Chengun Care Homes Ltd

Beeston Lodge Nursing Home

Inspection report

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23 February 2017

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 February 2017 and was unannounced.

Accommodation for up to 28 people is provided in the service. The service is designed to meet the needs of older people living with or without dementia. There were 24 people using the service at the time of our inspection.

A registered manager was in post and was available throughout 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.

Risks were not always managed so that people were protected from avoidable harm. People were not always safely assisted to move and infection control practices required improvement.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were safely managed.

External professionals were involved in people's care as appropriate. Staff received induction, training and supervision. However, our observations during the inspection suggest that training and supervision was not fully effective.

People's rights were not always protected under the Mental Capacity Act 2005. People received sufficient to eat and drink, though the mealtime experience could be improved. People's needs were not fully met by the adaptation, design and decoration of the service.

Staff did not always respect people's privacy and dignity. Interactions between staff and people who used the service were mixed. Some interactions were kind but some were very task focussed.

People and their relatives were involved in decisions about their care and advocacy information was available to people. Visitors could visit without unnecessary restriction and people's independence was promoted.

Activities required improvement. People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

Some systems were 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. However, their comments were not always acted upon.

Staff told us they would be confident in raising any concerns with the management team and that appropriate action would be taken. A registered manager was in post and statutory notifications had been sent to the CQC when required.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back 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.

Risks were not always managed so that people were protected from avoidable harm. People were not always safely assisted to move and infection control practices required improvement.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices.

Medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received induction, training and supervision. However, our observations during the inspection suggest that training and supervision was not fully effective.

People's rights were not always protected under the Mental Capacity Act 2005. People received sufficient to eat and drink, though the mealtime experience could be improved.

People's needs were not fully met by the adaptation, design and decoration of the service.

External professionals were involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always respect people's privacy and dignity.

Interactions between staff and people who used the service were mixed. Some interactions were kind but some were very task focussed.

People and their relatives were involved in decisions about their care and advocacy information was available to people.

Visitors could visit without unnecessary restriction and people's independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities required improvement.

People received personalised care that was responsive to their needs. Care records contained 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.

Some systems were 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. However, their comments were not always acted upon.

Staff told us they would be confident in raising any concerns with the management team and that appropriate action would be taken.

A registered manager was in post and statutory notifications had been sent to the CQC when required.

Beeston Lodge Nursing 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 22 and 23 February 2017 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care 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 to 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, three visiting families, two visiting healthcare professionals, the cook, a domestic staff member, a laundry staff member, a maintenance person, three care staff, the registered manager and the owner. We looked at the relevant parts of the care records of 10 people who used the service, 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

A person raised a concern that staff did not support them to move safely. They said, "Mostly they're ok handling me but a couple of [staff] can be a bit rough with my leg." We observed that staff did not always assist people to move safely and staff did not always use moving and handling equipment competently. We observed two staff moving a person using an unsafe practice. We also observed two staff using moving and handling equipment unsafely. This put people at risk of avoidable harm. We raised these issues with the registered manager who took immediate action to address the issues.

A visitor told us that home smelt unclean at times. We looked at all bedrooms, toilets, shower rooms and communal areas and not all areas were clean. Parts of the home smelt of urine at times and some equipment was stained or deteriorated so that effective cleaning could not take place. This included a ripped pressure cushion and stained bedrail protectors which meant that people were put at risk of acquiring infection.

Staff did not always follow safe infection control practices which included the handling of soiled laundry which presented a risk of cross contamination. Cleaning schedules did not contain sufficient detail to allow the provider to check that staff were regularly cleaning all areas of the home. The outside clinical waste bin was overflowing and not secure which presented a risk to members of the public.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with told us that they felt safe living in the home. A person said, "Nobody's bothered me here. I've not seen anyone treated badly." Visitors felt that their family member was safe. A visitor said, "[My family member's] very safe due to the staffing levels and having someone to raise concerns with easily."

Staff told us they had undertaken adult safeguarding training. They were aware of the signs of abuse and said they would report any concerns to the registered manager or the provider. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety.

People told us that they were not unnecessarily restricted. A person said, "I can go where I like in here. I've no restrictions really." Another person said, "I can plan my day, what I want to do and when I want to go to bed too." We observed that access to the garden was unnecessarily restricted. We raised this with the registered manager and action was immediately taken to remove the restriction which had been put in place for a person who was no longer using the service.

Risk assessments had been completed to assess common risks such as falls, using bedrails, developing pressure ulcers and nutritional risk. There were also risk assessments for additional individual risks such as the use of a wheelchair or a hoist. Actions to reduce risks were identified and were in place; however, staff did not always assist people to move in a way that minimised the risk of harm. Risk assessments had been

updated monthly to ensure they remained accurate.

Pressure-relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. We saw that people received support to change their position to minimise the risk of skin damage in line with their assessed needs as set out in their care plans. However, we saw people sitting in armchairs and wheelchairs with their moving and handling slings in place. These slings were not designed to be left in place and put people at risk of skin damage.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals. Accidents and incidents were analysed to identify any trends or themes so that actions could be taken to reduce any risks of them happening again.

We identified some risks regarding the safety of the premises. Not all bedroom wardrobes were fixed to the wall and a first floor bathroom window was not restricted and put people at risk of avoidable harm. We raised these issues with the management team and action was taken.

We saw that checks of the equipment and premises were taking place. However a legionella risk assessment was not in place and water flushes had not taken place for at least four months to minimise the risk of legionella. Hot water temperatures had not been monitored for two months to minimise the risk of avoidable harm.

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

Most people felt there were enough staff on duty but felt that they did not spend quality time with them. A person said, "There seems to be enough but it depends what they're busy doing." Another person said, "Staff don't stay long with us as they're always on the go."

Care, domestic, laundry, maintenance and kitchen staff all felt that they had sufficient time to complete their work effectively. During the inspection we observed staff promptly attending to people's needs and call bells were responded to within a reasonable time. Staff monitored the communal areas and provided one to one input to people with complex needs.

Systems were in place to identify the levels of staff required to meet people's needs safely. The registered manager explained that they considered people's dependencies when setting staffing levels and monitored them closely to ensure that staffing levels remained at the correct level.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People were happy with how their medicines were managed. A person said, "[Staff] give me my tablets with some liquid and wait beside me." A visitor said, "[My family member]'s medication is well handled."

Staff administering medicines told us they had completed medicines training and received competency

checks for medicines administration. We observed the administration of medicine; staff checked against the medicines administration record (MAR) for each person and stayed with the person until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines. One person was being given their medicines covertly at times. The necessary approval had been obtained from the person's GP and the pharmacist had been involved. Covert medicine is medicine disguised in food or drinks.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability. Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. The temperature of the room was above recommended limits on several occasions within the current month. We were told the service were considering the most effective way of improving the ventilation to the room and in the meantime used a portable air conditioning unit when the temperature rose.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were competent. A person said, "[Staff] don't need to do much for me but they seem good enough for others that need them." A visitor said, "They seem very capable." However, we observed during our inspection that not all staff competently supported people in the areas of moving and handling, infection control, nutrition and dignity.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. Training records showed that staff attended training which included equality and diversity training. They told us they received regular supervision and records we saw confirmed this. However, our observations during the inspection suggest that training and supervision was not fully effective in the areas of moving and handling, infection control, nutrition and dignity.

A person told us that staff usually asked for consent before giving care. They said, "[Staff] do ask me and I can say yes or no if I'm not ready." However, we saw that staff did not always ask permission or explain what they were doing before assisting people to move. We also observed at lunchtime that not all staff asked people before putting a clothing protector on them.

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 DoLS. We checked whether the service was working within the principles of the MCA.

Mental capacity assessments were completed and best interest decisions documented when people were unable to make some decisions for themselves. However, when bedrails or sensor mats were being used, we did not find evidence of consent or a capacity assessment and best interest decision in relation to these decisions. When people were being restricted, DoLS applications had been made. Staff had an appropriate awareness of MCA and DoLS.

Care records contained guidance for staff on how to effectively support people with behaviours that might challenge others. However, we saw that one person's care plans had not been reviewed following an incident where they hit another person using the service. This meant that there was a greater risk that appropriate guidance for staff was not in place to effectively support a person with behaviours that might challenge others.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. Three DNACPR forms had not been fully completed. The registered manager agreed to contact the relevant professionals to review them.

We received mixed feedback on the food provided by the service. A person said, "I like the food. We get a choice of two things usually." However, another person said, "I'd say the food is adequate. I look forward to the Saturday cooked breakfast most. Lunch is a bit cold, especially chips, as I'm at the end of the corridor run with the lunch trolley." A visitor said, "[My family member]'s lost weight in the three weeks [they've] been here. [They] don't like the food, they say, so they're picking at things. We bring in treats to top [them] up." Another visitor said, "[My family member] says the food is just 'alright'. We've not seen it but it smells ok. They've done well feeding [my family member] up as they weren't eating at home."

We observed the lunchtime meal in two dining rooms. In one dining room the mealtime was poorly organised and not a relaxed experience for people who used the service. Tables were covered with plastic tablecloths and a plastic placemat, some still with crumbs from breakfast. No cutlery or napkins were laid on the table. No menu was on obvious display. Meals were placed in front of people with no explanation and some food was going cold by the time the person was assisted by a staff member to eat. Staff were on occasion assisting two people at the same time and all staff had to leave the person they were assisting a number of times to carry out a task elsewhere. They did not apologise or speak to the person they left and just returned and continued to assist. During the meal, the owner came into the room and began to re-allocate staff to people waiting to be assisted which meant that several people were left alone mid-meal. Interaction by staff whilst assisting people was minimal with just general encouragement to try another mouthful.

In the second dining room people were more independent and did not require assistance from staff. We noticed that those people with a good appetite were provided with large plates of food whilst others were given small plates so as not to "over face" them. One person did not eat much of their main meal and when the member of staff commented on this they said the meat was tough. They were not offered an alternative. Although people had been given a choice of main meal prior to the meal, everyone was served the same dessert. One person who had not eaten their main meal was provided with the dessert and they shortly afterwards pushed it away saying to the staff that they did not like rice pudding. They were not offered an alternative and when we later asked the member of staff if there was an alternative dessert, they said they did not think there was.

People told us that they had sufficient to drink. A person said, "I have tea and water mostly. I don't really get thirsty." A visitor said, "[My family member] has a lot of water and tea or cold milk. We've seen [staff] make sure [my family member]'s drunk up their drinks."

We did not see jugs of water in people's bedrooms and people told us that the drinks trolley did not come to people in their rooms. A person said, "They seem to forget upstairs for the tea trolley so I just get a hot drink with meals. I have to buzz if I want one otherwise." Another person said, "I have tea a lot and we have a trolley. I've got nothing in my room to drink from."

Nutritional screening and assessment were completed and eating and drinking care plans were in place. We saw staff had made referrals to other professionals such as a speech and language therapist and dietician when there were concerns about people's nutrition or ability to swallow. When people required the consistency of their food and drink to be modified this was clearly identified in the care plans. We noted some people, who were being cared for in bed or who required a hoist to move them, had not been weighed for some months. One of the care records indicated it was not possible to weigh them as there were no hoist

scales at the service. Although a mid-upper arm circumference (MUAC) had been recorded, this provides only a general indication of a person's body mass index and is not accurate. We would have expected the service to have some arrangements for monitoring the weight of people who were unable to sit on chair scales. The owner told us that they would bring hoist scales from another service to allow those people to be weighed.

People's needs were not fully met by the adaptation, design and decoration of the service. A visitor said, "The first day we walked in, I hated the place. Horrendous place and run down." We noticed that a lot of bedroom furniture was in poor repair on cupboard edges and some worn surfaces. Décor throughout the home was generally dated, with chipped paint on doorways and walls and some stained or frayed carpets. Wall pictures were not appropriate for people with visual impairment. Bedrooms did not have names or any identification other than a painted colour and room number. Corridors were bland and although some signage was used to direct residents to communal areas or the lift, the signs were not large and bold. Parts of the home were being redecorated during our inspection and the registered manager told us that bedroom signage had been removed in preparation. The owner told us that the whole home was to be redecorated.

People told us they were supported with their healthcare needs though did not have access to regular dental care. A person said, "[Staff] got the doctor when I had a chest infection. The optician and chiropodist come here to do me. And the hairdresser gives me a free trim!" A visitor said, "[My family member] gets [their] nails painted here and hair done. Plus [they've] had the chiropodist already." The registered manager told us they would be contacting a local dental practice to arrange preventative checks for people using the service.

We saw people had regular consultations with their GP. A healthcare professional told us staff called them in a timely way when people showed signs of ill health and were knowledgeable about people's care and support needs. We also saw people had access to a range of other professionals such as the continence advisor, dietician, speech and language therapist, dentist, chiropodist and optician.

One person had a pressure ulcer and we saw the type and frequency of dressing changes were clearly identified and regular assessments of the progress of the wound were being carried out. Photographs of the wound had been taken at intervals and these demonstrated that the wound was reducing in size and healing was progressing. A tissue viability nurse had reviewed the ulcer and their instructions for the type of dressing to be used were being followed.

Requires Improvement

Is the service caring?

Our findings

People had mixed views on whether their privacy and dignity were respected by staff. A person said, "[Staff] don't knock, just walk in." However another person said, "They always knock on my door first."

We observed some staff adjusting people's clothing after hoisting to maintain their dignity and a fleece blanket was often placed across their knees. However, we saw that other people's dignity was not respected at all times. We saw people sitting in armchairs and wheelchairs with their moving and handling slings in place. This did not respect their dignity. We also saw a person being moved in an inappropriate sling which caused their clothes to move exposing their body and not protecting their dignity.

A person said, "Staff talk over me in their [own language]. I tell them to speak English." We also saw two staff in the lounge talk to each other using a language that was not English. There were a number of people sitting in the lounge at the time and this did not respect them. We raised these issues with the registered manager who took immediate action to address the issues.

We also saw that one toilet/shower room on a main corridor could not be fully closed or locked and people's privacy could not be respected. We also saw that other bathrooms either did not have a lock or any sign to show when they were in use.

People views were mixed on whether staff were caring and kind. A person said, "I find they're alright." Another person said, "A lot don't say a word to you just hello if you're lucky." A third person said, "Just a couple of [staff] who talk over me and aren't friendly really." A visitor said, "I do think they're kind but they don't have a lot of time for people. [My family member] says some days [they] just feel like crying."

We observed some staff speaking in a kind manner with people, making eye contact and holding hands on occasion. We also saw some members of staff had good relationships with people and involved them in conversation. They were attentive to people's needs and provided them with reassurance when they were anxious. However, other staff were less empathetic and more task-focused.

People told us that they felt they did generally have involvement in their care planning. A person said, "[Staff] chat to me about my care and I do my own money arrangements here." A person and their visitor said, "We're both kept well informed. Any issues, they tell us. We have care plan meetings regularly and we both get to see it."

Care records contained evidence of regular contact with people's close relative, to keep them informed about changes to their relative. There was also evidence of involvement of a person and the relatives of two other people, in the review of their care plans.

Advocacy information was not available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Where people could not communicate their views verbally their care plan identified how staff should identify their needs. However, we observed that staff did not always take time to clearly and effectively communicate with people.

We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. Staff were able to describe the steps they took to protect people's privacy and dignity such as knocking on their door before entering and closing the curtains during personal care.

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.

People told us they were encouraged to be independent where possible. A person said, "[Staff] let me do what I want really." Another person said, "I can still feed myself and ask for help if I need it." Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

A visitor said, "We can come 24 hours any time. I get to stay for lunch with [my family member] too if I want." Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

Requires Improvement

Is the service responsive?

Our findings

People told us that often they entertained themselves by reading or watching TV, as activity provision was not regular. A person said, "I read the paper, have a walk round. Or I'll lie on my bed thinking about my past. They've got a garden but only the smokers use it." Another person said, "Just sometimes [staff] do things with us. I get a bit bored so I'll go and have a nap." A third person said, "I get bored. I listen to TV or read the paper mostly. I don't bother joining in if it's a game." A visitor said, "We bring in colouring books for her. There seems to be things on sometimes like games." Another visitor said, "I come every day and see him going downhill mentally. I dread coming in as I know he'll be sat there with nothing to do. His mobility is going down too, being sat for hours."

No activities timetable was displayed in the home and we observed limited group and individual activities taking place during our inspection. Most people were observed to be sitting not actively engaged, reading the newspaper or watching the television. Although we did see one person knitting, a hobby that they were interested in. Recreational care plans were in place which provided information about activities people were interested in participating in. A "Map of Life" was also completed for each person and these included hobbies, interests and life history. Recorded activities were limited. No outings were regularly arranged. The registered manager told us that an activity co-ordinator visited one day a week, to stimulate people and also to educate staff to carry out activities on other days. They also told us that an additional staff member was on duty in the afternoon so that staff could support people with activities.

People told us they received care that was responsive to their needs. A person said, "I decide when to turn my TV off around midnight if I'm watching something. I wake up when I'm ready in the morning. I can call the shots with most things." Another person said, "I go to bed and get up when I'm ready." People told us that they received a shower or bath when they wanted one. They also told us that staff responded promptly when they used their buzzer. A person said, "I rang when a chap near me was on the floor from falling out of bed. [Staff] came quite quickly." Another person said, "I woke up the other night for the loo and fell slowly on the floor, lying flat. The alarm was in reach and they came quite soon and got me up as I was ok."

An individual profile was completed for each person which summarised their personal care needs, important things about their life and the things they enjoyed. An initial admission assessment was completed and care plans were in place for people's care and support needs. These contained a good level of detail and information about personal needs and preferences. Care plans for people's health needs also gave clear instructions for staff on the management of their health condition and to ensure any signs of ill health were recognised. Care plans had been reviewed monthly and updated as required. Care plans reflected people's current needs.

A visitor told us that their family member preferred a specific gender of staff member for personal care and staff respected this. Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs.

A person told us they had raised a concern with the registered manager and were pleased with their

response. The service had not received any recent complaints. Guidance on how to make a complaint was in the guide for people who used the service and displayed throughout the home. There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them.

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 effective as it had not identified and addressed the issues we found at this inspection. We saw that regular audits had been completed by the registered manager and other staff, including a representative of the provider. Audits were carried out in a range of areas including infection control, medicines, health and safety, kitchen, laundry, domestic and care records. However, these audits did not always identify shortcomings and clear action plans were not always in place to ensure that actions took place to address identified issues. This meant that people's health, safety and welfare were put at risk.

We saw meetings for people and visitors took place where comments and suggestions on the quality of the service were made. We noted a comment had been made regarding the temperature of food for people in their rooms. This same issue had been raised at this inspection four months later which meant that appropriate action had not been taken in response to the comment made.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors told us there were meetings where they could feedback on the quality of service provided. A person said, "I think there's a meeting here tomorrow." A visitor said, "I've been to a few meetings but not many turn up. The last one was just me so I had a one-to-one session with the manager." We saw that one meeting for people and visitors took place on the morning of the second day of inspection and another was scheduled for the evening. We saw surveys just been sent out to people and visitors to ask for their views on the quality of service provided.

A whistleblowing policy was in place and staff told us they would be prepared to raise 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. However, staff were not observed to act in line with them at all times during our inspection.

A person commented on the atmosphere of the home, "It's mostly ok here." A visitor said, "It's happy enough." A staff member said, "It's a lovely atmosphere."

We received positive feedback about the registered manager. A person said, "She's nice and helps us out with questions." The registered manager was also the nurse on the floor on a regular basis and whilst this reduced their time to undertake management duties it also meant she was available to talk to people using the service and staff, she knew people well and was available to them. In addition, she was an excellent role model in terms of her interactions with people and her caring attitude.

A member of staff described the manager as, "Lovely and always there to listen." They said both the registered manager and her deputy were approachable and they would act on any concerns. We saw that staff meetings took place and the management team had clearly set out their expectations of staff.

A person said of the owner, "He's very hands-on but loses his temper and shouts a lot. He wants high standards but belittles the staff sometimes." Staff told us that they did not always receive feedback in a constructive way from the owner.

A registered manager was in post and was available throughout the inspection. They told us that they felt supported by the provider. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required.

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 Identified risks to people were not always managed safely. 12 (1) (2) (b) (e) (h)

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 provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b)