Kudos Care (UK) Limited

Knightsbridge 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

Overall summary

This was an unannounced inspection which was carried out on 16, 18 and 19 January 2015.

The service had not been inspected since it had become a limited company in October 2013.

A registered manager was in position. 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.

Knightsbridge Lodge provides care to 22 older people. At the time of the inspection there were 19 people in the home. The accommodation was across two floors with a passenger lift for access to the first floor.

Improvements to the service were being made and the management team were working to an annual action plan which had been implemented in May 2014.

People were not fully protected against risks of infection because there were shortfalls in the service's infection

Summary of findings

control policy and procedure and the staffs' understanding of some of these arrangements. There was a potential risk that poor or inconsistent infection control practices may put people at risk of infection.

Robust staff recruitment practice had not been adhered to when the service had needed new staff urgently. This had put people at risk of being cared for by staff who may be unsuitable. Effective quality monitoring checks were not always in place leading to some shortfalls identified in this inspection having not been identified by the provider. Actions to rectify these shortfalls had therefore not been put into place. Risks to people were therefore not being sufficiently identified and addressed.

Care was centred around the people who live in Knightsbridge Lodge and the environment was comfortable and welcoming. One relative said, "I would highly recommend the home, it's very good". All the staff were involved in promoting the wellbeing of those that lived there. The staff told us they were happy and felt supported by the management team.

Opportunities for staff to have designated time to talk with managers about their training needs and performance had varied for each member of staff. The management team recognised they needed to allocate more time to organise and complete formal support sessions with staff. The registered manager and deputy manager worked together on a day to day basis and provided joint leadership to the staff. They communicated effectively with staff and their ultimate aim was for people to be respected, treated with dignity and to receive the care and support they needed in a caring environment.

Staff had been provided with basic training so as to care for people safely, or, they had received this in previous care jobs. Although staff lacked formal training in areas such as end of life care, dementia care, equality and diversity and infection control procedures this had not had a negative impact on the people living in the home. This was because there were staff with the appropriate knowledge to advise them and monitor care practice.

People's risks were identified and managed. Risks such as poor dietary intake, falls, problems with swallowing and the development of pressure ulcers were all addressed.

Care records were in place to give staff guidance on how to meet these risks. People had an opportunity to review their care plans each month or if they were unable to do this, their representative did so. One health care professional said, "This home actually implements the care they write in the care plans". Staff worked alongside health and social care professionals to ensure people's needs were met in the best possible way.

People's preferences and wishes were known to the staff. This included their likes and dislikes with regard to their food, delivery of personal care and social activities. People told us they enjoyed the food and confirmed they were given the choices we saw advertised. When people were particularly poorly the cook provided food which the person "fancied" on the day. People's preferences regarding social activities varied. For example, two people we spoke with were happy with what was being provided and one other felt they needed more stimulation. Staff were looking at how they could make activities more suited to the individual person. People told us they felt included and involved in decisions and changes made in the home.

Staff recognised the need to support and encourage people to make decisions and choices whenever possible. Where this was not possible, due to a lack of mental capacity, staff adhered to current legislation to ensure people were protected.

People told us they were treated with dignity and respect and a survey carried out by the management in December 2014 confirmed this was a majority view. End of life care was planned so as to ensure any discomfort or distress was managed effectively. This involved community health care professionals who provided support where needed. One relative talked to us about their relative's recent death they said "she died with dignity, they really cared for her and the family."

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The evidence was gathered prior to 1 April 2015 when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in force. You can see what we asked the provider to do about this at the end of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were discrepancies between the home's written infection control procedures and what staff actually did to prevent infection spreading. In places this had led to some confusion in staff practices.

Recruitment practices had not always been robust enough to protect people from potentially unsuitable staff.

There were enough staff to deliver very personalised care and address people's risks, although at times people did not always receive this care immediately when they wanted it.

People were protected from abuse because there were systems in place to ensure this happened.

People were protected against medicine administration errors.

Is the service effective?

Requires Improvement

The service was not as effective as it should be. Staff did not have regular formal supervision and although staff support was given it was ad hoc; it was not always within designated and protected time.

Staff lacked training in some specific areas of care. This had not however had a negative impact on the quality of people's care.

People who lacked mental capacity or who may be deprived of their liberty were protected because the staff adhered to current legislation.

Staff sought advice from health and adult social care professionals to ensure people's needs were met. People had access to relevant health care specialists when required.

Is the service caring?

Good

The service was caring. Staff really wanted to improve people's quality of life and achieved this by ensuring people mattered and by making sure they were listened to.

People were treated with respect and provided with the privacy they wanted or required.

Staff took the time to communicate effectively with people, giving them support and explanations where needed.

People at the end of their life were cared for in a dignified, compassionate way. This care was planned so as to eliminate any distress or discomfort.

Summary of findings

Is the service responsive?

Good 

The service was responsive. Care records gave staff up to date and relevant information for guidance and people were involved, or their representatives were, in reviewing these.

There were opportunities for people to socialise and join in activities and staff were working hard to try and tailor these to people's individual preferences.

There was a complaints procedure and although the service had not received any complaints, concerns that had been expressed had been taken seriously, listened to and addressed.

Is the service well-led?

Requires Improvement 

The home was not always well-led. The importance and benefits of carrying out quality monitoring checks had not always been fully appreciated. An ineffective monitoring system in some areas had resulted in the registered manager not always being aware of what required improvement.

Staff were being provided with leadership and support on a day to day basis and they were aware of their responsibilities and the standard of performance managers' expected to see.

People had opportunities to be involved in the running of some aspects of the home if they wished and visitors felt welcomed and able to approach the management staff.

Knightsbridge Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16, 18 and 19 January 2015 and was unannounced. This inspection was brought forward after we received information of concern about the service. The inspection was carried out by one inspector. Before the inspection we reviewed the information we held about the service which included notifications. Notifications contain information from the provider about significant events. We looked at the latest contract monitoring report from the local adult social care commissioners. We also gathered information from health care professionals who visit the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and what improvements they plan to make.

We spoke with 11 people who live in the home and seven relatives. We spoke with four members of staff, including the deputy manager and registered manager. We spoke with one visiting health care professional and obtained the views of two other professionals who visit the home. We spoke with two representatives of the provider. We looked at four people's care records as well some care related records for other people, such as bathing records and medicine administration records. We looked at two staff recruitment files as well as other staffs' training and support records. We also looked at two policies and their procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One person said "I feel perfectly safe here." One relative said, with regard to the person's safety, "I would not want her to be anywhere else." One visiting health care professional said "I have no concerns about here."

People were potentially at risk of infection. This was because, although the training record showed staff had received infection control training, they were not always able to adhere to the service's policy and procedures for infection control. This was because, in places, the procedures were not relevant to the service and equipment stated in the procedures was not always in place. For example, the procedures stated that commode pans were to be sanitised in a sanitising machine but the service did not have this piece of equipment. The procedure for managing spillages of blood could not be followed because the equipment stated to be used was also not in place.

Staff had also recently altered the arrangements for the cleaning of commodes to ensure these were cleaned properly, but the registered manager was unaware of the change and the documented procedure had not been altered. When we spoke with staff about how spillages of body fluid should be managed there was confusion about how the recorded procedure would be adhered to without the appropriate equipment in place and differing accounts on how these situations had been managed.

We found that the registered person had not protected people against the risk of potential infection because staff were not sufficiently trained in line with procedures that were relevant to the service. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Other arrangements were in place on a daily basis to help prevent the spread of infection and to keep the environment clean. For example, cleaning schedules were followed and there were no offensive odours. All cleaning equipment was colour coded so as to reduce cross contamination. A system of segregation and non-handling of soiled laundry was in place to prevent the spread of infection and cross contamination. Staff wore protective gloves and aprons when delivering care or when serving food. Hand sanitiser had been placed around the building and liquid soap and paper towels were in toilet areas.

People were not always protected from unsuitable staff. One member of staff had been recruited following full clearance by the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. However the second recruitment file inspected showed a member of staff had started work before any checks by the DBS had been completed. The registered manager explained that due to a staff vacancy and the remaining staff needing to cover additional hours, they had been "desperate" to recruit someone quickly.

We found that the registered person had not protected people against the potential risk of unsuitable staff. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People told us there were enough staff to meet their needs but they also said there can be a wait when they ring their call bell for staff to attend. One person said "I had to wait 10 minutes this morning before someone came." However, other people told us staff usually came to explain to them that someone would be with them soon if the care staff were already with someone. People potentially did not always have their needs met when they preferred to have them met, but people we spoke with told us waiting for a short period of time was not a problem for them.

The registered manager explained that the answering of call bells was everyone's responsibility. They said if care staff were with a person then other staff on duty would go and see if the person was safe and see if they could help them.

People were protected against abuse because staff had been trained to recognise abuse and report any allegations of abuse. Staff also knew how to raise concerns they may have about other staff member's behaviour towards people they cared for. Prior to this inspection we had received information of concern around allegations of abuse which

Requires Improvement

Is the service safe?

we had shared with the local County Council. This had been investigated by both the County Council and the registered manager. These investigations found no evidence of abuse taking place in the home.

Medicines were managed effectively to ensure people received their prescribed medicines and to reduce the risk of medicine errors. One error had been reported by staff to the deputy manager in January 2015. The deputy manager had investigated this and to prevent a reoccurrence had organised alterations to how the medicine was packaged and stored. Staffs' medicine administration competencies were then checked and staff received relevant re-fresher training.

One person had been supported to remain independent with their medicines. However, this then meant that the storage arrangements for this person's medicines did not protect others from the risk of consuming medicines that may harm them. This situation was resolved during the inspection.

An audit completed by the supplying pharmacy in January 2015 stated there were "excellent arrangements" in place for medicines within the home. Particular arrangements were in place to ensure people who were at the end of their life received medicines they required without delay.

There was an emergency contingency plan in place and arrangements for shelter in the event of the staff needing to fully evacuate the building. The employer's liability insurance certificate and certificate for Legionella testing were both in date.

Requires Improvement

Is the service effective?

Our findings

Staff support and supervision was mainly undertaken on an informal basis. The registered manager and deputy manager told us they spoke to staff on a daily basis about how they were coping and what support they needed. Very little of this support had been recorded but staff confirmed this was the case. Time away from their practical work in order to talk about their training needs, worries and their performance had been limited to one or two sessions in the last year for some. Both managers were aware that more designated time was needed to support staff and to carry out checks on their competencies. However, where poor practices had been identified, staff had received one to one support and appropriate action had followed, such as further training or a check of their competency. Competency checks and additional training had been provided as a matter or priority recently in medicine administration.

People told us their needs were met effectively. One relative said ,"since she has been here her health has really improved." Another relative said, "I would highly recommend the home, it's very good". One person said "all the treatment here is fine." Another person said "I am just so glad to be here".

People were cared for by suitably skilled staff who had received training in subjects such as fire safety, infection control, safe moving and handling, first aid, health and safety, food safety, safeguarding adults, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Several staff held nationally recognised qualifications in care. The staff training record showed a lack of training in some specific areas such as, end of life care, dementia care and equality and diversity. However where staff lacked formal training they received practical support and guidance from senior staff who had received additional training in these areas of care. Where needed staff also sought support and advice from specialist health care professionals to ensure people's needs were correctly met.

A health care professional commented that staff were very efficient in referring people to them. They said staff were very attentive to detail, knowledgeable about the people they cared for and communication from them was excellent.

Staff were supported to provide best practice based care through the involvement of health care specialists when required. For example, one person had complex needs. The deputy manager had specifically requested that a specialist health care professional review this person's needs and give staff guidance on the person's health condition. As a result a specialist nurse visited and organised further health support for the person and also explained to staff the course the person's illness would take. They talked about the things staff needed to prepare for in order to help the person remain comfortable. We spoke to this person's relative who was very involved in their relative's care, they said, "I am very happy with the care". The relative spoke with us about a period of deterioration in their relative's condition and said "they (the staff) were straight on to this and they involved a specialist."

People living with dementia or who exhibited behaviour that could be perceived as challenging had their needs met well. One health care professional told us staff were particularly good at supporting people who were distressed and agitated. Specific risk management strategies were in place for these people. For example, we spoke with staff about one person who could get upset and agitated. They told us they followed the risk management strategies in place which helped to support this person. The health care professional confirmed that the staff always implemented the strategies that had been agreed and always followed their advice. They confirmed that staff delivered care in the least restrictive way and rarely did the person require a re-referral back to them.

Despite the lack of formal training for staff in end of life care, people received good care at the end of their lives. Advanced care plans were in place for people who wanted their end of life wishes known. For example, some care plans stated that the person wished to remain cared for at Knightsbridge Lodge in their last few days of life. We met the family of one such person. They could not praise the staff enough for the care their relative had received. Staff worked alongside community nurses at this time of a person's care to ensure their needs were fully met. Feedback given to Healthwatch (a local consumer champion who gather views of those who use local health and social care services) by a relative complimented the staff on their relative's end of life care. We spoke with a person who was receiving palliative care and they confirmed they were involved in the planning of their care and in the decisions being made about their treatment.

Requires Improvement

Is the service effective?

Staff were supporting this person to remain as independent as possible and to help them feel they had some control over what was happening to them. For example, the person was making their own decisions with regard to how their pain was managed, although staff were monitoring this to ensure the person was not in unnecessary pain.

People's consent to care and treatment was sought appropriately. Staff were aware of and understood their responsibilities in line with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of adults ensuring that if restrictions on their freedom and liberty are required to keep them safe, the need for these are assessed by appropriately trained professionals. We were told by the deputy manager that no-one currently lacked mental capacity with regard to decisions about their care or treatment. We were not aware of anyone being deprived of their liberty unlawfully during the inspection. One person had lacked capacity and staff had submitted a referral for DoLS. DoLS were authorised but the needs of this person had become more than the staff could safely manage and had led to the person being moved to a care setting which was more appropriate for their needs. The registered manager was aware of who legally had been appointed to make health and welfare decisions on behalf of their relative. This ensured that the appropriate people were involved when best interests decision needed to be made.

We saw Do Not Attempt Resuscitation (DNAR) orders in place for some people. These were recorded on the recognised document for Gloucestershire so emergency health care professionals would note these instantly in an emergency. They were kept in an easy to access folder. The orders had been discussed and reviewed with the person they referred to by the person's own GP.

People were supported to have sufficient food and drink. People we spoke with said they enjoyed their food. One person said "Yes it's alright, you pick what you want from a menu." Another person told us they were going to look at the options for tea time. These were pinned to a notice board outside the dining room at a height this person could read. One member of staff discussed the choices with this person. There were two options each day at lunchtime, apart from a Friday when it was fish, although alternative options were available if people did not like fish. Another person told us they felt the choices were sometimes "odd" for example, they said they had been offered sandwiches or a bacon sandwich. This person went on to tell us that on the day they were given this choice the staff cooked them "just what they fancied" and they told us they had "really enjoyed it."

We saw drinks beside people in their bedrooms; one person had an adapted drinking cup to help them continue to drink independently. We also saw squash and beakers available in the main communal room for people to have a drink in-between the set coffee and tea rounds.

Some people were at risk of not maintaining sufficient weight so people's weights were monitored. Staff used an assessment tool called the Malnutrition Universal Screening (MUST) tool to also measure people's body mass index (BMI) and as guidance for referring to the GP. If needed a person's GP had prescribed a nutritional supplement to increase their calorie intake. People with swallowing problems were assessed by a speech and language therapist and staff then given guidance on what sort of diet would be safe for the person to eat.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were very caring. One relative said, "We looked at a lot of care homes before we chose here. You can approach them here, they are like one big family". Another relative said "They are angels; so considerate and kind." One person who lives in the home said "They are very patient with me, we have a laugh here." Another person confirmed staff were kind to them. Two further people told us, "They are all lovely girls, so kind."

Staff made people feel they really mattered and their actions had made a big difference to the quality of people's lives. For example, additional shelving had been put up in one bedroom and the room moved around to accommodate the person's paperwork, computer, printer and television. This was all important to this person who had moved quickly from their own home into care. The person said "He (the registered manager) did all of it for me, I was too poorly." The registered manager also came in on one Sunday and took one person to their relative's house for lunch. The registered manager said, "They had a really rotten week, their relative could not collect them, so I just did it". Other small actions were carried out by staff in order to make a difference to people's lives. One person said, "They always put my hearing aid in each morning, it makes a difference". One person said "I am very slow and they are so patient with me". We observed this person being supported to walk by a member of staff who remained with them and who was patient and encouraging towards them.

People's distress and discomfort was addressed immediately and in a caring way. One health care professional said, "The quality of care residents get is good particularly when they are suffering from emotional distress". They said this was because staff had good relationships with people, they knew them well and staff communication skills were good. Action was taken to ensure plans were in place to quickly address any discomfort or distress at the end of a person's life. One family told us their relative had died peacefully and in a dignified manner. One person said, "They organised a new bed for me, I can bring my knees up and then adjust the back height. It takes a few adjustments and then I can get comfortable and can go to sleep."

People told us that the people that mattered to them were involved in their care. Relatives told us they were consulted about their relative's care where this was appropriate. One health care professional said "They are very compassionate and caring towards their residents. They appear to approach care on a very individualised basis". Another professional said, "The home is set out so that people's bedrooms express the individual that lives there, with personal photo's etc, it's very homely". This professional also said, "The staff take an interest in people's life histories". We saw these recorded in people's care records and information from this was used in the care planning.

People's differences in faith were recognised, accepted and met. Staff had organised for a local Catholic Priest to administer Holy Communion to those who were Catholic. Another person had spoken to the "leader" of their church about their funeral plan.

Particular efforts were also made by staff who were not involved in delivering people's care but who worked in the home and who could contribute to the quality of people's lives. Several people told us how they enjoyed the garden and in the summer how they talked with the staff who attended this. For example, more flowers were planted outside of the patio doors of the most frequently used lounge as a result of the gardener listening to the views of those that live in the home. A member of staff who lived locally and who was not on duty sat with one person at the end stage of their life.

Good

Is the service responsive?

Our findings

People's needs were addressed with personalised care plans. The care plans were reviewed regularly and gave staff up to date information about the person concerned. The care plans also gave staff guidance on how a person's care was to be delivered. People or their representative had been involved in their development.

Care plans were devised following an assessment of a person's needs. Prior to admission people's needs were assessed by senior staff to ensure the service could meet these. Examples of these were seen in the care records we viewed.

The deputy manager told us people were very much involved in the planning of their care. Care plans showed that the individual's preferences and wishes had been included. For example, one person had expressed they did not want a specific type of health intervention when they became more poorly. This was recorded in the relevant care plan for staff in the home and medical staff to be aware of. This person's care plans gave detailed guidance on each area of care so the person received care that was safe and appropriate. It was delivered in the way the person wanted it delivered. Where it was appropriate people's representatives were involved in this process on their behalf.

Where people's health and care needs had changed staff told us their handover meetings were particularly helpful because these highlighted any changes that may have taken place since the last time they were on duty. People's needs were reviewed, for example, one person's personal hygiene care plan, written in January 2014, required alteration in May 2014 when the person's needs altered. A change in the support to be given was then incorporated into the care plan so staff continued to give the level of care the person required. Since then the person's needs had remained the same and a monthly review had recorded this fact.

Staff were aware of when people wanted to be alone or if they preferred their own company but they were also aware of people who were at risk of becoming socially isolated. One person said, "I enjoy the quiet of my bedroom and this is ok with me". Staff had been supporting another person to use the lounge more frequently. We later saw this person sitting in the lounge and they said "It makes a change from being in my bedroom."

There was a program of activities and social gatherings pinned up on a notice board for people to read. People told us the activity co-ordinator was new to the job and was trying different things out with them. One person did not find the activities stimulating enough but others disagreed. The activities coordinator was looking into tailoring activities to people's individual's needs. Some adjustment had been made to the quizzes provided to try and accommodate the person who felt they were not mentally stimulated. Activity care plans and life histories were in place so the activities co-ordinator knew what would be relevant to people and what their likes and dislikes were. On one of the inspection days the Salvation Army Band visited. They did this each month and we saw people singing and fully engaged with this. One relative said "There is always something happening here (name of person) has also been on a boat trip and to the Pantomime."

People told us they would go to the registered manager or the deputy manager about any concern they had. Information relating to how people could make a complaint was in the reception area. The complaints procedure was also contained in the information people received on admission. The registered manager told us there had been no "written or formal complaints" received. They said when small concerns were raised they were addressed straight away. For example, one of these had been items of clothing not being returned from the laundry or being returned to the wrong person. This had been addressed by reminding relatives and staff to ensure people's clothing had their name in it.

We witnessed one person express irritation that their cream, which had been prescribed by the GP in the morning, had not turned up by the afternoon. We learnt that it had arrived by the early evening. The person's obvious dissatisfaction about this was managed politely and calmly by the registered manager.

Some of the information received by us prior to the inspection was alleging poor or inappropriate care. Each case had been investigated by an adult social care professional and the registered manager. There had been no evidence of poor care or intentional poor practice. One health care professional, who visited the home on a regular

Good

Is the service responsive?

basis, said “I have no concerns about the care here.” Another health care professional commented that they and their colleagues had no concerns about the care and attention people received.

Requires Improvement

Is the service well-led?

Our findings

People were at risk of inappropriate care and treatment because the systems in place for the assessment and monitoring of quality were not always effective. They did not always have the appropriate information to enable them to effectively assess, monitor and manage risks relating to the health, welfare and safety of those in the home.

Care records were maintained predominantly by the deputy manager to ensure information about people and guidance for staff was up to date and correct. The registered manager told us they selected a number of care files to monitor as part of their quality monitoring. They told us that this process and their findings were not recorded. We asked how they fed back any shortfalls they found to the staff and how they communicated what they wanted done about these. They told us this was done verbally and informally. There was however, no system in place to follow up any required actions. Although the care records reviewed were all maintained according to the provider's expectation, people could potentially receive unsafe or inappropriate care or treatment because the content of their care files was not monitored or checked for accuracy.

Effective quality monitoring systems were not in place to determine if staff had received adequate and appropriate support. The registered manager was not aware of the current frequency of staff support and development meetings. A lack of effective monitoring of this had meant the registered manager was not aware if staff were receiving adequate or appropriate support.

Health and safety records were maintained by the maintenance person and the registered manager who checked these overall, these included the infection control arrangements. Although the registered manager, for example, visually checked to see if the environment was clean, ensured segregation of soiled laundry took place and staff wore appropriate protective equipment such as gloves and aprons when delivering care, none of these observations were recorded. The registered manager explained that any shortfalls identified when doing this were "kept in their head" and dealt with informally. Monitoring of infection control was not in line with the criterion stated in the Code of Practice for health and adult social care on the prevention and control of infections. This document could not be found during the inspection. The registered manager was therefore not using the appropriate tool under the Health and Social Care Act 2008 to monitor and assess if the home was compliant. In this case, with current legislation in relation to cleanliness and infection control.

The registered manager told us they had started to review each policy as part of their quality monitoring arrangements to ensure they were relevant to Knightsbridge Lodge and to ensure staff were aware of the contents. The infection control policy and procedures had been signed off by the registered manager, as going through this process, in November 2014. When we viewed the infection control procedures, some were not relevant to Knightsbridge Lodge. Effective checks and an audit of the procedures against staff practices would have highlighted the discrepancies we found but as it stood, the registered manager was not fully aware of these. There was not an effective system in place to ensure they had the appropriate information to enable them to effectively assess, monitor and manage risks relating to the health, welfare and safety of those in the home.

We found that the registered person had not established systems and processes that effectively ensured compliance with relevant regulations and legislation. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Some quality monitoring checks were recorded such as those carried out on the medicines system and associated records. A detailed medicines audit was completed monthly and the last audit, in December 2014, had not identified any shortfalls. Accidents, predominantly falls, were recorded each time they took place. The registered manager monitored these and there was a system in place to examine more closely the events leading up to a fall. This was done to identify the cause and to look for any trends or patterns which maybe evident and to determine the best action to take to prevent a reoccurrence. For example, in one person's case this process had triggered a need for their GP to review their medicines. Following an adjustment to these the person's falls reduced significantly.

The registered manager told us because the business was run by the family, plans for improvement were often decided on informally or on the "spur of the moment".

Requires Improvement

Is the service well-led?

However, the deputy manager told us that regular senior management meetings took place where action plans were agreed. They showed us an action plan that had been implemented in May 2014. This was clearly a working document with entries on it where actions had been completed or moved forward. The last senior management meeting had been on 12 January 2014 where the action plan had been reviewed. The deputy manager said "a more structured approach has definitely helped us make more improvements."

The registered manager or deputy manager were present in the home most days of the week. They shared the management of the home with the deputy manager taking a lead on all care matters. Both held a recognised and relevant qualification in social care leadership and management. During the inspection they constructively discussed issues, were able to be reflective and consider things collectively. It was evident that both these managers were very aware of what was going on with each person in the home. Both managers spoke to us about their aims and visions for the home which were to ensure people received the best care possible in a place they could call their home. These were repeated by the staff we spoke with. They told us that care delivery always came first but it was sometimes difficult to organise some of their additional managerial duties. These included carrying out staff competency checks, staff support and training. The registered manager told us they had already recognised this as a problem and was looking at how this could be addressed.

An open door policy was in place and during the inspection several people came to the care office to talk to either the registered manager or deputy manager. People visiting the home were welcomed, listened to and made to feel at home. One relative said "You can approach them here."

Meetings were held with the people who live in the home every three months. Some of the people we spoke with told us they attended these. In the last meeting they told us they were involved in making decisions about social activities, what was included on the menu, how they wanted to celebrate Halloween and how they could raise money at Christmas. Plans for fireworks night had also been agreed and this had resulted in a fireworks display, drinks and relatives attended. Information relevant to people was also passed on to them in these meetings, such as the new enhanced arrangements in the area for GP services and how this effected them.

People who wanted to had been encouraged to be involved in some aspects of the running of the home. One person had been asked if they would like to contribute towards the staff recruitment process. They had done this twice and their views on the candidates had been taken into consideration at the point of selection. One other person had wanted to know what went on in a staff meeting so they had been invited to one. The registered manager explained that no confidential information about people was shared in this meeting.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not ensured that people were protected from potential infection because the training provided to staff was not in line with a policy and procedures that were relevant to the service. Current guidance and legislation was not being followed to ensure these arrangements were in place and effective. Regulation 15(1)(a). (This regulation corresponds to regulation 12 of the HSCA (RA) Regulations 2010 Cleanliness and Infection Control)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not operated effective recruitment procedures in order to ensure that relevant information specified in Schedule 3 was available and considered prior to the employment of staff. Regulation 19(2)(a)(b)(3)(a)(b). (This regulation corresponds to regulation 21 of the HSCA (RA) Regulations 2010 Requirements relating to workers).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not fully protected people by means of the effective operation of systems designed to identify assess, monitor and manage risks relating to the health and welfare and safety of people and others who use the home. Regulation 17(2)(b).

This section is primarily information for the provider

Action we have told the provider to take

(This corresponds with regulation 10 of the HSCA (RA) Regulations 2010 Assessing and monitoring the quality of service provision).