Care First Class (UK) Limited

# Cherry Lodge

**Inspection report**

6 Manningford Road
Druids Heath
Birmingham
B14 5LD
Tel: 0121 430 5986

Date of inspection visit: 17 and 18 September 2015
Date of publication: 07/12/2015

## 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** |

## Overall summary

This was the provider's first inspection since registration in October 2014. The inspection was unannounced and took place on 17 and 18 September 2015. We planned this inspection to address concerns that had been shared with us about people falling and a number of safeguarding notifications.

Cherry Lodge is a residential long term care home providing accommodation and residential care for up to 46 people. The home also provides short stay interim beds for people discharged from hospital, who may require further assessment of their care and support needs before returning to their own home. At the time of our inspection 45 people were living at the home.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

# Summary of findings

The home had not been maintained to an acceptable standard of cleanliness. This failed to provide people with a pleasant and homely place to live. It also posed a risk of contamination with the potential to cause people illness.

Staff understood their responsibility to take action to protect people from the risk of abuse and harm because the provider had systems in place to minimise the risk of abuse. However, we saw that staff did not always follow the assessments to minimise the risks associated with people's care and this put people at further risk of injury.

The provider had not always recognised when the care being offered had put restrictions on people's ability to choose and move around freely. Restricting people's freedom to move around without the necessary authorisation meant that the provider was not meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards, therefore people's human rights were not protected. You can see what action we told the provider to take at the back of the full version of the report.

People were supported to receive their medicines but some people did not always receive their medicines as prescribed.

People were supported to receive care and treatment from a variety of healthcare professionals and received treatment if they were unwell.

There was some caring and compassionate practice and staff demonstrated a positive regard for the people they were supporting. Staff understood how to seek consent from people and how to involve people in their care. Although preserving some people's dignity had not been consistently maintained.

People were asked to join in a range of activities but they were not always person centred and suitable to meet people's individual choices. There was little evidence to support people had been able to maintain interests that they had before moving to the home. For much of our inspection people were sleeping and there were limited opportunities for people to engage or be motivated

There was a complaints process that people and relatives knew about. There were inconsistencies experienced by relatives as to the effectiveness of the complaints process. Systems were not in place to help the provider learn and develop the service from feedback and outcomes of complaints.

Systems were in place to monitor the quality and safety of the service but they had not always been effective and timely action had not always been taken to bring about the improvements needed.

People were able to choose what they ate and drank. Although some people did not always have a pleasant meal time experience. The provider was not always effective when people requested a different choice of meal, from that being offered on the day.

There were sufficient staff to meet people's identified needs. The provider ensured staff were safely recruited and they offered the necessary training to meet the support and care needs of people.

# Summary of findings

## 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 consistently safe.

The standard of cleanliness was poor and meant people had to live in a home that smelt unpleasant, was dirty in places and which could make them ill.

People were at risk of having their care needs unmet because their assessed needs for care were not always followed by staff.

People had not always received their medicines as prescribed.

People felt safe living at the home.

**Is the service effective?**

Requires improvement

The service was not consistently effective.

There were arrangements in place to ensure that decisions were made in people's best interest. However, the deprivation of liberty safeguards had not been followed. This did not ensure people's rights had been protected.

Most people enjoyed the meals provided but some people could not be certain they would receive a meal of their individual choice.

Some people with dementia were confused about their environment because the provider did not have effective dementia friendly signage and communication aids in place to support people.

**We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'**

**Is the service caring?**

Requires improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Individual staff demonstrated kindness and compassion.

People were supported to maintain their independence.

**Is the service responsive?**

Requires improvement

The service was not consistently responsive.

People received a service that was not always based on their individual needs.

People were supported to participate in a range of group or individual activities but these were not always centred on the person's individual choices.

The systems in place to listen and learn from people's experience were not always effective.

# Summary of findings

**Is the service well-led?**

The service was not consistently well led.

People did not benefit from a service that was well led. The processes in place to check and monitor the quality and safety of the service and manage complaints were not effective and had not ensured people were benefitting from a service that met their needs.

The registered manager did not demonstrate good leadership in ensuring people's rights were protected.

People felt happy with the service they received.

**Requires improvement**

# Cherry Lodge

**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 unannounced inspection took place on 17 and 18 September 2015. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed information we held about the service. This included information about deaths, accidents and safeguarding alerts that the provider is required to send to us by law. We contacted the local authorities who purchased the care on behalf of people to ask them for information about the service and reviewed information that they sent us on a regular basis. We had received information about people falling and safeguarding notifications which also informed our inspection planning.

During our inspection we spoke with 15 people, 12 relatives, five health care professionals, the registered manager, the provider and seven staff that included care workers, team leaders, kitchen and domestic staff. Because some people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a 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 records in relation to five people's care and three medication records to see how their care and treatment was planned and delivered. Other records looked at included three staff recruitment and training files. This was to check staff were recruited safely, trained and supported, to deliver care to meet each person's individual needs. We also looked at records relating to the management of the service and a selection of the service's policies and procedures.

Requires improvement

# Is the service safe?

## Our findings

There was a strong and unpleasant odour throughout the home. We asked people, their relatives and staff about the cleanliness of the environment around the home. One relative told us, "There are a few smells, there does seem to be a smell of wee somedays." Another relative said "It's not very nice when I come into [person's name] bathroom and it smells." A third relative told us, "I know [person's name] room smells of urine but it can't be helped." A member of staff told us, "Sometimes we run out of cleaning materials." During our inspection, we saw staff had access to cleaning materials and had access to and used protective clothing when supporting people. We looked around the home and found an uncovered bin containing used tissues, a bag of clinical waste awaiting disposal left unattended in a communal bathroom, a dirty bath, the external casing of a toilet facet was soiled and carpets that did not smell fresh. We observed broken and missing bathroom fittings and damaged tiles that would not facilitate full or effective cleaning and washing of hands.

We brought our findings to the attention of the provider and the registered manager. Although domestic staff was present on the day, one domestic staff member was on holiday which left them short staffed. We saw that staff were cleaning the premises and had sufficient supplies on their cleaning trolleys and there was a cleaning rota in place. However, when we asked to see the carpet cleaning schedule, we were told there was not one and that the carpets were cleaned, "As and when". We were also told that usually the home had two carpet cleaners however, one of the carpet cleaners had recently broken and the provider was in the process of getting it repaired. The registered manager explained the odour was from the night before and the domestic staff had not finished their morning cleaning regime but that they would ensure the situation would be improved upon by the end of the inspection.

Cherry Lodge as well as providing long stay care, the provider also provided interim short term care for some people who were recovering following a stay in hospital. People usually stayed for approximately six to eight weeks before being assessed as sufficiently recovered to return home. The first floor lounge contained a small kitchenette area. The registered manager explained the kitchenette was used by a health care professional to assess people's capability to prepare and cook food before they went home. Although we were told the kitchenette had not been used for some time because the microwave oven was out of order, the registered manager confirmed the fridge in the kitchenette was also used by people who lived at the home, visitors and relatives if they wanted to make their own drinks. We saw the fridge contained food and drinks. The registered manager was unable to explain to us what systems they had in place to make sure out of date food and drink was monitored and discarded when out of date. There was no daily record of the fridge temperature to ensure food and drinks were stored at a safe temperature. We observed out of date and decaying food in the fridge which if eaten or used would have caused a person to be ill.

Risk assessments had been completed for people when they moved into the home. We saw equipment such as pressure relieving mattresses and cushions were in use to support people who were at risk of developing skin damage. However, the identified risks to people were not consistently managed. For example, a recent risk assessment for one person, had identified there was an infection in their legs and they required cream and a course of antibiotics. Staff had been unable to administer all of the cream because the person regularly refused treatment from them. The person's mental capacity to consent to medicine fluctuated. The risk assessment should have contained information for staff on how best to encourage and support the person to receive their treatment. The registered manager explained the family would visit and administer the cream and confirmed the person would refuse assistance from staff, but they would contact the GP and ask them to visit the person again.

People were supported by staff with their medicines. People we spoke with told us they had no concerns about their medicines and confirmed they received their medicines on time and as prescribed by the doctor. We observed one person asked for their medicine. A staff member told them that they had already received it. The person explained they had not. After making additional checks, the senior care staff confirmed to the person they had not been given their medicine and apologised for the oversight. Although the person had not experienced any adverse effects as a result of the omission, the medicine aided their indigestion and as this happened after their lunch, the person could have suffered some discomfort.

Requires improvement

# Is the service safe?

Medicines were stored appropriately in order to keep them secure and maintain their effectiveness. We saw that the correct quantities of medicines were in stock. All medicines received into the home were safely stored, administered, recorded and disposed of when no longer in use.

Safety checks of the premises and equipment had been completed and was up to date. During the inspection there was fire alarm activation. Within five minutes, floors had been checked and a roll call completed. The provider had safeguarded people in the event of an emergency because they had procedures in place and staff knew what action to take.

People we spoke with told us they felt safe living at the home. One person said, "They look after me well and keep me safe." Another person told us, "I feel safe." A relative said, "I feel my mom is safe here." People and relatives felt they could raise concerns with the registered manager if they were worried. Health care professionals we spoke with felt their clients were safely cared for at the home.

All the staff we spoke with had a good understanding of how to safeguard people. They told us what they would do if they had concerns about people and how they were being looked. One staff member said, "I would go straight to the manager and if the person had a social worker, I'd let them know." Staff told us they had received safeguarding training and were clear about their responsibilities for reducing the risk of harm. Staff told us about the different types of abuse and explained what signs they would look for that could indicate a person was at risk. We saw that staff received training and refresher training updates were in the process of being reviewed and arranged for 2015.

People and relatives felt there were enough staff, but we were told that there had been shortages in the past. A relative told us, "Staffing has got a lot better in the last few months." We saw that call bells were answered in a reasonable length of time and there was sufficient staff on duty to meet people's needs. Although speaking with staff, they expressed mixed opinions on staffing numbers. A staff member said, "I'd say people are safe, they are always staff around." Another staff member told us, "I think residents are safe but sometimes we can be short staffed." A further staff member said, "Sometimes, there's not enough staff." We asked the registered manager how they managed any staff shortages. They told us the service had experienced some difficulties in the last few months with staffing. They had to dismiss some staff members because they had not displayed or worked to the professional standards the provider required. The registered manager confirmed they did not employ agency workers and instead offered overtime to staff so that people had continuity of care. We saw they were in the process of recruiting additional staff for the vacancies they had at the home.

The provider had a recruitment process in place to make sure they recruited staff with the correct skills and values. The registered manager explained it was more important they recruited people who demonstrated the right values. They continued to tell us it was not necessary for new staff to have experience because training would be provided. Three staff files showed all the pre-recruitment checks required by law were completed, including a Disclosure and Barring Service (DBS) check and references. The DBS check helps employers to make safer decisions when recruiting and reduces the risk of employing unsuitable people.

Requires improvement

# Is the service effective?

## Our findings

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. DoLS requires providers to submit applications to a 'Supervisory Body' for permission to deprive someone of their liberty in order to keep them safe.

We spoke with staff about their understanding of DoLS and they were all able to provide a basic explanation and identified people who they felt could be put at risk if they were not restricted, for example, from leaving the home unsupervised. One staff member told us, "[Person's name] wants to go home and we have to tell them they can't." Two people became anxious and upset when they were reminded by staff that Cherry Lodge was their home and they were unable to leave. We saw that some people were closely supervised and some people had been subjected to a restricted practice, in their best interest, to prevent injury to themselves or others. Although the registered manager had submitted two DoL applications, no applications had been made for at least three people. The provider had not followed the requirements of the DoLS. The registered manager told us they understood their responsibility to make applications effectively and recognised that applications needed to be made to the Supervisory Body. They told us that they would start the referral process. Measures in place did not make certain that the provider had taken steps to ensure the legislation was appropriately applied and people's rights upheld. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We discussed the Mental Capacity Act 2005 (MCA) with the manager. The MCA sets out what must be done to protect the human rights of people who may lack mental capacity to make decisions about care and medical treatment. They showed that they were knowledgeable about how to ensure that the rights of people who were not able to make or communicate their own decisions were protected. We saw care records showed that the MCA principles had been followed when decisions were made in people's best interest. The registered manager recognised that important decisions needed the involvement of other health and social care professionals and they told us about the steps that they had taken to arrange 'Best Interest' meetings.

People we spoke with told us they were offered choices at every meal. Although we saw that the menu had not been provided in different formats so that people who communicated in different ways could understand. We discussed this with the provider and the registered manager and by the end of the second day of our inspection, the provider had compiled picture menus to assist people with their choices.

One person explained that they did not always get the choice of meal they had asked for. For example, we saw the person inform staff the meal given to them was not what they had ordered. The person became distressed when they were unable to have the meal they had previously chosen. After some discussion between the kitchen and care staff and checking the person's menu choice, the meal was eventually replaced with the person's preferred choice. Effective arrangements were not in place to ensure that people received their preferred choice of meal.

The atmosphere in the dining area was generally calm and relaxed. Staff provided support to people who required it and people, if they chose to, were able to eat their meals in their bedrooms or the lounge areas. We saw that staff supported people to access snacks and drinks throughout the day which encouraged people to eat and drink enough to keep them well.

Staff told us people were assessed to meet their individual needs and to ensure people received a healthy and balanced diet. One relative told us, "[Person's name] seems to eat well; they [staff] keep checking their weight." We saw that people's dietary needs, preferences and allergies, were shared with kitchen staff. Fortified food and drinks were provided where needed and records showed people were referred to a dietician and Speech and Language Therapist support (SALT) where appropriate

Cherry Lodge as well as providing long stay care, the provider also provided interim short term care for some people who were recovering following a stay in hospital. People usually stayed for approximately six to eight weeks before being assessed as sufficiently recovered to return home. We saw the corridors were spacious and free of trip hazards. There were seats available around the home, on the ground floor, for people to sit and relax when walking around. People were able to walk independently about the home. However, one person required assistance to find the ground floor bathroom. They had become confused, all doors on the ground floor, including bedrooms, were the

Requires improvement

# Is the service effective?

same colour with no dementia friendly signage displaying where the bathroom was. We discussed this with the registered manager and they told us this was something they were already reviewing with the provider.

**We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.**

People received support from staff that was trained to carry out their roles. Staff we spoke with felt supported in carrying out their roles. One person told us, "I think the staff has the right skills to care for me, they always explain things." A relative told us, "I'm confident the staff have the correct skills to support [person's name], the care is very good." We saw the provider had an ongoing training programme to support staff and had introduced an induction programme for new staff to incorporate the Care Certificate. The registered manager explained the staff would receive the benefit of external tuition and support as well as support from the registered manager. One staff member told us, "My induction was good, I've learnt a lot."

Staff told us they had received supervision. One staff member told us, "We do have supervision and if I am worried about anything, I can talk to the manager or the seniors." We saw records that showed that staff supervisions had taken place.

People said they were regularly seen by the doctor and other health care professionals. One person said, "I've just had a visit from the nurse." Staff spoken with were knowledgeable about people care needs and how they preferred to be supported. We saw during our inspection a number of health care professionals visit people. A relative said, "I'm very happy with the home, [person's name] could not wait to return after their stay in hospital." Health and social care professionals had told us they found the staff to be knowledgeable of people's health and support needs. Staff would contact them, when a person's needs changed, which supported people to maintain their health and wellbeing

Requires improvement

# Is the service caring?

## Our findings

People and their relatives generally told us the staff were caring and kind. One person said, "The staff are alright some are better than others," another person said, "They [staff] are kind to me, it's very good here." A staff member told us, "From what I've seen it's ok here. Most staff are kind and caring." A relative told us, "Most of the staff are very good, but some don't acknowledge you." Another relative said, "Sometimes the staff just ignore us when we visit." We discussed this with the registered manager who confirmed they had experienced some difficulties with staff. The registered manager explained that certain staff had not displayed the 'qualities' Cherry Lodge promoted and had been dismissed.

People felt they could approach staff although they were concerns that staff were sometimes busy with one person saying, "They can't just sit and talk to a person." This was supported by a relative who told us, "Staff are very kind here but mom waits." The registered manager showed us they were in the process of recruiting new staff and had a number of interviews scheduled over the next few days. During the two days of our inspection, we saw that the home was very busy but that staff responded to people in a timely and flexible way.

There were a number of people living at the home with dementia who communicated in different ways. We saw staff responded to people with a caring and calm manner and their approach was flexible to meet the person's individual needs. We saw from the expressions on people's faces and their body language that they were happy with how the staff were supporting them. A relative said "The staff are very kind here." Staff told us people chose what time they got up and what time they went to bed. One staff member said, "We let people get up when they want to, it's their home."

People who could tell us felt they were listened to by staff. Staff explained how they supported people who could not express their wishes. Staff told us that once they got to know people, they could tell by facial expressions and body language whether the person was happy with their care. Alternatively, staff could also identify from a person's reaction when they were not happy. Staff said they would make sure they would deliver care in a way the person was happy with. If the person was not happy, staff told us they would find different ways to deliver the care until the person was happy. Staff told us they treated people with kindness and empathy; they understood people's communication needs and gave people the time to express their views, listening to what people said. We saw a staff member come down to the eye level of one person who had become distressed. They spoke to the person in a soft, calm manner. We saw the person became more relaxed. Staff were able to demonstrate they knew people's individual needs, their likes and dislikes and this assisted staff to care for people in a way that was acceptable to them. We saw and heard staff respond to people in a patient and sensitive manner.

During most of our inspection we saw that people's privacy and dignity was promoted. One person told us, "All the staff treat me with respect and observe my dignity". Another person told us, "The staff are very respectful." We saw that staff knocked on people's doors, referred to people by their preferred name and were polite and courteous. However, we saw one instance where a staff member brought a person into the general office to attend to the person's support needs. We spoke with the staff member and suggested that maybe the person's bedroom would be more appropriate. The person told us they were happy to go to their room. The staff member left the office and went with the person to their room. We discussed what we had seen with the registered manager. They explained this was most unusual although the person did not always agree to go to their room with staff to receive personal care. This was not what our observations showed.

People who could, chose to walk freely around the home. A number of people were supported to walk by the staff at a pace suitable for the person. In the downstairs lounge, we saw the interactions between staff and the people were respectful. At lunchtime, to promote independence, we saw one person helped to lay the dining tables and helped with clearing the tables. People were dressed in their individual styles of clothing that reflected their age and gender.

People had been supported to maintain relationships with family members and friends they said were important to them. A relative told us "We visit at different times and days." During our inspection, we saw a high number of relatives and friends visiting their family members. There

Requires improvement

# Is the service caring?

were opportunities for relatives to meet on the first floor lounge for privacy or in the person's bedroom; giving people the opportunity to meet with their relatives in private.

Requires improvement

# Is the service responsive?

## Our findings

We saw one person who wanted to retire to bed. They waited 25 minutes for the hoist to be brought so that they could go to bed. During that time the person became distressed. We were told by the provider that the home had one hoist and one stand aid. There was a high number of people living at the home that required support with a hoist. With only a limited number available, we saw this put people at the risk of not receiving a responsive service in respect of the care and support they needed, at the time they requested it.

Staff were able to tell us about people's individual needs, their likes and dislikes. The care plans we looked at confirmed an assessment of people's needs had been undertaken when they moved into the home and these had been reviewed. Relatives confirmed that most staff supported their family member, in a way that was responsive to their individual needs. One relative told us, "They keep telling mom that she's not trying hard enough, but that just makes her cross." We discussed this with the registered manager they told us this may be a training need for staff and their awareness of the person's diagnosis. They told us this would be addressed with training.

All staff shared responsibility for providing activities for people to do. Everyone we spoke with told us they were bored. One person told us, "There really isn't much to do, I just sit here." Another person said, "There's no activities." Most of the relatives we spoke with felt more could be done, by the provider, to take people out and provide them with more 'meaningful things' to do with their time. There were no person centred activities or hobbies although we saw some people were reading newspapers and magazines. Staff were speaking with and encouraging people to take part in some group lounge activities. Two people were putting a jigsaw together however the table they were using was too small for all the pieces. A card game being used by one staff member who asked people to identify what the object was, was described by one person as, "A bit patronising."

On the second day of our inspection, we saw group activities were offered to people which included bingo although a number of people showed no interest in it. There was not enough information in people's care plans to help staff support people to engage in individual interests they had enjoyed in the past. A visiting professional commented they would like to see more activities and dementia friendly visuals. We discussed the comments made by people, relatives and professionals with the registered manager and the provider who explained they had regular activities, arranged trips out with more planned for the future.

There was a mixture of opinions about communication between the home and relatives. One relative told us, "The communication here is poor. We have to keep asking for what is happening. It's never quite clear and nobody seems to know what's going on." Another relative said, "We get regular calls from the manager, they always make sure we know what's going on because we can't always get to visit each week." Health care professionals told us, they felt the provider responded appropriately to requests made by them.

People and most relatives told us they felt free to raise any concerns but there was mixed opinions on whether they would be addressed. One person told us, "If I wanted to make a complaint, I would go to the office." Another person said, "The staff would contact my family. If I had any concerns, I would tell the staff." A relative said, "I have had to raise a couple of things and have always found the manager really good at sorting things out." Another relative told us, "I had to make a complaint but wasn't really satisfied with the outcome." We looked at how complaints had been managed and found these had been investigated by the registered manager. We saw action plans had been developed but no outcomes had been recorded to identify trends. Identifying themes and trends from complaints would enable the provider to learn and further develop the service

People we spoke with told us they were happy with how their care and support needs were being met. One person said, "The staff ask me if I am happy with the care they give me." A relative told us, "I have regular discussions with staff about [person's name]." Staff we spoke with knew about the people they supported and were able to provide a personalised approach to care based on people's needs. We saw from care plans that people and relatives had been involved in reviews. One relative told us, "I'm involved in all the care planning reviews." Another relative told us that they had attended all their family member's reviews.

Requires improvement

# Is the service well-led?

## Our findings

There was a registered manager in post. The registered manager had notified us about the events that they were required to by law. There had been a high number of falls at the home, which had been recorded and reported. There were quality assurance systems in place based on auditing the service at regular intervals. However, they were not always effective at identifying areas that required improvement. Although action plans had been devised on those areas that had been identified, there was no system in place to monitor trends in respect of accident, incidents and safeguarding incidents. We saw that information in relation to these were not always communicated effectively and recorded within their processes. Therefore the provider could not be confident the records and audits would be an accurate reflection of the service. Improvements were needed to some people's care records to ensure that they were accurate and up to date.

We saw that there were some formal processes in place to get feedback from people and their relatives. We saw the provider was in the process of gathering feedback. There were also opportunities to raise issues in meetings held for people and their relatives. However, not everyone we spoke to was aware these meetings took place. One person told us, “I don’t know of any meetings,” Another relative said, “I can’t recall being invited to any meetings.” The registered manager told us they did put notices on the notice board but acknowledged that maybe more could be done to ensure relatives were aware when meetings were due to take place. We saw that meetings had taken place but noted there was no process to let people and relatives know what was going on within the home for example through a newsletter. One relative told us, “It would be nice to get a newsletter this would keep us up to date with what’s going on.” We discussed the newsletter with the registered manager and the provider, they told us this was something they would consider for the future.

Generally everyone was complimentary about the service. Most of the people, relatives and staff spoken with told us, and we saw that the atmosphere in the home was welcoming. People told us they knew who the registered manager was and saw them on a regular basis. One person said, “I know the manager and they make themselves available to me and my family.” A relative told us, “The manager is brilliant; they have been so supportive of my family through what has been a very difficult time. Another relative said, “I haven’t seen the manager much.” People and relatives told us that they could speak with members of the management team, at most times because there was an ‘open door’ culture to the office. We saw that people approached the registered manager and other staff freely during our inspection visit.

Staff we spoke with told us they were able to raise concerns at staff meetings which were held approximately every six weeks. Staff were supportive of the provider’s vision for the development of the service, one staff member said, “I do love working here.” Another staff member told us, “You do get support from the managers they are very friendly and they come out onto the floor.” Most of the staff we spoke with told us they felt like they belonged in a team. They felt ‘motivated’ and committed to providing a ‘personalised service’ to the people living in the home. One staff member said, “The manager is very approachable, they will get involved with things.” A second staff member told us, “There is a nice feel to the home, management will listen, and everybody gets on well.” We saw team meetings were held approximately every four to six weeks. Staff training records confirmed staff had training opportunities and were supported through supervision.

The management structure was clear within the home and staff knew who to go to with any issues. Staff told us they would have no concerns about whistleblowing and felt confident to approach the registered manager, and if it became necessary to contact Care Quality Commission (CQC) or the police. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations. We saw the provider worked well with the local authority to ensure safeguarding concerns were managed.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People who use services and others must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5) |