. Staff ensured any risks were closely managed.

We reviewed the systems for the management of medicines and found that people received their medicines safely. Medicines were closely managed and this ensured people received their medication exactly as prescribed.

The manager was aware of risks within the service and was undertaking an analysis of risks. The service had emergency plans in place and took action when they became aware someone was at risk. Accidents and incidents were appropriately monitored and analysed and the manager and staff critically reviewed all incidents to determine if lessons could be learnt.

We found that the service was clean and staff adhered to appropriate infection control procedures.

We found staff were passionate about providing a service that gave all equitable choices and experiences. Staff knew the people they were supporting well. The manager and staff were focused on delivering a personalised service. However, we discussed with the manager how the assessments could be enhanced, as the provider only supplied pre-admission template and therefore there were no documents for staff to use to assess the current position. This meant staff had to go through the whole care file to find out detailed information about individual's physical and mental health conditions and any changes to their health.

We found there was no documentation to support the capacity assessments made, or corresponding 'best interests' decisions. The manager and staff reported that the previous manager had removed all of this documentation and they would ensure it was re-instated. Also, we found that not all Deprivation of Liberty safeguards (DoLS) authorisations were in place, albeit the staff recorded when these were sent they did not always update the records about any outcome. Staff were also unaware of actions best interests assessors had recorded on the DoLS forms.

Staff supported people to make decisions for themselves and spoke with people about their wishes and preferences. People were supported to be as independent as possible and could access advocacy services if needed. The manager, staff and activity coordinator regularly sought peoples' views and acted upon their comments. A volunteer ran a relatives meeting and this year held a meeting in a local restaurant, which provided the opportunity for informal discussions about the service and the creation of a support network.

People were treated with dignity and respect. We found that staff were compassionate and people told us

the staff were always kind and caring towards them. We saw that staff continually engaged in conversations with people and took an active interest in individual's lives. People told us they were aware of how to raise a complaint and felt that any issues raised would be thoroughly investigated and resolved.

We heard how the activity coordinator had developed a range of interesting activities for people to engage in, formed links with local organisations and worked with volunteers. However, we found the service would benefit from additional activity workers as the coordinator was not always able to cover all the units. Also, they were reliant on staff volunteering to accompany people on trips.

People were supported to maintain a healthy diet and to access external professionals to monitor and promote their health.

People, relatives and staff described the manager as being an effective leader. Staff told us that they could contribute their ideas about how to make improvements at the service. We found the regional manager and manager immediately acted upon any issues and in between our visits addressed all the points we raised on the first day. Staff received regular supervision and they were in the process of receiving annual appraisals.

The manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to good governance. You can see what action we told the registered 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?

Good

The service was safe.

Staff recognised signs of potential abuse and reported any concerns regarding the safety of people to senior staff.

Overall there were sufficient skilled and experienced staff on duty to meet people's needs. Robust recruitment procedures were in place.

Risks were monitored and managed appropriately with the least restrictive option always considered

People lived in a clean and well maintained service with environmental risks managed appropriately.

People's medicines were managed safely and audited regularly.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not have comprehensive assessment template. This meant information about people's needs was not easy to find and created volume of repetitive care plans.

People's consent was sought at all times. However, documentation linked to the application of the Mental Capacity Act 2005 was not always in place.

Staff were supported to gain the knowledge and skills to support people who used the service. Additional training around supporting people who displayed behaviours that challenge had been sourced.

People were provided with a choice of nutritious food and their on-going healthcare needs were managed and monitored.

Is the service caring?

Good

The service was caring.

People were treated with respect and their independence, privacy and dignity were promoted.

Staff knew people and used this knowledge to care for them and support them in achieving their goals.

Staff interacted with people in a way which was kind, compassionate and caring.

Staff took time to speak with people and to engage positively with them.

People were consistently involved in conversations and contributed to making decisions about their care.

Is the service responsive?

Good

The service was responsive.

The service was tailored to meet the individual needs of people in receipt of care.

We saw people were encouraged and supported to take part in a wide range of activities.

The people we spoke with were aware of how to make a complaint or raise a concern.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance processes were in place but these did not always pick up issues at the service. The provider's monthly report needed to be developed in order to ensure identified issues were reported in full to them.

The new manager was applying to become the registered manager and detailed a range of improvements they intended to make to the service.

People's and relatives' views were sought and acted upon.

Rydal 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 registered 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 unannounced inspection took place on 6 and 12 December 2017. On the first day of the inspection the team consisted of an adult social care inspector, a bank inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales.

We also reviewed reports from recent local authority contract monitoring visits.

During our inspection we spoke with 12 people who used the service and five relatives. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We also spoke with the manager, regional manager, deputy manager, two nurses, a senior care staff member, seven care staff, the activity coordinator, the cook, two domestic staff members, the hairdresser and a volunteer.

We observed the meal time experience and how staff engaged with people during activities. We looked at six people's care records, four recruitment records and staff training records, as well as records relating to the management of the service.

We looked around the service and with permission went into some people's bedrooms. We also looked in all of the bathrooms and all of the communal areas.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us they felt the service was safe.

One person told us, "I find the staff are always around." Another person commented, "I feel better here as I know staff are around to make sure I am alright."

One relative told us, "The manager and the nursing team are very good. [Person's name] sometimes shouts and screams, but they have one-to-one support now (paid for by the CCG). I'm very happy with the last 12 months of care. The safeguarding team was involved at one point, which I was fine with. They are not overly staffed, but they're not short and it is well staffed at night."

We received mixed views about staffing levels. Some people who used the service and relatives told us there were enough staff to meet their needs and others said staffing levels could be better and the communication between themselves and staff needed to be improved. One relative commented, "The unit is often short staffed at the weekend. For example, the buzzers tend to go on for longer. Communication can be lax, with notes not always written up or passed on. You end up repeating yourself. If there are any urgent issues they'll ring, but they don't always share information between themselves."

For the 50 people who used the service there were two nurses, a senior care staff member and nine care staff on duty during the day, plus four people received one-to-one support. Overnight there were two nurses and five care staff. The manager worked during the week and the deputy manager plus an activity coordinator were on a rotating shift so often covered weekends. In addition to these staff, there were four domestic staff (three domestics and one housekeeper) and a laundry staff member on duty each day, a cook and assistant cook who worked seven days a week.

The provider had a tool that forecasted how many staff may be needed and this was based on the assessment staff made around people's dependency. We found the way staff completed the dependency tool would benefit from review, as they were judging people who required one-to-one support as 'medium dependency', which was incorrect. This incorrect analysis of need could lead the provider to assume fewer staff were needed. Although people and staff felt that in general there were sufficient staff on duty each day to meet people's needs, we observed that at times staff were stretched. We discussed this with the regional manager and manager who undertook to immediately check that people's dependency levels were correctly assessed.

Safeguarding and whistleblowing procedures were in place to protect people from the types of abuse that can occur in care settings. The staff we spoke with described what they would do to ensure people remained safe. Staff told us they would report any concerns, including those in relation to actions that might be found to be discriminatory, to the manager. The senior care staff member said "I know what to do and reported a safeguarding issue recently." We found the manager thoroughly investigated any safeguarding concerns and where appropriate, this was in partnership with the local authority safeguarding team.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with vulnerable children and adults.

Risks to people using the service were assessed and plans put in place to reduce the chances of them occurring. For example, plans were in place to manage risk of falls, choking and when people went out in the local community. Risk assessments were regularly reviewed to ensure they reflected any current risks and that the measures in place were not overly risk adverse or restrictive. Accidents and incidents were monitored for any trends and critically reviewed to learn lessons and identify where improvements could be made.

On our arrival at the home the manager made us aware of the procedure to follow in the event of a fire. Staff told us when they first started working in the home they were given fire instruction and shown the fire procedure. Staff completed hot water checks and the records showed this were within appropriate ranges. Also fire drills were completed. Maintenance safety checks such as those related to legionella and utilities supplies had been completed.

We spoke with two domestic staff about the arrangements in place to keep the home clean and hygienic. They had a good understanding of their roles and responsibilities in relation to this. They said "We had training in infection control. Nearly every day we do a pull out (deep clean). There are always plenty of plastic gloves and pinnies (aprons). We use red bags to take soiled things to the laundry", and, "We wash paintwork, doors and frames and behind people's beds. There are mattress audits every month to make sure they are clean and not damaged." During the inspection we saw staff regularly use the readily available hand sanitizers, as well as wear protective clothing to prevent the spread of infection.

A relative told us "There are always cleaners in". We found the service was clean and free from unpleasant odours. However, we did note a very small number of beds' valances were stained with unknown substances and a number of sensor mats were dirty. On the first day of the inspection this was brought to the attention of the manager and regional manager and we confirmed on the second day that these issues had been addressed.

We saw the manager had recently carried out an audit of the environment and identified potential risks to people's safety. For example, a damaged mattress, and these issues were being quickly addressed. We saw mobile hoists were available for staff to use and that people had been individually assessed for their own moving and handling sling. We also saw that there was a standing aid available for staff to use. During our observations on the unit for people with 'residential' care needs, we saw some people had great difficulty standing from the seating in the communal areas. We spoke with staff who stated they felt the use of an additional standing aid would be beneficial in this area of the service as well as a review of the type of communal seating provided. We saw people were wearing appropriate footwear and staff had made sure people's walking aids were within easy reach; all of these measures minimising the risk of people falling.

We found the manager checked that staff were using equipment such as hoists appropriately and when gaps in practice were identified they took immediate action. They had identified the need for more standing aides and put an order in for this equipment.

Medicines were safely administered and securely stored, and stocks were monitored to ensure people had access to their medicines when they needed them. We looked through the Medication Administration

Records (MAR's) and found medicines had been administered and recorded correctly. Information was available about the protocols staff needed to follow when administering 'as required' medicines but at times they needed to include more detail around what would suggest these were needed. We spoke with staff about this and they immediately added the further detail. All staff who administered medicines had been trained and had completed competency checks to ensure they could safely handle and administer medicines.

Requires Improvement

Is the service effective?

Our findings

We found issues with records and recording related to people's individual needs.

The provider only supplied a pre-admission template and therefore following people moving to the service there was no other document for staff to use to assess their current care needs. This lack of a comprehensive assessment had led staff to using care plans as the assessment tool and meant that numerous care plans were generated. The use of care plans in this manner meant the person's priority needs were lost and staff would find it difficult to readily identify when care records were updated. This meant it was difficult to gain a clear understanding of people's presenting needs and picture of how these had impacted them. We discussed with the manager how the service could be enhanced by the introduction of comprehensive assessments. The regional manager and registered manager accepted this was a gap. They told us the provider was in the process of reviewing the documentation and considering how to improve the assessment of people's needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff had received training in the MCA 2005 and DoLS authorisations. Although staff in practice adhered to the principles of the MCA and determined the range of ways they could support people to make informed choices, they needed to be able to access the MCA code of practice in order to ensure their practices were in line with expectations. We found there was no documentation to support the capacity assessments or corresponding 'best interests' decisions. Staff were also unaware of actions best interests assessors had recorded on the DoLS forms.

We found the provider's care record template did not prompt staff to establish who had enacted lasting power of attorney for care and welfare or finance and if the Court of Protection had appointed anyone to act as an individual's deputy. Also, it did not support staff through the process for referring individuals to the Court of Protection when they objected to being subject to a DoLS authorisation.

We found that not all DoLS authorisations were in place, albeit the staff recorded when these were sent they did not always update the records about any outcome. For example, one DoLS authorisation had been put in place for a three month period, as the assessor found the care records were not completed so the

assessor could not determine if the person was supported in the least restrictive manner. They felt the three month period would be sufficient for staff to rectify this matter, yet staff were not aware that they had been required to complete a full assessment.

The manager told us that they were contacting the supervisory body to confirm who had authorised DoLS and request associated paperwork.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been trained to meet people's care and support needs in topics such as working with people who lived with dementia and managing physical healthcare conditions. Records showed staff had received training in subjects that the service deemed to be mandatory, such as moving and handling, health and safety, safeguarding and first aid and this had been kept up to date. Mandatory training and updates were deemed by the provider as necessary to support people safely. However, we found that care staff had not received training around working with people who display behaviours that challenge or in-depth training around working with people who live with dementia. We discussed this with the manager and regional manager who confirmed they were in the process of sourcing these training courses.

Since coming into the post the manager and regional manager confirmed they had been reviewing staff training and were putting more face-to-face courses in place, as they found this a better model of learning for staff.

People and relatives told us they were happy with the service and we found staff to be very knowledgeable. A relative said, "The staff understand how to support my relative." Another relative said, "[Person's name] likes the food here and they would say something if they didn't. All the food is easy to eat things, like mince and dumplings." Another relative said, "The manager said she was here, not just for the residents, but to support the families. I found that very reassuring."

We saw that staff promptly responded to any indications that people were experiencing problems or their care needs had changed. The staff discussed the action the team took when people's needs changed to make sure they updated the care plans and continued to meet people's needs.

Staff were supported with regular supervisions and were in the process of completing their first annual appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Appraisals are usually carried out annually and are a review of staff's performance over the previous year. Staff said they found these meetings useful and records confirmed they were encouraged to raise any support needs or issues they had.

People told us the meals were good, they were given a choice and alternatives were provided if they did not like what was planned. People could eat in the dining rooms or their own rooms. The tables in the dining room were set out well and consideration was given as to where people preferred to sit. People were offered choices in the meal and staff knew people's personal likes and dislikes.

We saw that MUST tools, which are used to monitor whether people's weight is within healthy ranges, were being accurately completed. Where people had lost weight the staff ensured referrals were made to the GP and dietitians. Care records showed other professionals such as GPs, falls prevention staff, and community nurses were contacted for advice and support. Relatives told us about the professionals involved in their care and relatives said they were kept informed about appointments. One relative said, "They always call me

to let me know if [person's name] is not feeling well."

The environment was designed to support people's privacy and dignity. The provider and manager were currently refurbishing the service and were using the latest dementia care guidance to inform the design of the units. They showed us the plans for this and we noted that a wide range of techniques were being incorporated to make the environment user friendly.

Good

Is the service caring?

Our findings

The people we spoke with said they were happy with the care provided at the service. They told us that staff respected them and were considerate. People told us they found that all of the staff were kind. The majority of relatives told us they thought the care being received was very good.

People's comments included; "The staff are kind", "I think they are great", and "The staff really look after us really well." One relative told us, "All in all, I'm happy with the care and [person's name] is happy here. Carers are very kind."

During the inspection we saw staff interacting with people in a very caring, affectionate and professional way. We spent time observing care practices in the communal areas of the care home. We saw that people were respected by staff and treated with kindness. We saw staff communicating well with people, understanding their gestures and body language. We saw one person become upset and anxious and staff understood the best way to support them at this time, providing them with reassurance, warmth and understanding.

We heard staff address people respectfully and explain to people the support they were providing. Staff knelt or sat down when talking with people so they were at the same level. They were patient and waited for people to make decisions about how they wanted their care to be organised and closely followed people's way of communicating.

Staff interacted with people at every opportunity. For example, saying hello to people by name when they came into the communal areas or walking with people in an unhurried manner, chatting and often having a laugh and joke with them. People were smiling, laughing and engaged with staff and their environment. Staff told us, "We try to make sure people are always asked for their views and we follow their lead on what they want to do."

Staff were compassionate when working with people who used the service. Staff told us, "First and foremost this is people's home" and "I lost my grandparents a few years ago but consider myself fortunate to have the opportunity to work with these wonderful people. I always look after them how I would have done if they were my grandparents."

The manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussions that all staff knew people very well, including their personal history preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs.

People were seen to be given opportunities to make decisions and choices during the day, for example, what activities to join. The care plans also included information about personal choices such as whether someone preferred a shower or bath. The care staff told us they used this information and took the time to read the care plans of new people.

The manager and staff knew how to assist people to access advocacy services, if this was needed. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. We heard how the manager and staff had actively supported people to voice their views and express their desires about how their care should be delivered. Staff told us, "This is people's home so they must have the say on what happens", "We make sure people are involved in making decisions about their care and treatment; this might be difficult for some people so we may ask relatives, but it should be wherever possible the person's choice."

Good

Is the service responsive?

Our findings

People and relatives told us that staff had a good understanding of individuals' needs and were able to spot what people wanted from the smallest of signals. One person said, "We have good staff. [Activity coordinator's name] puts on interesting activities."

We found that the staff made sure the service worked to meet the individual needs of each person. Although the care records contained a lot of information and were difficult to navigate, staff had worked diligently to ensure each individual's care records contained relevant information and were reviewed regularly. Daily handovers were used by staff to ensure they were kept informed of any recent changes in a person's needs.

People and their relatives told us they made choices about the care and treatment they received. We observed that people were consistently asked for their views and given choices about all aspects of their care and treatment.

We found that staff working on the nursing unit for people living with dementia were very skilled and had enabled people to function to their full potential. They worked in ways that promoted people's independence and encouraged the retention of existing skills.

We found that staff had a good understanding of the actions they needed to take when individual's needed end of life care. Care records contained evidence of discussions with people about end of life care, so that they could be supported to stay at the service if they wished.

The activity coordinator told us they had worked at the service for six months and were in the process of extending the range of activities on offer. They said, "We do singing, gardening, bingo, knitting, arts and crafts, trips out to Beamish Museum, the Copper Beech (the local pub - for lunches) and the Railway Museum, which is free. We take three people out, one to one, on trips; more if we've got the volunteers. It all depends on volunteers. There will be a panto visit for the residents. If we're going to take people out, we take it in turns to make it fair. In January I'm going to start a new arts and crafts group with a very artistic resident taking up the running of it. Recently we made handmade Christmas cards and they'll be sent to family members of residents."

The activity coordinator worked on a rolling rota so worked at weekends as well as during the week. The service had a budget for activities and the activity coordinator told us they had also been raising funds. We heard that they had slept out one night on the town streets, to raise funds for the home, through sponsorship. The activity coordinator told us, "Residents also visit other local care homes in the area and invite each other to come to their homes activities."

We found the service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and friendships. Relatives and friends were encouraged and supported to visit the home. Relatives confirmed that as well as in-house activities, outings in the community were also arranged. For example, they described how their family member had enjoyed a trip out for lunch at a local

pub and also a shopping trip.

We found that staff would often come in on a voluntary basis to support the activity coordinator to take people out on trips or to engage in activities in the service. Also the activity coordinator and manager had encouraged people from the local community to volunteer their time. This had led to volunteers coming into the service and one relative acting as the chair for meetings. This person ran the relative meetings and had organised a meeting in a local forum. This provided opportunities for people to develop a support network.

We found that the activity coordinator, volunteers and staff worked hard to provide a full range of meaningful activities but the size of the service meant they could not be visible on all units. We felt rather than being reliant on the good will of the staff to assist them, additional activity workers would benefit people who used the service. We discussed this with the regional manager and manager who agreed and confirmed they had been reviewing this provision.

The manager discussed the plans to incorporate best practice guidance for dementia care and how they intended to create destination points on units, which would feature interactive activities. Also they were in the process of creating rummage boxes and purchasing materials that would allow people to independently engage in meaningful activity. The recent redecoration programme in the service had only just been completed, so these additions were to commence before the end of the year. The manager showed us what their plans were and the types of items being bought some of which, such as scented sweet bottles for reminisce activities, were being used on the units.

Relatives we spoke with said they would have no hesitation in making a complaint, although they were very happy with the care being provided. A relative told us, "I have no complaints about the carers they have a lot to put up with."

Procedures were in place to investigate and respond to complaints. We found that the manager understood how to investigate complaints and take action to rectify concerns. Records showed that since they had taken over the running the service, no one had made a complaint. The regional manager discussed the range of ways the provider was encouraging people to make comments about the operation of the service including the use of online surveys.

Requires Improvement

Is the service well-led?

Our findings

At the time of our visit, the manager had been in post for just over two months and the regional manager had been in post for six months. Although they had been reviewing the service and making changes we found prior to the manager taking up post, there was little evidence to show effective processes were in place to monitor the service. For example, the provider had not identified that the staff team were incorrectly completing the dependency tool and there was no assessments or MCA compliant documentation in place. This demonstrated that there had been a lack of regular auditing of standards of care.

We found the quality assurance procedures in place lacked 'rigour'. Although some auditing and analysis was carried out, this was not always effective. For instance, the tool the provider had supplied for monitoring care records did not assist staff to look at wider issues, so they had not considered if the current process of using care plans to assess people was effective. We found the quality monitoring systems had not picked up that the previous manager had removed all of the MCA compliant documentation or that DoLS authorisations paperwork was not in place. The system had not readily identified that the previous provider undertaking to repair the second lift had not occurred, so only recently had action started to be taken to fix the lift.

Staff told us, "Some people can be volatile and we haven't had the training to deal with the situations that arise, such as when someone gets distressed and tries to hit us", "We could do with more staff, as on this unit two staff are very often hoisting and one is permanently in the lounge, so that only leaves one other person to deal with any problems", "The activity coordinator's workload is too much they are always busy so they don't have time to run activities on this unit", and, "At meal times there are enough people to support residents. Residents do seem to get the same food over and over again. I don't think there is enough variety, but residents don't tend to complain but I think that is because the teamwork is very good here."

We found that the provider's monitoring systems had not picked the above issues up, or that the general nursing unit was spread across two floor and the staff were predominantly deployed on the top floor, which meant people on the ground floor needed to be able to manage the majority of their needs independently . We discussed this with the regional manager and manager who were aware of these issues and taking steps to address them. They had reviewed the people using the ground floor of this unit and were finding accommodation upstairs for individuals who needed more support.

The provider's monthly visits form did not require that the regional manager to critically review the service and record areas of deficit. The form had not enabled the regional manager to reflect the feedback from staff and relatives we received about gaps and areas for improvement. This meant that all the provider received was information about positive aspects of the service, which would not assist them in taking prompt action should there be identified shortfalls.

This is a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Since coming in to post in September 2017 the manager had submitted an application to become the registered manager. CQC's registration team were in the process of dealing with this application. We found they provided focused leadership and demonstrated a great desire to provide an excellent service. They adopted an approach that empowered staff to constantly look at how improvements to the service could be made but the quality assurance processes needed to be developed further to support them to do this effectively.

During the inspection we saw the manager was active in the day to day running of the home. We saw she interacted and supported people who lived at Rydal Care Home. From our conversations with the manager it was clear she knew the needs of the people very well. We observed the interaction of staff and saw they worked as a team. For example, we saw staff communicated well with each other and organised their time to meet people's needs.

Staff told us "I find [name of manager] supportive as a manager. If they say they will do something I know they will do it". We saw that all staff had regular supervision meetings with a senior member of staff. This provided staff with the opportunity to talk about their training needs and reflect upon their care practice. A senior member of staff responsible for arranging supervisions said, "I do my supervisions. I try and do at least two a month because it's good for staff to have their say."

Staff told us that the deputy manager and nurses were really supportive and always at hand to help. They said they would explain their approaches and this assisted staff learning. People, relatives and staff told us that they had an excellent relationship with the manager and they were comfortable about raising matters with them as and when needed. Staff told us the manager truly valued them as well as the people using the service. A member of staff said, "The manager is brilliant, very approachable. If you have a problem you can go to her. There is on-going training, such as, moving and handling, sensory loss training, food and nutrition and dementia awareness. There is also a lot of E-Learning."

The people and majority of the relatives we spoke with were generally complimentary about the service and how it was run. People's comments included; "The staff are lovely", "I find the manager is always checking in with me and making sure I am happy", and "It seems to be well run."

The manager said they were extremely well supported by the provider and regional manager. They told us that the provider gave them autonomy to operate the service. They told us the provider had been receptive to their suggestions and had agreed that they could introduce destination points and dementia focused environmental changes to the units.

The manager had started to hold regular discussions with the people who used the service, relatives and staff, which provided a forum for people to share their views. Questionnaires were being sent out to people and their relatives, and resident and relative meetings were held. Records confirmed that a wide range of topics were discussed at these, for example, food and activities. The manager analysed the feedback to identify areas where people felt improvements could be made.

The staff we spoke with displayed pride about the service that they worked in. One member of staff said, "I love working here." All the staff members we spoke with described that they felt part of a big team and found the manager supported them to work toward delivering excellence. Staff told us they worked well with the local healthcare professionals and this was assisting them to ensure their practice remained current.

Services that provide health and social care to people are required to inform the CQC of deaths and other important events that happen in the service in the form of a 'notification'. The manager had informed CQC

of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems and processes that were in place to assess and monitor the quality of the service were effective. Regulation 17 (1)