Minster Care Management Limited

Chestnut Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Chestnut Lodge is a care home providing personal and nursing care to up to 64 people. The home has four units and at the time of the inspection was at capacity. The home cared for people who were living with the experience of dementia and for people being cared for at the end of their lives. Minster Care Group has a number of care homes throughout the UK.

People's experience of using this service and what we found
During the inspection we identified a number of environmental concerns such as people being able to access cleaning products that meant risks were not always managed safely. We also found COVID-19 risk assessments and risk management plans were not always in place. Medicines were generally managed safely, however we found out of date creams and creams were not always stored securely.

The provider had quality assurance systems in place to monitor and manage the quality of service delivery. However, these were not always effective as they had not identified the various areas we identified during our inspection as needing to improve.

The provider had systems in place to safeguard people from the risk of abuse and staff knew how to respond to possible safeguarding concerns. Safe recruitment procedures were followed and there were enough staff to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were supported to maintain healthy lives and access healthcare services appropriately.

Staff were supported to develop their skills and provide appropriate care through inductions, supervisions, appraisals, training and team meetings.

People and their relatives told us people were cared for by kind and supportive staff who knew the needs of the people they cared for.

Care plans were personalised and recorded people's preferences, so staff knew how to respond to people's needs appropriately.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 10 March 2020 under a new provider and this is their first inspection. The last rating for the service under the previous provider was good published in October 2018.

Why we inspected
This was a planned inspection based on the date of registration.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Chestnut Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors, a nurse specialist advisor 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 care service.

Service and service type
Chestnut Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since registration. We also sought feedback from the local authority who works with the service. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is

information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We spoke with 13 people who used the service and two relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, deputy manager, nurses and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• We saw environmental and maintenance checks has been completed to help ensure people lived in a safe environment. This included fire equipment, lighting, electrical, gas and lifting equipment checks. An environmental cleanliness audit was also completed.
• However, during the inspection, we saw a large pile of rubbish outside the home that needed to be removed.
• We found toilets being used as storage rooms. In one of the toilets there was a cleaning trolley and potentially harmful cleaning products were not stored securely. We discussed with the managers removing the toilet signs and locking the doors.
• We also saw medicines cupboards behind the nurses' station with unlocked doors. Medicines trolleys in the cupboards were locked but one cupboard had medicines in boxes on a shelf, which meant there was the possibility of people accessing them.
• In addition, we saw a trolley with tools left unattended in a bedroom.

We found no evidence that people had been harmed however, the provider had failed to robustly assess the risks relating to the safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's records included risk assessments and risk management plans. Areas of risk assessed included medicines, mobility, skin care and personal care. These were integral to the care plan and provided guidance for staff to meet people's individual support needs.
• Staff understood people's needs and were able to explain these to us during the inspection. We also observed staff supporting people to mobilise safely and supporting them to eat safely.
• People had personal emergency evacuation plans (PEEPs) which indicated how each person should be evacuated evacuate safely in an emergency. They additionally had a London Fire Brigade person-centred fire risk assessment.

Preventing and controlling infection
• The provider had infection prevention and control procedures in place. However, we found there were not individual COVID-19 risk assessments for people using the service. Additionally, not all staff had completed COVID-19 assessments. This meant indicators such as ethnicity and underlying medical issues which could have increased the level of risk to a person if they were to develop COVID-19, had not been considered.
• The provider had enough personal protective equipment (PPE) and we saw most staff using and disposing of it appropriately. However, we observed some staff wearing masks that were not fully covering their nose

and mouth.
• There were posters explaining infection control, handwashing technique and how to put on and take off PPE reminders throughout the home. There were also hand sanitisers, soap and paper towels available.
• Staff said they felt supported throughout the pandemic and had received infection control training.
• An enhanced cleaning schedule had been implemented to help prevent the spread of COVID-19 and we observed the home to be clean.
• Visitors were aware of the infection control procedures and we observed these were followed. People and their relatives consistently told us staff wore PPE including gloves, masks and aprons.
• The provider undertook COVID-19 testing for everyone in the home and we saw evidence that people using the service and staff had been vaccinated against the virus in line with government guidance.
• In addition, the home is part of a UK Health Security Agency study that checks people for both COVID-19 and antibodies to help understand the spread of COVID-19 in care homes.

Using medicines safely
• Medicines were generally managed safely but we found that barrier creams were not always stored securely. We also found an out of date cream in one person's room. Creams were checked on a monthly basis, however we noticed some gaps in the recording book when care workers applied creams. We raised this with the nurse who said they would address it.
• Additionally, we found that room and fridge temperatures where medicines were stored had not been recorded over the weekend.
• Staff had appropriate training and medicines competency testing to help ensure they were administering medicines safely.
• Records indicated people received their medicines as prescribed and there was guidance on when and how to give people 'as required' medicines, for example, for the relief of pain. We also observed time specific medicines were administered appropriately.
• The provider undertook medicines audits to help ensure medicines were administered safely and errors were acted on and addressed.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems and processes in place to help safeguard people from abuse and avoidable harm. People told us they felt safe at the service. One person said, "I am at ease. I feel comfortable here. I have no worries now" and a relative confirmed, "I'm happy with [person] being here. I know they are safe here'.
• Staff had completed relevant training around safeguarding adults and knew how to raise any concerns. One staff member told us, "Anything [of concern] I would inform my manager. Like physical signs and their expression. We know them, we are like a family. They can't speak but we know them well and what they are trying to tell us. If we see [anything of concern] we tell the senior".
• The provider had safeguarding policies and procedures in place. When a safeguarding concern was identified the provider had alerted the correct agencies and worked with the local authority to address the issue and put actions in place to help prevent future reoccurrence.

Staffing and recruitment
• There were enough suitable staff working at the service. The provider followed safe recruitment practices. Appropriate pre-employment checks including references from previous jobs and criminal record checks had been completed. After being recruited, staff undertook an induction and training, so they had the required knowledge to care for people.
• We observed enough staff to meet people's needs. Staff agreed and told us, "Yes [there is enough staff]. I've worked on every floor. It's teamwork. We have 12 hours shifts, you have to get on with your colleagues at all times" and "I think its fine. We can get additional help when we need it and we try to give a safe, good service

for residents. We can manage."
• The provider used very little agency staff which meant people received care and support from regular staff who knew their needs.

Learning lessons when things go wrong
• The provider had systems for learning lessons when things went wrong. Incidents and accidents were recorded and demonstrated appropriate action had been taken to address the identified concerns. This included immediate action taken and recommendations to prevent future incidents.
• Records indicated there had been learning following shortfalls. For example, we saw supervision records contained information about ensuring people had enough fluid intake and that this was followed up over time to monitor improvements.
• The provider completed a monthly analysis of trends and a quarterly record of lessons learned from incidents and accidents to help improve their service delivery.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
• The provider had system in place to manage dietary requirements, but these were not always robust enough. For example, the pre-order menu forms did not include if people were diabetic, so they could be supported to make appropriate choices in terms of diet.
• The pre-order menus did not record who required fortified food. Fortified food is food with additional calories. Food was not fortified by kitchen staff but by staff in each individual unit and there was no record of when staff fortified food. We discussed one person's weight who had instructions from the dietician to have fortified food. It was noted that the person's weight went up, but there was no evidence that the dietician's instructions were being followed and the person was assessed to be at high risk regarding their weight. We found no evidence of harm and the impact was minimal but the recording systems for fortified diets were not robust enough.
• A menu order form, with a choice of meals, was completed daily. It contained people's choices and known food preferences. Some dietary requirements such as 'pureed' were also included on the form.
• Care plans included assessments of dietary needs and preferences. When required, people's nutritional needs and weight were assessed and monitored for changes.
• The staff encouraged good hydration and we saw people consistently had drinks within easy reach.
• People told us they enjoyed the food and said it was "nice and tasty". They also said 'Fish and Chips Friday' was a popular meal.

Adapting service, design, decoration to meet people's needs
• Chestnut Lodge is a purpose-built home. Communal areas were appropriately decorated, and we saw good examples of tactile decorations particularly in the hallways. However, the home supported people living with the experience of dementia and signage needed to be improved so all communal rooms and rooms such as toilets had picture signs as well as word signs. This would help people know what was behind a door even if they could not read the sign. In other places there was good signage for toilets and bathrooms with both clear symbols and words. Photos of people on their bedroom doors helped to orientate them to their rooms
• We observed numerous items of interest throughout the home for people to touch and look at. These included, textured wall hangings and one hanging made of metal tools such as spanners for people to look at and touch.
• People's rooms were en-suite and personalised to their tastes. When required, people had specialist beds and sensor equipment which we observed to be in working order and checked regularly by staff.
• People had access to an onsite hairdresser, pub, reminiscence room, garden room and music room. We

found evidence of the pub being used, but we did not see evidence of use of the other three rooms. There was also a garden for people and their visitors' use.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were assessed prior to moving to the service to determine if the service could meet the person's needs. The information indicated the person and their relatives had been involved in the assessment and professional assessments and support plans from the local authority were also included in the records.
• These were used to develop the care plans which were detailed and personalised and meant staff had relevant information to support people with their choices.

Staff support: induction, training, skills and experience
• People were cared for by staff who had relevant skills and experience.
• Staff were supported to develop best practice and keep up to date with relevant guidance through inductions, supervisions, annual appraisals and team meetings.
• Staff had received all the relevant training and told us they felt they had enough training, A course around behaviour management was identified as being helpful to manage the anxiety and distress sometimes experienced by people living with dementia. One staff member said, "We get training, but if you forget there are colleagues to ask or the manager or deputy, or seniors. There is a lot of support." Staff also confirmed they found supervision and team meetings helpful.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Care plans recorded personalised information about people's healthcare needs and there was evidence of the provider worked with other professionals including the GP, tissue viability nurse, speech and language therapist, optician, dietitian and palliative care nurses to help ensure people received appropriate care. They also had a good working relationship with the memory clinic.
• Records were kept for a number of areas including food and fluid consumption, behaviour and repositioning. These helped to monitor people's care needs.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• We found the principles of the MCA were being followed. People's mental capacity had been assessed and best interests decisions had been made appropriately and as required.
• Where necessary, the registered manager had made applications for DoLS authorisations in accordance with people's best interests so people's freedom was not unlawfully restricted.

• Staff had received training around the MCA and asked for consent before providing care.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People were treated with dignity and respect and were supported by staff who understood the needs of the people they were caring for.
• People's care plans contained information about their diverse support needs. For example, guidance for staff in care plans stated what religion the person was known to have observed and if they still were actively undertaking religious observations. If they were, then these were stated and what support might be needed.
• Staff had undertaken training in equality and diversity and were aware of the importance of respecting people's individual needs and protected characteristics.
• The home held different themed days that celebrated cultures from around the world.
• We observed positive and caring interactions between people and staff. We observed one person unable to understand why they were in the service and this upset them. Staff members engaged with the person and showed a genuine interest in what the person was saying. They distracted the person by asking about their family life, the local area and things that interested the person. Staff clearly knew the person well as they were able to talk at length about these things with the person.
• All staff were seen to be patient and proactively engaging people in adult to adult conversations. There were jokes, light banter and encouragement for people to join in and not remain alone in their bedrooms.
• We observed another occasion where staff sat beside a person and had a meaningful conversation with them, in an unhurried way. One staff member said, "Sometimes it's just enough to have a nice chat. [Person] is often frightened. I just hold [their] hand and talk to [them] and [they] will calm down. Sometimes a cup of tea or sitting with them at meals. We show we respect them. We are like one big family. They need support more than other people, that's why we are here."

Supporting people to express their views and be involved in making decisions about their care
• Care plans contained guidance about what everyday decisions people could make. Where people had difficulty expressing their wishes, relatives were involved in care planning to help ensure people's needs were met in a way that was best for them.
• People appeared content with the care they received and told us, "I can't say anything against staff, they're pretty good" and "I never have to ask for anything".
• We observed care workers give people a choice of drinks and asked if they wished to eat or not. We saw examples of people's decisions being respected about when they wanted to get up in the morning, having a late breakfast, returning to their rooms and joining in activities or not. One person liked walking into the garden. It was cold on the day of the inspection and they were supported to dress warmly so they could go outside. Another person told us, "I get up when I want depending on how I'm feeling but they bring my breakfast if I don't get up."

Respecting and promoting people's privacy, dignity and independence

• People's privacy and dignity was respected, and staff encouraged people to maintain their independence. We observed people were supported to eat independently when possible. For example, some people used plate guards and the pre-order menu plan recorded when people found it easier to have 'finger foods' which could be held and eaten rather than using cutlery. This allowed people to manage eating by themselves. People were encouraged to bring their empty plate back to the kitchenette if they could, and a couple of people carried their own dessert plate back to the dining table.

• People were dressed appropriately and were supported to remain tidy and well groomed. Staff approached people and offered support in a sensitive manner. They encouraged people to change their clothes or use the toilet in a discreet friendly manner. One member of staff told us, "In personal care, doors are closed and curtains are closed. I whisper, do you what to use the toilet? Always treat them like you would want to be treated. We must maintain privacy and dignity at all times."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People received personalised care that was responsive to their needs. Care plans were person centred and recorded people's preferences about how they wished to receive care. Background history and individual interests were recorded thoroughly. Information such as the person's culture, religion, preferred language and food preferences were also clearly recorded.

• Tasks such as personal care, moving and handling support and support to manage distress or agitation had clear guidance for staff on how to meet people's needs. For example, one person needed staff to offer medicines when they were out of bed as they would not take medicines in their bed. Another person required two staff members to offer personal care. One to talk with the person, engage and encourage them while the other completed the personal care activities.

• Care plans were on an electronic system. Staff had handheld devices which prompted them when tasks were due. This included for example, checking someone in bed to make them comfortable.

• In terms of planning care, relatives told us they felt that their input, comments and suggestions were listened to and acted on by the staff.

• People's care plans were regularly reviewed and updated to reflect current needs. Changes to care plans were also discussed during shift handovers. One staff member confirmed, "Always we have handovers on every shift. Always if they have anything new, or if anything changes, [the seniors] tell us and if we see anything we report to the senior. Communication is vital."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs had been assessed and care plans included information about this, including if they required assistive aids such as glasses or a hearing aid.

• There was guidance about how to communicate with people including how to understand people's non-verbal communication. For example, one person who did not verbalise used flash cards and communicated through writing. Staff confirmed this and said they understood the person well because of familiarity with their sounds but they also used flash cards and a tablet to help with understanding. A relative said about another person, "Staff have found a way of communicating with [person]. They know what mood they're in from their sounds."

• Staff spoke a range of languages so they could communicate more effectively with people whose first

language was not English.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The provider employed an activity co-ordinator who arranged a variety of group and individual activities on a daily basis, which care workers then provided support to. An external activities provider also came every two weeks to do arts and crafts with people. On a Friday, the pub hosted a fish and chips lunch and people could have a drink with their meal. Other activities included music and massage. On the day of the inspection we saw people were invited to an afternoon cinema with popcorn in the activities room. The smell of popcorn cooking was a good sensory experience for people.
• Reminiscence was a strong theme in the home and there were some good items of interest to provoke memory and conversation.
• People told us they had the opportunity participate in activities if they wanted to, but that there were not always enough varied activities available for them. One person said, "I know we've had bingo but they should have more activities for us to join in with".
• The provider told us there was an entertainer who visited people in their room on a one to one basis as did the activity coordinator, but during the inspection, we did not observe activities with people confined to their bedrooms in the nursing units.
• On several occasions we observed warm and meaningful interactions between people and staff with staff sitting beside people reading with them or having conversations.
• The provider promoted maintaining relationships. People were supported to communicate with their family through tablets, phone calls and visits to the home in line with COVID-19 guidance. We observed one person being encouraged to come and sit and talk to their family member on the phone. Another person's care notes indicated they were supported to maintain contact with their family in another country as this helped with the person's emotional wellbeing.

Improving care quality in response to complaints or concerns
• The provider had procedures in place to respond to complaints. People and their relatives said they felt comfortable raising concerns and their comments were listened to.
• All complaints were logged. When a complaint was received the provider completed a complaints investigation form and responded appropriately to the person making the complaint.

End of life care and support
• People were well cared for at the end of their life to be comfortable. Staff worked with other professionals to achieve this and relatives were supported to be with people at this time.
• Completed end of life care plans helped to ensure people's wishes and preferences for care at the end of their lives was known.
• We reviewed some good examples of end of life care plans and found they were undertaken with people and their families and contained a good level of detail.
• We also saw these were available in easy read format when required.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care
• The provider had systems for assessing, monitoring and mitigating risk and improving the quality of the service. However, these had not identified some of the issues we found during the inspection. For example, we saw a number of environmental risks such as accessible medicines and cleaning products. Medicines audits had not identified out of date creams in people's bedrooms or when they were not stored correctly. There was also a lack of recorded evidence to demonstrate people's food was being fortified as required.
• We also found COVID-19 risk assessments and risk management plans were not always in place.

Failure to effectively operate systems and processes for monitoring the quality of the service and identifying risks was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider undertook several checks and audits to help ensure continuous learning and improving care. These included medicines, a incidents audit, care plans and an infection control audit. Audits were analysed to identify issues and improve service delivery.
• The provider had an electronic system that supported managers with monitoring and flagged up when something was due, for example staff training or care plan reviews. Monitoring reports from this system were also viewed by senior managers in the organisation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service was person centred and open. People and their relatives indicated they were satisfied with the care provided. One person said, "I think they do, on balance, look after us well."
• Staff told us they enjoyed working in the service and felt supported. One staff member commented, "I like the support and the residents. The home does everything well. I wouldn't have stayed so long otherwise. I love my job. There's nothing negative to say. [The registered manager] was very supportive through difficult times."
• Care plans were person centred with clear guidance to help achieve good outcomes for people. Staff told us they read people's care plans so they were aware of their needs and any changes. One staff member said, "We monitor the residents and ask colleagues how residents are and always look at the care plan as all information is in there."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
• The registered manager understood their responsibility around the duty of candour. They were open about sharing information during the inspection.
• Records indicated that incidents or concerns were promptly reported to the relevant bodies including the local authority and the Care Quality Commission.
• People and their relatives felt they could raise concerns and we saw that the provider had responded appropriately to any complaints or concerns.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The provider had clear management and staffing structures in place. The registered manager was supported by a deputy manager who was also the clinical lead. They were appropriately experienced and qualified and kept up to date with relevant guidance and legislation.
• The provider had processes to monitor the quality of services provided and make improvements as required.
• Relatives and staff were positive about the management of the home and the support they received. Comments included, "[The registered manager] is always there and works so hard to help everyone, the staff and residents" and "The managers are good, very good, very nice, like a family, understanding."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Stakeholders were engaged in how the service was run. The provider asked people for their views and we saw evidence of completed satisfaction surveys which were positive. Most relatives said the care people received at the home was good or excellent.
• Emails were sent out regularly to families with information such as how COVID-19 was affecting the home but also with photos of activities people had been engaged in.
• There had been three 'residents' meetings' in the last year. Team meetings were held every two months to share information and give staff the opportunity to raise any issues.
• The registered manager told us they operated an open door policy and feedback from all stakeholders indicated the manager was approachable and listened to people's views. Staff told us, "They are the best management here. Very helpful" and "[The registered manager] is a good manager." A relative said, "I know I can talk to [the registered manager] about anything and they know about what's going on."
• The registered manager also walked around the building daily which gave them the opportunity to engage with people and staff in the individual units.
• Care plans identified people's individual needs and provided guidance for how to meet these. For example, people were supported to maintain their religious and cultural observances.

Working in partnership with others
• Records indicated the provider worked with other professionals to maintain people's wellbeing. These included the dietician and nurses from the community. The registered manager said they had a good professional relationship with their GP surgery.
• Where appropriate the provider shared information with other relevant agencies, such as the local authority, for the benefit of people who used the service.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always assess risk to provide care in a safe way to service users. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not always effectively operate systems and processes for identifying, monitoring and mitigating risk. Regulation 17