HC-One Limited

Berry Hill Care Home

Inspection report

Berry Hill Lane
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11 October 2016
12 October 2016

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 October 2016 and was unannounced.

Accommodation for up to 66 people is provided in the home over two floors. The service is designed to meet the needs of older people. There were 56 people using the service at the time of our inspection.

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

Sufficient numbers of staff were not on duty to meet people's needs. Staff did not always safely manage identified risks to people. However, people felt safe in the home and staff knew how to identify potential signs of abuse. The premises were managed to keep people safe. Staff were recruited through safe recruitment practices. Safe medicines practices were followed.

People's rights were not fully protected under the Mental Capacity Act 2005. However, staff received appropriate induction, training, supervision and appraisal. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service.

Staff were kind and compassionate and knew people well. There was some evidence to show that people had been involved in the care planning process and improved documentation had been put in place to prompt staff to better involve people. Advocacy information was made available to people. People's independence was promoted and visitors could visit without unnecessary restriction. We observed two instances where dignity was not fully respected but at all other times, staff treated people with respect and protected their dignity and privacy.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain sufficient information to support staff to meet people's individual needs. However, a complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, although they were not fully effective. People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that appropriate action would be taken.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Sufficient numbers of staff were not on duty to meet people's needs. Staff did not always safely manage identified risks to people.

People felt safe in the home and staff knew how to identify potential signs of abuse. The premises were managed to keep people safe.

Staff were recruited through safe recruitment practices. Safe medicines practices were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005.

Staff received appropriate induction, training, supervision and appraisal. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and knew people well.

There was some evidence to show that people had been involved in the care planning process and improved documentation had been put in place to prompt staff to better involve people. Advocacy information was made available to people.

People's independence was promoted and visitors could visit without unnecessary restriction. We observed two instances

where dignity was not fully respected but at all other times, staff treated people with respect and protected their dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities required improvement.

Care records did not always contain sufficient information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service.

Staff told us they would be confident raising any concerns with the registered manager and that they would take action.

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

This inspection took place on 11 and 12 October 2016 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, six relatives, a domestic staff member, a laundry staff member, the cook, three care staff, a nursing assistant, a nurse, a representative of the provider and the registered manager. We looked at the relevant parts of the care records of nine people, three staff files and other records relating to the management of the home.

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.

Requires Improvement

Is the service safe?

Our findings

People's views were mixed on whether there were sufficient staff to meet their needs. A person said, "There is so much waiting time. Every day I'm waiting after breakfast. Sometimes I go to sleep waiting and when I wake up I'm still in the dining room. They need more staff." However a relative said, "Oh yes, I think there are enough staff. I have never seen anyone have to wait long if they need help."

Staff views were mixed on whether staffing levels were sufficient to meet people's needs safely. One staff member told us that on the whole, staffing levels were sufficient to meet people's needs. They commented that the dependency of the people using the service fluctuated and that as a result "There would never be enough staff." Another staff member said, "There are sufficient staff some of the time but not all." A third staff member said, "We could do with more staff in the morning."

We observed that there were not always sufficient staff to meet people's needs. On the first day, we identified that a person required assistance and pressed their call bell as they were unable to press it themselves. It took 32 minutes before staff were available to support the person. We saw that staff were not always visible in communal areas. On the second day, there were insufficient staff to support people to get washed in a timely way.

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. Staffing levels were calculated according to the amount of people who used the service and whether they were defined as requiring residential or nursing care. However, no documentation was in place to show whether people's differing dependency levels had been considered when calculating staffing levels.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service, including a volunteer. The files contained all relevant information and appropriate checks had been carried out before staff members started work. Clear staff disciplinary procedures were being followed where appropriate.

A person told us they had fallen a year ago and suffered an injury. They told us that actions had been taken to minimise the risk of it happening again. They said, "I have a frame now and regularly do my exercises and walk along the corridors to keep everything moving."

Risks were not always managed so that people were protected and their freedom supported. A range of risk assessments had been completed to assess the risk of people developing pressure ulcers, sustaining falls and any nutritional issues or choking. The risk assessment documentation showed that risk assessments should be reviewed at least monthly but they had not always been completed this frequently. Not all people had detailed risk assessments in place for the use of bed rails to prevent them falling out of bed. This meant

that there was a greater risk that not all risk factors would be considered when deciding to use bedrails.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans in order to minimise the risk of re-occurrence. Falls were analysed to identify patterns and any actions that could be taken to prevent them happening. Monthly falls meetings took place where trends were identified and discussed with staff.

We saw that a person had fallen and had attended hospital. On their return a care plan had been developed to detail the monitoring the person required in line with the instructions from the hospital. However, the person's falls risk assessment had not been reviewed following the fall and their mobility care plan had not been updated to record the fall and any preventative measures put into place. When we talked with a member of staff about the person falling and whether any additional measures had been put into place to reduce the risk of further falls, they told us the person had previously been living on the upper floor of the home and the distance between their room and the communal areas was felt to be a factor as their strength reduced. They said that following discussion with the person and their relatives they had moved to a room on the ground floor.

Pressure relieving mattresses were in place for people at high risk of developing pressure ulcers and they were functioning correctly. They were set at the appropriate weight for the person and were checked regularly. A person who used the service said, "[Staff] check it every day." We found records of re-positioning were in place for people at risk of developing pressure ulcers and two hourly checks were in place for people who stayed in bed or were at risk of falling. Records had been completed but did not always show that checks and repositioning took place as regularly as required. This meant that there was a greater risk that people were put at risk of avoidable harm.

We observed staff using equipment to support people to move. On the first day of our inspection, staff used equipment safely and explained to people what they were doing with clear instructions where needed. On the second day of inspection we observed that staff did not use equipment as effectively. Staff didn't explain clearly to people when they were supporting them to move and were not well organised.

We saw that the premises were well maintained, safe and secure. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified. Staff told us they did not have any problems in obtaining equipment that people needed and they said when equipment required repair it was actioned in a timely manner.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

A person said, "I have never seen anyone being badly treated here!" A relative said, "[My family member] has been well looked after here and when I leave, I know [they are] safe and happy."

Staff were aware of the signs of abuse and gave examples of when they had identified concerns and action had been taken to investigate and report these as necessary. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety. Safeguarding records were kept which showed that appropriate action was taken in response to potential safeguarding issues.

Staff told us they did not use restraint and would not use it as they had not been trained. However, they said they did not have the need to restrain anyone using the service. When asked about people who presented with challenging behaviour or who refused personal care they said they would walk away and leave them for a few minutes if necessary, or use a different approach. They demonstrated their knowledge of individual people's behaviour and the best way to gain their cooperation.

People told us that they received their medicines safely. A person said, "I have my medicine brought to me in a little pot and then they put it on a spoon for me to take because sometimes I find it hard to swallow." A relative said, "[My family member] is given all his medication by staff." Staff told us they had their competency to administer medicines checked by the manager at least annually and they had undertaken training in the administration of medicines.

We observed the administration of medicines and saw how staff checked peoples' medicines against the medicines administration record (MAR) and then stayed with people until they had taken their medicines. We observed a person spitting their medicine out after the staff member had left. However, another staff member also saw this and quietly asked the person, "Do you really not want to take your [medicine name]?" The person said, "I suppose I should take it shouldn't I?" The staff member said, "Can we try again then?" The person confirmed that they were happy to try again. The staff member gave the person another tablet and the person opened their mouth to show that they had swallowed it.

Systems were in place for the timely ordering and supply of medicines and we did not find any examples of non-administration of medicines due to a lack of availability. Medicines were stored safely in locked trolleys and cupboards within a locked room. The temperature of the room and refrigerator had been recorded daily and were within acceptable limits. Liquid medicines and topical creams were not always labelled with the date of opening as is required. This meant that there was a greater risk that they could be used past the date where they would lose effectiveness.

MARs contained a photograph of the person to aid identification and a record of any allergies and the person's preferences for taking their medicines. We saw the MARs of two people who were receiving a medicine which requires their blood to be monitored regularly and the dose of the medicine adjusted according to the results. We noted the most recent results from one of these tests were not available in the MAR and therefore it was not possible to check whether that the person was still receiving the correct dose. We talked with a member of staff about this and after checking with the person using the service they told us the results had been given to them but they were not sure where the results were. There was a chart in the MAR to record the results of the test but from this the most recent instructions for the daily fluctuations in dose were not clear. This meant there was a lack of clarity about the dose of the medicine the person required.

Requires Improvement

Is the service effective?

Our findings

We saw that staff mostly asked permission before assisting people and gave them choices. However we did observe that a staff member moved a person without explaining what they were going to do. We also saw that a person appeared to indicate that they did not want to go to the dining room when staff asked them. However, a different staff member decided that the person should be taken to the dining room then and the person was moved to the dining room. The person did not object to this.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were not being followed as when a person lacked the capacity to make some decisions for themselves; a mental capacity assessment and best interests documentation had not been completed. The registered manager told us that no MCA documentation had been completed under the previous management team and they had focussed on making DoLS applications since starting as manager.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people were being restricted, DoLS applications had been made. Staff had a good understanding of MCA and DoLS.

Staff were able to explain how they supported people with behaviours that may challenge others and care records generally contained guidance for staff in this area. We saw staff usually responded well to people with behaviours that might challenge. However, we heard a person calling out repeatedly for attention during the day of the inspection. When staff attended the person, they often did not need assistance and appeared to just want company. Staff did not spend any extended time with the person but provided reassurance before going on with their tasks. The person was living with dementia and their care plan identified this but did not mention this behaviour, any action to reassure or occupy the person, or ways to minimise the behaviour.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had been completed appropriately.

People told us that staff were sufficiently skilled and experienced to support them effectively. We observed that staff competently supported people and interacted appropriately with them.

Staff felt supported. They told us they had received an induction. A staff member said, "I was shown in the right way, not dropped in at the deep end." Staff felt they had had the training they needed to meet the needs of the people who used the service. Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training. Staff told us they received regular supervision. Supervision and appraisal records contained appropriate detail.

People told us they were happy with the food they were provided with. A person said, "The food here is brilliant. I never go hungry." Another person said, "I really like the food here and there is always plenty of it."

We observed lunchtime in the two dining rooms. Tables were set with tablecloths, table mats, napkins and condiments. People were offered a visual choice of meals and were provided with regular drinks. Some people ate their meal independently while others received appropriate assistance to eat and drink.

Nutritional risk assessments had been completed and eating and drinking care plans were in place. A "Diet notification record" had been completed to provide information about people's dietary needs and preferences however these did not always provide any detail about the person's favourite foods or dislikes. Food and fluid charts were also not always fully completed.

A person using the service said, "They are worried about my eating but I am gaining weight and I am starting to enjoy the food." The person was low in weight and this suggested staff were alert to the risks this may pose and were encouraging the person to eat. We saw that people's weights were being monitored and action taken when appropriate. Monthly nutrition meetings took place where trends were identified and discussed with staff.

People told us they saw external professionals when they needed to. A person said, "I don't have to see my GP unless I am ill. I do see the chiropodist he comes regularly but my daughter takes me to the opticians." Another person said, "The District Nurse comes three times a week to dress my legs."

There was evidence of the input of other professionals into peoples' care as appropriate. For example, the Parkinson's disease specialist nurse, an advanced nurse practitioner, GP and speech and language therapist. However, there was limited documentation in care records regarding the involvement of the optician, dentist and chiropodist.

When people were receiving insulin to control their diabetes, their blood sugar levels were monitored, however these were not always monitored consistently. One person's blood sugar levels were measured twice daily on some days and once daily on others. Another person's levels were measured once daily on most days but not at all on the other days.

A person said, "I have this lovely room which is beautifully decorated, so what more could I want? It is like my own little flat." People told us that they enjoyed living in the home.

Adaptations had been made to the design of the home to support people living with dementia. The home had been recently refurbished and people's bedrooms were clearly identified. Bathrooms were clearly identified and toilet seats and handrails were brightly coloured so that people could identify them easier.

Good

Is the service caring?

Our findings

People told us that staff were kind and compassionate. A person said, "Everyone is so friendly and chatty. I really like the banter with the [staff]. It is nice having people who really care about you and not just because it is their job." Another person said, "Staff are very, very kind and helpful." A relative said, "Staff have behaved with extreme sensitivity and compassion. They have made a difficult situation as easy as they could."

Staff were kind and caring in their interactions with people who used the service. We observed staff were considerate, polite and courteous. People who used the service and staff joked and laughed with each other.

We saw that the cook showed genuine concern for people who used the service during the meal serving. They had a good relationship with people and good knowledge of their likes, dislikes and eating habits.

We saw staff responded appropriately to people when they showed distress. We observed one person who was shouting out and the staff were attentive, identified why the person was anxious, and took action to reduce the person's anxiety.

There was some evidence to show that people had been involved in the care planning process. A person said, "I know they do talk to me about my care, but I can't remember what they said. My daughter deals with all that really." A relative said, "[Staff] communicate well with family."

We saw that care reviews took place and it was documented that the person was present at the review but their views on the care they received was not always documented. There was some evidence to show that people had been involved in the care planning process. The registered manager showed us new documentation that would prompt staff to include people more in the care planning process.

Advocacy information was available for people if they required support or advice from an independent person. Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us.

People felt that their privacy and dignity were respected. We saw staff take people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. We saw staff were careful to protect people's dignity when moving them using equipment. However, we observed a staff member speaking to a person in a way that did not respect their dignity. We also saw two staff talking about a person without involving that person. This did not respect the person's dignity or privacy. We raised both issues with the registered manager who agreed look into them.

Staff told us they knocked on people's doors to promote their dignity and closed the door and curtains when providing personal care to maintain their privacy. They told us they had a dignity screen on the ground floor to use if they needed to provide privacy for someone in the communal areas, for example, if they had fallen and required the use of a hoist to move them.

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner. Staff talked about encouraging people to maintain their independence when they were able and providing discreet support when they needed assistance.

People told us that their relatives and friends were able to visit them without unnecessary restriction. A person said, "My family take me out regularly and can visit at any." A relative said, "Oh it's good here. Not at all what I expected to find in a Care Home really. We can visit any time we like, we are always made to feel welcome and we have this lovely Café where we can just help ourselves to a drink and chat with [my family member] and whoever else is around. They even leave biscuits and cakes out for people sometimes. Occasionally there is no hot water for drinks, but we only have to ask and it's done." Another relative said, "I actually like visiting and I never thought I would."

Requires Improvement

Is the service responsive?

Our findings

People were mostly happy that the service was responsive to their needs. A person said, "They know I like my tea at 7.30am and then they bring me my breakfast about 8am. I have the same thing, porridge and then toast." We asked if they would ever have something different and they said, "I do sometimes have a fancy for something else. I only have to ask when they bring me my tea and they organise it." Another person said, "I go out with my family for days out and they always make sure I am ready, dressed and washed when they come to get me." A third person said, "I hadn't bought any clothes for a long time and one of the carers took me shopping – in her own time – and I bought some lovely things. I really enjoyed it. She said she would take me again if I wanted to." However a relative told us that they had to push so that their relative received the support they felt they needed. However, they said, "I know the [registered] manager does understand now."

However, we observed that people did not always received care that met their personalised needs. On the second day of inspection, we observed that people living in one part of the home had not received support to get washed by 11.15am. We raised this with the registered manager who told us, after discussion with staff working in that area, that staff had decided that everybody living in that part of the home was to have breakfast in bed before receiving support to get washed. This was because two staff had been providing support for a family whose relative was receiving end of life care which meant that they had not been able to support other people in a timely way. This decision to not provide timely personal care meant that people did not receive care that was responsive to their own personalised needs.

Care records did not always contain sufficient information for staff to provide care that met people's individualised needs. In one person's care records we found there was a lack of detail in the care plan about the person's preferences and the information was inconsistent with our findings during the inspection. For example, a fall had not been recorded in the care plan and the care plan had not been updated as a result. In addition, the person was of low weight and had lost a further 2Kg between June and September. Their nutritional assessment documentation identified this and it was identified that the person should be weighed weekly but their eating and drinking care plan did not identify this and the review in September 2016 said there were no issues and they enjoyed their meals. Another person had been admitted into the home in the last two weeks. They had no care plans to support staff to provide care that met their needs.

We reviewed a care plan for a person with diabetes and found there was no mention of the need for an annual diabetes review or eye screening. We saw this person's care plan stated that they should receive insulin twice a day. Records indicated that on two days in the last week they had received insulin only once a day. The registered manager told us that the care plan did not provide sufficient detail to show that the insulin would not always be administered dependant on the person's blood sugar levels.

The registered manager told us that they had identified care plans as an area that required improvement. They told us they were working to ensure that all care plans were detailed, full of personalised information and up to date. We saw a copy of the record they were using to monitor the updating of care records and saw that the majority of care records had been updated, however, most were waiting to be audited to ensure that they were to the required standard.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People thought that activities could be improved. A person said, "I don't usually join in anything because it's not really my thing." Another person said, "I sometimes come to Communion when it happens, but I would like to go outside to a Church sometimes." We asked whether they had told anyone and they said: "Yes, I told [staff member] but nothing seems to have happened yet." A relative said, "There seem to be things going on here occasionally, but I wouldn't always say they were appropriate for everyone."

We saw limited activities taking place during our inspection. The registered manager told us that activity records were limited and that activities needed improvement. They felt that activities for people who sat in the lounge were good but they were not for people who were in other parts of the home including people who stayed in their bedrooms. The registered manager told us that weekly trips using the home's minibus were now taking place which will ensure that any person who would like to go on a trip will have opportunity to do so.

People told us that they felt able to make a complaint. A person said, "I really don't have anything to worry about, but I would not have any trouble complaining if I had to." Another person said, "I really have nothing to complain about, but you can be sure if I did, I would!"

Staff were able to explain how they would respond to complaints. Staff told us that if a person wanted to make a complaint they would report the issue to the registered manager who would deal with it. They said they received feedback on concerns and complaints at the daily staff meeting. We saw that the service had responded appropriately to complaints made.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received, however it was not fully effective as it had not identified and addressed the issues we identified at this inspection.

We saw that regular audits were completed by the registered manager and also by representatives of the provider. Audits were carried out in a range of areas including infection control, falls, medication, health and safety, mealtimes and catering. Action plans were in place where required but did not always cover all identified issues.

Meetings for people who used the service and their relatives took place. There were notices displayed in the home to inform people and their relatives of the upcoming dates. A person told us that they had attended meetings for people who used the service. They said, "I have been to a couple." A relative said, "I have been to a couple of Relatives meetings and as I couldn't get to the recent one, [staff member] is going to email me a copy of the minutes when they are done." The registered manager also holds a manager's surgery every Wednesday afternoon where people and their relatives can discuss issues with them.

Surveys were in place to obtain the views of people who used the service on the quality of care provided to them. However, the results of the last survey in June 2016 identified some issues, activities and involvement in care planning, which were still present at this inspection. We saw that surveys had also been completed by people regarding the quality of food.

A relative said, "I have filled out a questionnaire that came in the post a while ago, but I am not sure what happens then." Relative survey findings from June 2016 also identified some issues that were still present at this inspection. Issues included activities, people's needs being met appropriately, not being involved in care planning and staffing levels. We also saw that the action plan in response to the staffing levels comments contained an action that stated, "The home manager uses a staffing tool to calculate the numbers of staff and the skill mix needed." We observed that this action was not correct as no staffing tool was being used by the home manage to calculate staffing levels.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service and displayed in the main reception. A staff member said, "We should show kindness and care. Everyone is treated as an individual and with dignity and respect."

There was a positive, welcoming atmosphere at the service. A person said, "I really like it here, they do everything for me. If I had to go into a care home permanently, I would certainly be happy if it was here." Staff also said there was a good atmosphere. A staff member said, "The staff here genuinely care for people. They will come in at short notice on their days off if for example someone needed accompanying to hospital." An agency nurse said staff had made them feel welcome and were, "really friendly."

People and relatives were very positive about the registered manager. A person said, "It's lovely here now that she's back. It's a nicer atmosphere altogether now." Another person said, "The [registered] manager is really nice here. I hope she stays. We have had a bit of to-ing and fro-ing with managers. It would be nice to have one that stayed and this one does what she says."

Staff were very positive about the registered manager and were confident they would be listened to and the manager would act on any concerns they raised. A staff member said, "She is approachable, listens and sorts things." Another staff member said, "Any problems I can talk to her."

A registered manager was in post and was available during the inspection. She clearly explained her responsibilities and how other staff supported her to deliver good care in the home. She felt well supported by the provider. She told us that sufficient resources were available to her to provide a good quality of care at the home. We saw that regular staff meetings took place and the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The current CQC rating was clearly displayed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that was responsive to their needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not fully protected under the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs. Regulation 18 (1)