Brighton Lodge Limited

Brighton Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Brighton Lodge took place on 24 November 2016. We previously inspected the service on 7 May 2014; the service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Brighton Lodge provides care and support for adults who are living with a learning disability. The home has a maximum occupancy of 10 people, on the day of our inspection nine people were resident at the home.

The service had a registered manager in place. 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.

We found that not all aspect s of the premises and equipment had been serviced and checked in line with current regulations and good practice. On the day of the inspection we were unable to evidence a ceiling tracking hoist had been in serviced line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). However, after the inspection the registered manager provided us with evidence of the most recent safety check, completed during December 2016. Due to a delay in the completion of work to the gas cooker, the gas safety certificate for the home had expired, and although water temperatures in the two baths at the home were routinely checked, the temperatures of other water outlets were not monitored. This demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they felt their family member was safe and staff were knowledgeable about the types of abuse and the actions to take in the event a person was at risk of harm or abuse.

Each of the care records we reviewed contained risk assessments, individual to each person and relevant to their care and support needs.

There were enough staff on duty to meet people's needs and there was a procedure in place to reduce the risk of staff being employed who may be unsuitable to work with vulnerable people.

Staff were assessed as competent to administer people's medicines. Systems to record the stock levels of medicines kept at the home and the administration of variable dose medicines needed to improve.

New staff completed a programme of training and induction, however there was a lack of records to evidence the training staff had completed. Supervision for staff had not been completed on a regular basis but this had been identified by the registered manager and they had taken action to address this.

Our discussions with the manager and staff showed they had a good understanding of the Mental Capacity issues relating to consent and decision making.

Care records detailed peoples preferences in regard to their meals and staff were knowledgeable about the support people needed to eat and drink sufficient amounts safely. Peoples care records also evidenced the support they received from external professionals, such as their GP.

Relatives were very positive about the good care their family member received. Staff spoke to us about the people they supported in a professional, caring and knowledgeable manner. Staff knew people well including their likes and dislikes. When we observed the interactions between staff and people who lived at the home it was friendly and inclusive, people looked relaxed in the company of staff. Staff respected people's right to privacy and dignity, for example bathroom and toilet doors could be locked and people were able to spend time alone in their rooms if they chose to do so.

People were supported to engage in a wide range of activities and were enabled to maintain contact with family and friends.

Care plans were person centred and detailed people's care and support needs, as well as their likes and dislikes. Care plans were reviewed and updated on a regular basis to ensure they were reflective of people's current requirements.

Staff understood their duties and the standard expected of them whilst they were on duty. Staff were proud to work at the home and felt supported by the registered manager. There were systems in place to monitor the service provided to people, for example regular checks of peoples medicines, reviews of peoples care needs and regular staff meetings. However, these were not robust and had not identified the concerns we had noted. We have made a recommendation that the registered manager seek advice and guidance from a reputable source, regarding effective auditing systems.

You can see what action we told the provider to take at the back of the full version of the 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 always safe.

Not all aspects of the premises and equipment had not been serviced and checked in line with current regulations.

Staff were knowledgeable about types of abuse and were aware of how to report any concerns.

Peoples care records contained individual risk assessments.

The processes to record medicine stock and staff competency needed to be more thorough.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff supervision was irregular and there was a lack of records to evidence the training staff had received.

Staff understood the principles of the Mental Capacity Act but the documentation to evidence this process was not yet in place.

People were enabled to choose what they wanted to eat and drink.

Is the service caring?

Good

The service was caring.

The atmosphere in the home was warm and friendly.

People were treated with dignity and respect.

Staff encouraged people to perform tasks independently where they were able to do so.

Is the service responsive?

Good

The service was responsive.

People were enabled to participate in a range of activities.

Care plans were person-centred and were reviewed and updated at regular intervals.

There was a system in place to enable people to raise a complaint with staff.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

There was an absence of a structured, formal system of governance to monitor and review the quality, safety and effectiveness of the service people received.

The home had an experienced registered manager who was knowledgeable about the service they provided.

Staff were proud of the work they did and understood their roles and responsibilities.

Brighton 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 24 November 2016 and was unannounced. The inspection was carried out by two adult social care inspectors. Prior to our inspection, we looked at the information we held about the service and considered any information we had received from third parties or other agencies.

During our visit we spent time looking at three people's care plans. We also looked at four records relating to staff recruitment and training, and various documents relating to the service's quality assurance systems. We spoke with the registered manager a senior support worker, three support workers and two domestic staff. When we arrived at the home, eight of the people who lived at the home were out on activities, they all returned during the afternoon. Not all the people who lived at the home were able to communicate verbally, and as we were not familiar with everyone's way of communicating we were unable to gain their views; therefore we observed the care and support people received and the interactions between them and staff. Following the inspection we spoke with three relatives on the telephone to gain their feedback about the care and support their family member received at Brighton Lodge.

Requires Improvement

Is the service safe?

Our findings

Each of the relatives we spoke with told us their family member was safe. When we asked one relative they responded, "Oh absolutely."

One of the staff we spoke with told us when they reported any repairs or maintenance issues, they were resolved promptly. We saw that staff regularly tested the fire system for example the fire alarm and the emergency lights and we saw an external contractor had checked the fire system during 2016. We also saw a five yearly test certificate on the electrical wiring at the home had been completed in January 2013. However, we found people who lived at the home, staff and visitors were not always protected against the risks of unsafe or unsuitable premises and equipment.

However, on the day of the inspection we were unable to evidence a ceiling tracking hoist had been tested in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). A sticker on the hoist recorded the equipment should have been checked for safety in June 2016. We spoke with the registered manager regarding this and they said they would look into the reason why this had not been done. They contacted us after the inspection and explained the paperwork had been sent to another address and the issue had been overlooked. Following the inspection the provided us with evidence of the most recent safety check which had been completed during December 2016.

A new gas cooker had been fitted in the kitchen; however, due to a delay in the purchase and fitting of the overhead extraction canopy, the homes gas safety certificate had subsequently expired and had not been re-issued. Following the inspection we received confirmation from the registered manager of the date the outstanding work was to be completed and the subsequent gas safety checks. We have asked the registered manager to send us a copy of the gas safety certificate for our records, once it has been issued.

Water temperatures in care homes should be routinely checked by staff to reduce the risk of people being scalded by hot water but when we looked at a health and safety file, in the section 'water temperatures' there was no evidence these had been checked during 2016. Following the inspection the registered manager provided us with evidence a monthly temperature check on two baths at the home had been completed during 2016. They told us the water temperature was not routinely monitored from other taps as thermostatic controls were fitted, however, it is good practice to monitor these temperatures to ensure any equipment failings are identified promptly and therefore reducing the risk of a scalding injury.

The registered provide has a duty to ensure that premises and equipment are safe and properly maintained. These examples demonstrate a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were knowledgeable about the types of abuse and the actions they should take in the event they were concerned someone may be at risk of harm or abuse. One staff member said, "They told me at interview, if I saw anything, if I was concerned about anything, to speak up." Another staff member told us the incident would be recorded and reported and if it involved a member of staff, they may be removed from

duty while the issue was investigated. The staff member was also aware of the need to report the matter to the local authority safeguarding team and the Care Quality Commission. When we asked staff if they had any concerns about people's safety, no one raised any concerns, one staff member responded, "I have no concerns what so ever." This showed staff were aware of their responsibilities in keeping people safe from harm.

One of the staff we spoke with told us peoples care records contained a number of risk assessments. They said, "We try to keep everything as least restrictive as possible." Each of the care plans we reviewed contained a number of person specific risk assessments which had been reviewed at regular intervals. These included, use of the mini bus, accessing the community, using the kitchen and showering. We also saw one person who was identified as being at risk of choking had a choking risk assessment in place. One person required the use of a hoist to enable staff to transfer them, although there was a risk assessment in place, it lacked relevant details regarding the type of hoist and sling to be used and there was no record of how the sling should be fitted. We asked a member of staff about this and although they were able to tell us exactly how the equipment was used, they were not able to locate where this information was recorded. This is necessary to ensure all staff are aware of how the persons care is to be delivered to reduce the risk of harm to both the person and staff.

Nobody we spoke with raised any concerns regarding staffing levels at the home. The registered manager and the staff we spoke with told us the majority of the staff team had been employed at the home for a number of years and staff turnover was very low. Staff told us any staffing shortfalls were covered by either existing staff or bank staff. One member of staff told us agency staff were not used as they did not know the needs of the people who lived at the home. This helps to ensure people are cared for by staff who know them well.

We asked one staff member about the recruitment process, they said when they had commenced employment they attended an interview at the home with the registered manager and following this references and a Disclosure and Barring Service check (DBS) check had been requested. We reviewed a random selection of four staff recruitment files and saw potential candidates had completed an application form and a minimum of two satisfactory written references had been obtained. A recent DBS was seen in two of the files we reviewed, and for one of the staff whose DBS was dated 2010, we saw they had signed a document in 2015 and 2016 to confirm they had not been convicted of any offences since their last disclosure. In one of the files we reviewed we could not locate the DBS, however; we saw proof within their file that a DBS had been applied for and evidence they were not on the Protection of Vulnerable Adults list (POVA). This is a list of people who are banned from working in a care position in a registered care home. Following the inspection the registered manager told us they had been unable to locate the DBS for this member of staff, therefore they had commenced the process to apply for a new one. They also said in the interim period while they were waiting for the new DBS, a risk assessment had been put in place. This showed the registered manager had taken prompt action to address the issue once it was brought to their attention.

As part of our inspection we reviewed how people's medicines were managed, we found some areas of medicines management needed to be more robust.

All medicines were stored in a locked cabinet in the office. No temperature records were taken of the room to ensure peoples medicines were stored at a suitable temperature to ensure the efficacy of the medicine was not affected, but the temperature of the room felt satisfactory. There was no dedicated medicines fridge and the registered manager told us they had a lockable unit which would be placed in the fridge in the event this was required. A monitored dosage system (MDS) was used for some of medicines while others were

supplied in boxes or bottles. We reviewed a random selection of medicine administration records (MAR's) and saw there were no gaps, this indicated staff had administered peoples medicines and doses had not been missed.

Some people where prescribed a medicine to be taken 'as needed' (PRN) and we saw protocols were in place. This is a document which provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. For example, one person was prescribed PRN analgesia, the protocol recorded the name and strength of the medicine, when and why it could be taken and the maximum dose staff could administer within a twenty four hour period.

However, systems to record the stock and administering of PRN medicines was not robust. For example, staff showed us a box of a PRN medicine which was in the medicine cupboard, staff had signed the MAR to indicate the medicine had been administered on five occasions to a person, but the MAR indicated the home did not have any stock. We identified another PRN medicine where the person's MAR indicated they did not have any stock but staff had administered the medicine on six occasions and the medicine was located in the cupboard. The MAR also recorded staff could administer one or two tablets, but staff had not recorded the dose they had administered on any of the recorded administrations. This meant there was no accurate record of the stock held or of the dose administered. Following the inspection the registered manager told us they had taken immediate action to improve the recording of medicines stock at the home and refresher training had been booked for staff in January 2017.

Staff told us when a new staff member commenced employment they observed a minimum of three medicine rounds. The new staff member then acted as a 'checker' for a staff member administering the medicines for a further three rounds, then as long as they felt confident and they were assessed to be competent, they were allowed to administer people's medicines. Staff told us all medicine administration was completed by two staff, another staff member told us the process for administering people medicines was very good, adding, "There's no room for error." We reviewed the induction documentation for this member of staff and saw this process was clearly evidenced on their induction record. However, the induction did not breakdown all aspects of medicines management for example, ordering or destroying unused or discontinued medicines and administration tasks, for example, topical creams or eye drops. Recording this level of detail ensures there is a comprehensive record of the training staff have received.

Requires Improvement

Is the service effective?

Our findings

A relative we spoke with said, "They have experienced and well trained staff."

One of the staff we spoke with told us about the induction they had received when they commenced employment at the service. They said they had shadowed a more experienced member of staff as well as spending time getting to know people and reading their care plans. They also told us they had completed a range of training which they explained staff had to complete within their first three months of employment. When we checked this staff members file we saw a record of the induction they had completed but when we checked a further three staff files, their induction records could not be located. Following the inspection the registered manager scanned evidence of the three induction records to us. Having a thorough induction helps new staff to gain the knowledge and skills they need to perform in their role.

When we spoke with staff they told us they had received training in a variety of topics, including safeguarding, first aid, food hygiene and fire. One of the staff we spoke with told us they had recently returned to work at the home, they said, "All the staff are really well trained here." During our observations of staff interactions with each other and people who lived at the home and as they completed their daily tasks, we did not see anything which made us question staff knowledge and skills. However, when we looked at staff files we found very little to evidence the specific training courses staff had completed. For example, we did not see evidence in any of the four staff training files in regard to moving and handling, food hygiene, infection prevention and control or mental capacity. The registered manager said they had already identified a lack of evidence to support the training staff had completed, including not having a matrix to provide an overview of the training staff had completed. They told us an external company had recently been commissioned to implement a training package for staff and on the day of our inspection we saw a representative of this company at the home. They were reviewing all staff training records so staff could commence updating and refreshing their training.

We also asked staff if they had received regular supervision. One of the staff we spoke with said they had not but they were aware it was in the process of being organised. However, another staff member told they had received regular supervision with the registered manager. The registered manager admitted they were behind with staff supervision, however, they explained one of the senior staff had recently been receiving more intensive supervision and support to enable them to take on an active role in ensuring staff received regular supervision. This was confirmed when we spoke with this staff member and we also saw documented evidence of these supervisions in their staff file. All of the staff we spoke with told us they felt supported by the registered manager and staff team, however, having regular management supervision helps to ensure staff have the skills and competencies to meet people's needs.

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.

Staff we spoke with were able to tell us how they supported people to make choices. One staff said, "People here have different levels of capacity. Those who have less capacity we support them in what is their best interests." Another staff member said, "I like to give everyone a choice. They have a right." One of the care plans we looked at recorded the conversation between the person and staff regarding consent, '(name of person) had a talk about consent. We spoke about what it means and this is part of (name of person's) autonomy'. This showed staff showed understood the MCA and issues relating to consent.

People who lived at the home had the capacity to make day to day decisions with staff support. The registered manager told us they had identified a need to improve the recording of issues relating to capacity and best interests decision making. They showed us the paperwork which was to be implemented in peoples care plans over the coming weeks. Recording this process evidences openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

The registered manager told us they were only aware of one person at the home with Lasting Powers of Attorney in place. They said at a recent review they had requested a copy of the document so the staff were aware, that in the event the person lacked capacity to make a specific decision, staff knew who had the legal powers to make decisions for them. They also said that as part of people's future reviews this was going to be discussed with people and their families.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) as described in MCA. The manager told us five people who lived at the home were subject to a DoLS authorisation and a further two applications were awaiting review by the local authority. This evidenced, where people had been deprived of their liberty, the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure a person's rights were protected.

Staff told us the meals for the coming week were planned at a weekly residents meeting and everyone was encouraged to choose a meal for the week ahead. We asked how people who may have limited verbal communication skills made their choice known, one of the staff showed us a box of cards with pictures of various meals and food types. They explained these enabled people who used non-verbal communication to demonstrate their choice.

People care records detailed their needs, likes and dislikes. For example, one care plan recorded the person preferences on the thickness of the bread and the fillings they liked. Another care plan noted 'dislikes tuna, rice, spicy foods.' Staff we spoke with were knowledgeable about people's specific dietary requirements. For example, one person required blended food and another person's food was fortified to increase their calorie intake as they were highly active throughout the day. This showed people were supported to ensure they received appropriate nutrition.

Peoples care plans contained a synopsis of their care needs in the event they needed to attend hospital. One of these detailed 'what you need to know about me' and 'my likes and dislikes'. Where a person may not be able to fully communicate their needs, this information may reduce the risk of the person receiving inappropriate and unsafe care if they require hospital treatment.

We saw evidence in peoples care plans of the input of external health care professionals, for example, GP, continence nurse. We asked a staff member how people accessed their GP. They said some people went to the surgery for their appointments but sometimes people had a home visit, dependent upon their individual needs. This showed people received additional support when required for meeting their care and support

needs.

Brighton Lodge is a large converted property. The majority of people's bedrooms were on the first floor with two bedrooms located on the ground floor. There was no passenger lift at the home but staff told us everyone who had bedroom on the first floor was able to use the stairs safely. On the first floor there was a domestic bathroom with a bath, toilet and sink, there was a shower room on the ground floor and two people had an en-suite bathrooms. On the ground floor there was a large lounge and dining room and people had easy access into a large garden.

Good

Is the service caring?

Our findings

Each of the relatives we spoke with was extremely positively about the care and support their relative received. One relative told us how their family member said they were 'going home' when they went back to Brighton Lodge from a family visit. Another relative said their family member was, "Always dressed beautifully", they also said, "Staff have been there a long time and they know (person) very well. They understand (person) perfectly."

One member of staff said, "It is a really happy home. People are really safe and well cared for. They have a brilliant quality of life."

Staff spoke to us about the people they supported in a caring, professional and knowledgeable way. They told us some people who lived at the home needed a regular routine as this reduced their anxiety. One staff member said, "There is a lot of routine here, but that is what people like." We saw an example of this when, shortly before people were due back to the home after their day out, a member of staff strategically placed a pair of slippers by a lounge chair. When people arrived back we observed one person go straight to the chair, sit down, remove their shoes and put their slippers on. This showed staff respected people's routines.

Staff were able to tell us about individual's likes, preferences including details of the support they needed. We asked one of the staff about a particular person who lived at the home, they spoke to us in detail about the support they needed including the rationale for certain aspects of the individuals support. For example they explained the why the person used a specific drinking cup. This meant people were supported and cared for by staff who knew them well.

When we arrived at the home everyone had already gone out for the day, just one person remained and they were about to go out with a member of staff. We stood with them for a few moments prior to them going out and the carer told us where they were going and what they were going to do. The carer actively involved the person in our conversation and chatted with them and to us about the activities they were setting off to do. The person positively engaged with the staff member, smiling and laughing with them. Later in the day when the mini bus arrived to bring people home, staff went outside to meet people; chatter was natural, friendly and inclusive between staff and people who lived at the home.

Peoples care records detailed how they communicated. One person's record noted what their different body language may mean, for example, 'when I cover my face, I want quiet time; ask if I need a chat'. Another person's record noted, 'when I hold my hand out to you, palm upwards, I want you to spend time with me.' This is important as it ensured staff understood what people were communicating to them.

People's privacy and dignity was respected by staff and by the people who lived at the home. Communal bathrooms and toilets could be locked by people without needing staff intervention and staff told us people were able to lock their own bedroom doors when they wanted to. One of the staff we spoke with told us people were able to spend time alone in their bedrooms if they chose, they explained that even where people where supported by 1:1 staffing, they were enabled to have 'private' time if they chose to. One of the

staff we spoke with told us male staff did not support females' service users with personal care.

We asked staff how people retained their level of independence and where possible, learnt new skills. They told us many of the people at the home regularly visited a life skills centre which was operated by the registered provider. We asked staff about this, one of them said, "There is opportunity for service users to learn but to enjoy life at their own pace and their own style." Another member of staff told us about one person they supported and explained how they encouraged them to complete aspects of their personal care themselves, for example, brushing their own teeth. Staff also told us a particular life skill people at the home had learnt, was to knock on a door and wait before they entered. We were told one person who lived at the home had a job which they attended with their 1:1staff support, one staff member said, "(Person) earns money for their job and they really enjoy spending what they have earned." One of the care plans we reviewed contained a number of life skills certificates, including, public transport, road safety and personal hygiene. Enabling people to become more independent can improve their quality of life and is a key part of living well.

Good

Is the service responsive?

Our findings

One of the relatives we spoke with told us how staff at the home enabled them to keep in regular contact with their family member. They told us staff would always let them know if their family member had attended the doctor or if they had been unwell. Another relative said they received a letter from the home at least annually to tell them how their family member was and to update them about their care and support needs.

Staff told us and we saw evidence in peoples care records, that they participated in arrange of activities. Care records detailed the activities they enjoyed, for example, trips out to cafes and the seafront, as well as activities within the home, such as watching films or participating in theme nights. One person had a particular interest they enjoyed and we saw evidence in their care file of how staff had themed their birthday party around this interest. Another care record had a poster which had been written and animated by the person, 'what I like to do at the weekend', this included walks, the cinema, swimming and staying up late. We saw a letter from a local church in another care record, inviting the person to attend the church whenever they wished to. People's families were regularly involved. Staff told us about one person who often went to stay with their family another person had a future holiday booked with their relatives. Enabling people to maintain family contacts and take part in meaningful and enjoyable activities is a key part of living well.

Care records were written in the first person, they were detailed and person centred, combining a mix of simple words and pictures. People's daily routines were described in simple words and pictures, they detailed who supported the person, such as staff and family members, what the individual did and did not enjoy doing, how staff were to support them and peoples level of independence. Records also noted what was important to people, for example, one care record detailed the person liked, 'plenty to eat and drink, reassurance, naps, time outdoors'; and what they did not like, 'I do not like surprises. I do not like to rush'. This helps staff to know what is important to the people they support and help them take account of this information when delivering their care.

One person could at times exhibit behaviour which challenged others. Their care record detailed potential triggers for this behaviour, behaviours staff were to observe for which may indicate the person was at risk of expressing this behaviour and the strategies staff were to implement should the need arise. This ensured staff had to the knowledge to reduce the risk of these behaviours escalating and the approach to adopt in the event their behaviour escalation could not be avoided.

A daily record was completed for each person which recorded their care and support, their emotions, medication and activities. These were detailed and provided a personalised journal of how the person had spent their day.

The registered manager and the staff we spoke with told us care records were routinely reviewed every six months and we saw evidence in the records of updates and reviews. Relatives we spoke with also told us they were invited to and participated in regular reviews of their family members care and support. Reviews

help in monitoring whether care records are up to date and reflect people's current needs so that any necessary actions can be identified at an early stage.

One of the relatives we spoke with told us their family member had been living at Brighton Lodge for nearly twenty years, they said they had never had to complain. We asked what they would do if they were dissatisfied with any aspect of the service and they told us they would contact staff at the home immediately. The registered manager told us they had not received any complaints about the service. We saw the complaints procedure was available for people in an easy read format and contained Makaton symbols. This ensures it is easily understood by people who lived at the home.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post since 2012. They demonstrated transparency and knowledge about the people who lived at the home and the staff they employed. The registered manager told us the registered provider was a family run organisation and they had always felt very well supported by them.

From speaking with staff it was evident they understood their roles and responsibilities and they were clear about what was expected of them whilst they were on duty. Staff demonstrated their understanding of the responsibility they had to make sure that people were safe and supported in making choices and decisions. Each staff member we spoke told us they enjoyed working at the home. We asked one staff member if it was a good organisation to work for, they responded, "Yes it is. I wouldn't have stayed here otherwise." Other staff comments included, "It's a nice place to be" and "(Name of manager) is a brilliant manager, you can phone her up with an issue and it's dealt with. She is always there for advice if you need it." A relative told us the registered manager was 'lovely'.

The registered manager explained they were a 'hands on manager', they worked on the floor ensuring they were visible to both staff and people who lived at the home. They explained they did not have a formal management reporting system but the registered manager and registered provider met on a weekly basis to discuss any matters relating to the day to day running of the service. We asked if there were any other recorded systems of governance and audit to monitor the quality of the service provided to people, the registered manager said there was not. However, they explained that the reviewing of peoples care plans every six months enabled any shortfalls to be identified and appropriate action taken. They also said staff routinely checked people's medicines were correct at shift handover and when staff administered medicines to people, however, no documented audit was completed. The registered manager told us one of the senior staff was in the process of increasing their management responsibilities, to enable them to implement audits and systems to monitor the service people received. This was confirmed when we spoke with this member of staff.

The registered provider had a number of policies within the home which were available for staff to consult but the ones we reviewed, for example, confidentiality, complaints, recruitment and risk management had not been reviewed since 2012 and 2013. Reviewing policies enables registered providers to determine if a policy is still effective and relevant or if changes are required to ensure the policy is reflective of current legislation and good practice.

These examples demonstrate that although there were system in place to monitor the service, these were not robust. This was evidenced by the shortfalls we have identified in our report. It is important that registered providers regularly audit all aspects of the service, this enables them to ensure they are picking up on any shortcomings, identifying areas for improvement and that they are working to continuously improve the services they provide for people. We recommend the registered manager seek advice and guidance from a reputable source, regarding effective auditing systems.

We saw minutes of regular house meetings where the following week's menus were discussed but the meetings were not used as an opportunity to share other information or discuss any additional topics. Staff told us they attended regular staff meetings, one staff member said, "If I want to voice something, I tell (name of manager) and they will bring it up at the meeting." Staff told us there was a range of topics discussed including changes to people's needs, incidents and training. We reviewed a random sample of minutes and saw agenda items included dairy dates, staff training, incidents and the duty rota. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

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 15 HSCA RA Regulations 2014 Premises and equipment People who lived at the home, staff and visitors were not always protected against the risks of unsafe or unsuitable premises and equipment.