Bridge Care Residential Limited

Burn Brae Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Burn Brae Lodge is a residential care home based in Corbridge, Northumberland which provides personal care and support for up to 31 older people. People are accommodated over two floors. The last inspection of the service was carried out in March 2014 when we checked to see if the provider was meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, that had previously been breached. We found that they were. At the time of this inspection there were 26 people in receipt of care from the service; one of these people received care on a respite basis.

This inspection took place on the 26 and 27 May 2016 and was unannounced.

The registered provider was also the registered manager of the service and had been registered with the Commission in this role since October 2010. 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.

People were complimentary about the service and staff who supported them. They described staff as "kind" and "lovely". Staff were aware of their own personal responsibility to report matters of a safeguarding nature and we saw that historic safeguarding matters had been handled appropriately. Risks that people had been exposed to in their daily lives had been assessed and documented. Environmental risks within the home had been assessed and mitigated against. Accidents and incidents were monitored and measures put in place to prevent repeat events.

Recruitment procedures were robust and medicines were managed safely and appropriately in line with best practice guidance. Staffing levels were sufficient on the days that we visited the home to meet people's needs. Whilst we did not identify any issues with staff practice, skills or the care we saw being delivered, staff training records showed staff had not been supported to develop and maintain their skills through regular role-specific training. There was a basic induction programme in place but this was limited and did not incorporate the Care Certificate brought into force in April 2015, in line with best practice guidance. Supervisions took place regularly but there was no appraisal system in place. The provider told us annual appraisals of staff performance were due to be introduced shortly.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and although they informally assessed people's capacity when their care commenced and on an on-going basis when necessary, this was not documented. Decisions that needed to be made in people's best interests had been undertaken but records about such decision making were not maintained.

The staff approach was kind and caring and people said they enjoyed good relationships with staff. People were involved in the service and had signed their care plans to evidence they were involved in the care planning process. People received information about the service and explanations about the care that was being delivered to them. Advocacy services could be made available to those people who needed them. Most people living at the home at the time of our inspection had relatives who were actively involved in their care and who supported them in decision making.

Activities were offered regularly but some people expressed a desire for more stimulation. People were afforded the opportunity to make their own choices in their lives, although choices around food options were limited. A complaints policy and procedure was in place and no formal complaints had been received in the 12 months prior to our inspection.

People, their relatives and staff described an open culture within the home and we found a welcoming and homely atmosphere. The registered provider was actively involved in the operation side of the business. The requirements of the provider's registration were met and we were satisfied that notifications of deaths and other incidents were made in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

Audits were carried out but documentation around these audits and checks could be improved. Action plans were not utilised within the service as a tool through which to drive improvements. In some areas there were shortfalls in recording, for example, some care plans and risk assessments lacked detail, supervisions were basic and the application of the MCA was not appropriately evidenced through documentation.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 18 entitled Staffing, and Regulation 17 entitled Good Governance. You can see what action we asked the provider to take at the end 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?

Good

The service was safe.

People told us they felt safe living and receiving care at Burn Brae Lodge. Their relatives echoed this.

In practice, risks that people were exposed to in their daily lives were assessed and mitigated against. Environmental risks around the premises had also been assessed and were reviewed regularly.

Safeguarding policies and procedures were in place and staffing levels were appropriate to meet people's needs on the days that we visited the service.

Recruitment procedures were robust and the management of medicines was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us they felt supported by the provider, but we found training to be sporadic. The Care Certificate was not embedded into the provider's induction programme and staff appraisals did not take place in line with regulatory requirements.

The Mental Capacity Act 2005 was applied in practice, but decision making and assessments of people's capacity levels were not documented.

The feedback we received from people, relatives and visiting healthcare professionals was positive about the effectiveness of the service and reflected that staff were proactive in meeting people's needs.

People were supported with their nutritional needs, but food choices at mealtimes were limited.

Is the service caring?

Good

The service was caring.

People and staff enjoyed good relationships and the staff approach was gentle and kind.

People's privacy and dignity was respected and promoted. They were encouraged to be as independent as possible.

Staff offered explanations when delivering care. People were involved and informed about their care and aspects of the service.

End of life care was delivered effectively.

Is the service responsive?

Good

The service was responsive.

People had individualised care plans and risk assessments in place that were reviewed regularly.

People had choices about how they lived their daily lives. Activities were available for people to pursue, but people told us they would appreciate an expansion on the current activities programme.

There was an appropriate complaints system in place and avenues through which the views of people and their relatives were gathered.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were shortfalls in recording and a lack of evidence of actions taken following auditing.

Some analysis of incidents and care delivery was done but it was difficult to see how this had been used to drive improvements in the service.

The culture of the service was open and staff said they felt well supported. The home had a good atmosphere.

The conditions of the provider's registration were met.

Burn Brae Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 27 May 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to this inspection we asked the provider to complete a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed all of the information that we held internally about the service, including statutory notifications that the provider is legally obliged to inform us of. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern. We also sought feedback from Northumberland safeguarding adults team, local authority commissioning team and Healthwatch. We used the information that these parties provided us with to inform the planning of this inspection.

During our inspection spoke with the seven people who used the service, three peoples' relatives and two visiting healthcare professionals. We spoke with the provider, who is also the registered manager, the deputy manager, three care workers and the maintenance person. We looked at four people's care records and a range of other records related to the operation of the service, including four staff training and recruitment records, care monitoring tools and quality assurance documentation.

Good

Is the service safe?

Our findings

People told us they felt safe living at Burn Brae Lodge. They described staff as "very, very, nice" and "helpful". One person said, "There is nobody (staff) nasty or anything like that" and another person told us, "I have always felt safe here". One person's relative said, "Nothing at all worries me about here". Another relative commented, "There is nothing here that gives us cause for concern". Healthcare professionals we spoke with described how they did not have any concerns about the safety aspects of the service or any matters of a safeguarding nature. One visiting professional said, "I never come in here and think things are dangerous".

We observed staff delivered care that was both appropriate and safe. People had access to the equipment they needed to support their needs. For example, staff encouraged and enabled people to move around the home safely, either with walking aids or without, depending on their dependencies and abilities. We observed moving and handling manoeuvers and found that these were carried out safely and in line with best practice guidance.

Some risks that people were exposed to in their daily lives had been assessed and written instructions were in place for staff to follow in people's care records about how to manage and reduce these risks. However, not all risks that people faced had been formally documented and retained in people's care records, and some of those that had, lacked detail. Despite these shortfalls in record keeping we were satisfied that in practice staff were fully aware of how to manage and mitigate the risks that people faced appropriately. They described the steps they took to ensure people remained safe and confirmed that as they were a small staff team, this information was regularly discussed and any changes in risks were monitored and adjustments made to care delivery.

Environmental risks around the building had been assessed and these were reviewed on a regular basis. Regular fire and health and safety checks were carried out and documented. Equipment such as hoists and weighing scales were serviced and maintained regularly in line with manufacturers' recommendations. Checks were carried out on, for example, electrical equipment, the electrical installation within the building and utility supplies, to ensure they remained safe. We saw evidence that the risk of legionella bacteria developing in the water supplies of the home had been appropriately assessed and control measures were in place, such as testing water temperatures regularly and decontaminating showerheads. This showed the provider sought to ensure the health and safety of people, staff and visitors.

Accidents and incidents that occurred within the home were appropriately recorded and managed to ensure that people remained safe. Preventative measures that could be introduced were, and medical attention was sought where needed. For example, where people had fallen regularly the provider had sourced sensor mats and put in these in place, so that staff were alerted and could offer people assistance when they attempted to mobilise themselves. People had been referred to external healthcare professionals such as GP's and district nurses for input into their care, as a result of some accidents and incidents that had occurred.

An emergency planning file was in place and easily accessible. Personal Emergency Evacuation Plans (PEEPs) had been drafted so that staff had instruction and detail about the levels of support that each person would require should they need to be evacuated from the home in haste, for example if there was a fire or flood. A provider business continuity plan was in place; this was being redeveloped and redrafted by the provider at the time of our inspection, so that it was more extensive.

The provider had safeguarding and whistleblowing policies and procedures in place to protect vulnerable adults. Staff displayed an in-depth knowledge of safeguarding procedures and the different types of abuse and harm that people could potentially be exposed to. They were aware of their own personal responsibility to report matters of a safeguarding nature. All of the staff we spoke with told us they would not hesitate to escalate their concerns, should they not be dealt with appropriately by the provider. The local authority safeguarding team confirmed that matters of a safeguarding nature were reported to them by the management team at the home and records held within the home and our own databases confirmed this.

Staffing levels within the home were appropriate to peoples' needs on the days that we visited and we did not observe people waiting for assistance. Staff told us they felt staffing numbers were appropriate, although at some times throughout the day they were busy, for example, in the mornings when people were rising from bed. When people asked for assistance they were promptly supported by staff who were happy to assist. Some people said they were unsure about the staffing levels in the home and whether or not they were sufficient, but relatives reflected that they saw plenty of staff available to assist people when they visited regularly.

Staff files demonstrated the provider's recruitment and vetting procedures of new staff were appropriate and protected the safety of people who lived at the home. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. Any gaps in employment history had been explored by the provider and risk assessments had been carried out where there were any issues highlighted on DBS checks. This meant the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit and appropriately qualified to do their jobs.

The management of medicines was safe. People told us they received the medicines they needed, safely, and on time. Medicines administration records (MARs) were well maintained and reflected that the recording of the administration of medicines was in line with best practice guidance. Personalised plans were in place for the administration of 'as required' medicines but these lacked detail and did not always inform staff about how they would identify that a particular person needed this medicine. For example, it did not record how individual people displayed signs of pain. 'As required' medicines are prescribed to be administered when needed for example when people are in pain. All of the medicines we checked were within their expiry date and stored in line with manufacturers guidelines. Medicines that were no longer required or refused were disposed of safely via the pharmacy linked to the home. Controlled drugs, which have the potential for abusive use or dependency, were stored safely and a detailed and appropriate register of stocks was maintained. We carried out a random check of these medicines and found the stock balanced with the register.

Requires Improvement

Is the service effective?

Our findings

Staff were knowledgeable about their work and said they felt supported by the deputy manager and the registered manager/provider. They were able to describe individual people's needs when we asked information about them and also any historic issues or concerns. Staff told us that they had completed an induction although records showed that this was very basic in nature and involved staff reading the provider's policies. Staff told us they shadowed existing staff when they started working at the home so that the practical side of the job was also learned before staff worked alone. The Care Certificate was not embedded into the provider's induction programme, although the deputy manager told us there were plans to incorporate this. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and brought into force in April 2015. It is a set of minimum standards that social care and health workers stick to in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers.

Staff told us they felt supported and they received regular training. We had no concerns about the skills of staff or the care we saw them deliver, however, training records showed training was not regularly delivered and evidence in staff files showed that staff had not received training in key areas for several years. We looked at four staff training files and although staff told us they received regular training, we found training to be inconsistently delivered. In one case a staff member had not been supported to undertake refresher training in safeguarding since 2005, or in emergency first aid since 2006. Some staff had completed bespoke training in dementia awareness and nutrition, which was relevant to the needs of some of the people cared for by the service, but other staff had not done this training. There was no evidence that one member of staff had completed training in moving and handling or safeguarding vulnerable people. We saw certificates in two of these staff files for training in subject areas such as whistleblowing, safeguarding and equality and diversity, but the provider confirmed these were internal certificates he had drafted related to informal training he had delivered. Training was therefore not always delivered by an accredited person or company. This meant that staff were not effectively supported with a training programme that developed and maintained their skills, to ensure they remained up to date with any developments or changes in best practice guidance.

Supervisions took place bi-monthly. The records related to these supervisions lacked detail. Staff told us they felt supported as they could approach the provider at any time and he was happy to discuss any concerns or issues they may have. An annual system to review and appraise staff performance was not in place in line with legal requirements. The provider told us there were plans in place to introduce this shortly. Supervisions and appraisals are important as they are one to one meetings between staff and their line manager, at which discussions usually take place about job performance, training and development, and any other matters of a work or personal nature.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Staffing.

People told us that staff met their needs and assisted them whenever they needed help and support. One

person reflected, "Staff have helped me with anything I have asked for". Another person told us, "It is very relaxed here. The staff are very helpful and encouraging when necessary. Where it is necessary they help with everything". Other comments included, "I am quite happy; I think they help me with everything" and "Every member of staff is pleasant, they have loads and loads of patience". One relative told us, "We think X (person) is well looked after here. I think it is very comfortable and that all residents are well looked after". A second relative said, "Nothing worries me here; mum has improved since she came here".

Visiting healthcare professionals gave positive feedback about the service. One visiting healthcare professional commented, "The home is very good and they are proactive. They always have information ready for me when I come and people seem well looked after. It is calm here. Falls prevention is proactive they have already put measures in place such as crash mats and sensor pads before I assess people for referral. If I need to refer anyone for example to the challenging behaviour team, they are supportive and really they are normally already trying to put techniques in place to manage these behaviours". Another visiting healthcare professional told us, "They refer things to us appropriately they always ring up. X (deputy manager) has a good grasp of what is going on".

Staff, people and their relatives described good communication within the service. Staff said that because the service and staff team were small, communication was not a problem. They said that messages were passed between staff constantly and also the provider, who they saw most days as he lived on site. A diary system was in place to record any key points or issues with either the service or people's care, and also any up and coming appointments or visits to the service by external professionals. People said they felt that information was shared with them and relatives commented that they felt assured the service contacted them with any information they needed to know about their family member's care or health conditions.

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 so that they can 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for Deprivation of Liberty Safeguards (DoLS) had been made to the local authority safeguarding team in accordance with good practice. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were in place where people had consented to these, and where they were unable to consent, a best interest decision instigated by a clinician had been made. We were satisfied through our discussions with senior care staff, the deputy manager and the provider that the principals of the 'best interests' decision-making process had been followed in practice, and healthcare professionals told us they were involved in such decision making. However, the nature of the decision, and who was involved in the best interest decision-making process, was not documented and retained. In addition, there was no documentary evidence to demonstrate that people's capacity levels had been appropriately assessed in line with the MCA. We discussed this with the provider who advised us that in future, he would ensure that any assessments of people's capacity levels and any best interest decision making, was fully documented.

People were supported to eat and drink in sufficient amounts to remain healthy. People with specific dietary requirements (such as vegetarianism) were catered for and their needs shared with kitchen staff. No people living at the home at the time of our inspection needed any monitoring of their food and fluid intake to

ensure that this reached a minimum level. Staff were knowledgeable about the need for monitoring such intake should some people develop this need. People told us there was only one choice of main meal at mealtimes, but confirmed that alternative food options would be prepared for them if they did not like what was served. We discussed this with the provider who advised that he would review the menu and how meals were planned, to ensure that people had the option of more than one dish at mealtimes.

People received input into their care from external healthcare professionals such as opticians, chiropodists and general practitioners. In addition, where people needed more specialist from, for example speech and language therapists and challenging behaviour teams, this input was sought by the service. Prior to our inspection an incident occurred in which medical attention was not sought for one person in a timely manner. We discussed this with the provider and saw that lessons had been learned from this event. The provider had reviewed and amended existing policies, and introduced new policies, in order to prevent the same delay from happening again.

The premises were suitably maintained and homely. There were handrails in communal areas for people to use to aid mobility and adequate bathing facilities for the number of people who lived at the home. There was a lift available for those people who resided on the upper floor of the home, who needed assistance to get upstairs.

Good

Is the service caring?

Our findings

People told us they found the staff team to be caring and compassionate. One person said, "Oh the staff are lovely. Every member of staff is pleasant. They have loads and loads of patience". Another person told us, "The staff are lovely; they are very nice and understanding" and a third person commented, "The staff are lovely and the atmosphere is friendly and visitors are welcomed anytime". Relatives told us they felt welcomed when they visited and that staff were, "lovely", "approachable" and "helpful".

Our observations confirmed what people had told us. For example, we saw staff talked kindly with people, they comforted them when they were anxious and encouraged them in their daily life activities such as walking and eating. Staff also offered explanations when they were assisting people with their care. For example, during hoisting manoeuvres staff explained what they were doing and what they would be doing next, before people were moved backwards or hoisted into the air for a transfer from their wheelchair to a chair.

People told us they felt involved in their care and their relatives supported this, saying they were kept informed of any changes in their family member's care or health conditions. One relative said, "If there is anything I need to know they tell me". Another relative told us, "I am kept involved". Records showed that where people were able to do so, they had signed documentation to evidence they had been involved in the care planning and risk assessment process. In general terms people were involved in the service as staff regularly engaged with them and asked for their opinions and personal choices to ensure their input was recognised and respected. In people's rooms there was information about the service for people to refer to, including information about how to complain, should this be necessary.

Records were stored confidentially and securely in the office area of the home, where staff could access them in private. We saw staff held discreet conversations around the home, but only when needed, about aspects of people's care and their current conditions. In their everyday lives people's privacy and dignity was protected and promoted. For example, people were spoken to with respect, staff knocked on doors before entering people's rooms and they ensured that bathroom doors were closed behind them when assisting people with personal care. One person told us they were called by their first name which they liked and said they had been asked how they would like to be addressed.

People were also encouraged to do as much as possible for themselves. We observed this during our visit when we saw staff supported one person to reposition their body with their walking frame before they sat down. The person was slow in their execution of this task and despite being willing and able to help, staff did not take over and assist, enabling the person to retain their independence as much as possible.

Healthcare professionals involved with the service told us they were impressed with the end of life care delivered by the service. One healthcare professional told us, "They (staff) are very good with palliative care here. From a care point of view they (staff), along with the district nurses, provide good end of life care". A member of the district nurse team confirmed, "If someone is end of life, they (staff) always ring and they (staff) always carry out care in the way we ask them to". Whilst documentation around end of life care

needed more detail, and some people had not wished to state their preferences about this time in their lives, this feedback evidenced that the end of life care staff delivered was effective.

The deputy manager told us that no person living at the home at the time of our inspection accessed formal advocacy services as many people had relatives who advocated on their behalf. She confirmed that advocacy support could be arranged for people through their care managers in the local authority or directly with an advocacy service, should this be needed in the future.

Good

Is the service responsive?

Our findings

Care records were individualised. Pre-admission assessments had been carried out before people started using the service to determine their level of dependency and risks associated with their daily lives. People had an overall care plan in place which related to multiple needs such as sight, hearing, foot care and oral health. Risk assessments were in place but some of these lacked detail, giving staff limited instruction about how to deliver care effectively and in a person-centred way. Care plans, dependency assessments and risk assessments were reviewed monthly.

Care monitoring tools were used to ensure that people's care was delivered appropriately and changes in their health and presentation were identified promptly. For example, elimination charts were in place to monitor people's bowel movements where this was necessary. Night checks were carried out on a two hourly basis to check people's wellbeing, or more regularly if they were under some form of care monitoring overnight.

A diary system was used to pass information between changing staff shifts. A verbal handover also took place when staff shifts ended and began to highlight any areas of concern or monitoring of people's conditions as well as general information to note. This showed that measures were in place to support continuity of care. Daily notes were completed but these were basic often only including two words such as "slept well" or "usual day". They did not provide the reader with information, for example, about the person's mood, activities they had pursued that day or any visitors they had had. We did not find an impact on people, because of this lack of recording as verbal staff handovers also took place to ensure staff were kept informed. However, this meant staff could not look back at detailed records to reflect on people's behaviours and activities if they had not been in work. We discussed the issues we found with records and recording with the provider and deputy manager. They told us they would address these shortfalls as soon as possible.

People were happy with the care they received and told us they considered the service to be responsive to their needs. One person commented, "If you feel you need help, you ask and they help". Staff responded to people's requests for assistance throughout the days that we visited the home. People also commented that if they were ever ill, medical attention would be sought for them straight away. Relatives told us they had not experienced any issues with the service in terms of it's responsiveness and any issues no matter how small that they had raised had been dealt with promptly and efficiently by the provider or staff.

People's care needs were met. Records showed staff were responsive and involved GP's and specialists in people's care when needed, to promote their health and wellbeing.

An activities co-ordinator was in post who provided a range of activities for people to partake in if they so wished. These included baking, singing sessions and carpet golf amongst other things. However, people told us they felt bored and un-stimulated at times. One person said, "I don't think I have been asked about what I would like to do personally; I have a very active mind". Another person said they found life "incredibly dull" and they would welcome a discussion club where they could debate with other people and staff about

certain topics of interest such as fox hunting. We observed on the first day that we visited people were left for periods of time without social engagement from staff or activities to pursue, when the activities co-ordinator was not in work. We discussed this with the deputy manager and activities coordinator on our second day at the service. We fed back that people would appreciate an expansion on the current activities programme, especially when the activities coordinator was on her days off.

People were given choices in most areas. We saw people were able to move around the home freely, eat their meals in their rooms, or if they preferred in a communal area, and to go out into the community with relatives or friends. People told us they did not feel restricted in how they lived their lives, they were able to make choices, and they had as much independence as possible.

There was a complaints procedure in place that was made available to people and their relatives. Records showed that there had not been any formal complaints in the year prior to our inspection and the deputy manager told us that all complaints or concerns raised were dealt with immediately before they escalated to a formal stage. This supported what people and their relatives told us, which was that they had not had any reason to complain.

Systems were in place to gather the views of people's relatives. We saw the most recent survey results had been analysed and reflected that relatives were happy with the care that their family members received. 'Residents meetings' were held approximately every quarter and records showed people were asked, for example, about their food preferences, any trips out they wanted to do and if there were any concerns or issues. Staff questionnaires were not sent out by the provider but staff told us they were asked for their views about the service and how it was run during their supervision sessions.

Requires Improvement

Is the service well-led?

Our findings

We found that not all elements of the service were well led. For example, there were shortfalls in records and recording where staff supervision records and daily notes were at times not detailed enough. With regard to the MCA, the provider had not appropriately evidenced that they applied the Act lawfully as they had not retained good records about capacity assessments and best interest decision-making. Training had not been appropriately monitored and staff were not always supported to maintain their skills in line with up to date best practice guidance. In addition, the induction programme for new staff was limited and there was no appraisal system in place to discuss staff performance over the preceding year. Residents meetings were held quarterly and staff meetings had lapsed between June 2015 and March 2016 but had recommenced after that date. There was little evidence that the views of people and staff were gathered on a formal basis and then their feedback used to drive improvements throughout the service.

Auditing within the service was carried out. For example, there were audits undertaken to review infection control practices and the management of medicines. Health and safety auditing was carried out monthly. The provider told us he carried out "walk-around" auditing of the premises, but did not document his findings or where improvements were needed. The provider told us that a full health and safety review of the service was on-going at present.

An analysis of each accident and incident that took place in the home was carried out and actions taken recorded. There was no evidence of the provider using action plans following the results of checks or auditing in order to improve any issues that were identified. The deputy manager told us the provider visited the home to carry out a range of checks and assessments on the service, but documentation to support this evidence was limited. The fact that not all quality assurance and auditing of the service was well documented, coupled with the shortfalls already identified above and in other domains of this report, meant we could not be satisfied that the service was well led.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good Governance.

The registered provider was also the registered manager of this service as he was in day to day charge and actively involved in the operational side of the business. The provider had been registered with the Care Quality Commission as the registered manager of the service since October 2010. The registration requirements of the service had been met and we were satisfied that incidents had been reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

The culture of the service as described by people and staff was one of being open and honest. There was good partnership working with external healthcare professionals linked to the service and people accessed the local community with staff and relatives.

The provider's vision for the service, as stated in their statement of purpose, was to "create a homely atmosphere in which residents can flourish". We found the atmosphere in the home was "homely" and

residents' needs were met. A provider's statement of purpose for their business describes what they do, where they do it and who they do it for. Amongst other things it should include information about the services provided, aims and objectives and people needs that can be met. People, their relatives and staff all gave positive feedback about the provider describing him as "very approachable" and saying they considered the service to be well run. Staff said they felt supported and one member of staff said, "X (provider) is very supportive of my needs as a staff member". Another member of staff commented, "Whenever a member of staff makes a suggestion about something that will make peoples' lives better, I cannot think of a time he (provider) has questioned this; he (provider) does it straight away".

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 17 HSCA RA Regulations 2014 Good governance The service was not appropriately governed as there were shortfalls in training, records and recording that had not been identified through internal quality assurance systems or processes. Auditing was not always well documented and there was a lack of evidence to show how improvements had been driven forward in the service. Regulation 17 (1)(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported to maintain and develop their skills through appropriate induction, training and appraisal. Regulation 18 (2)(a)(b).