Alness Lodge Limited

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 December 2017 and was unannounced. At the last inspection in September 2016, the home was rated requires improvement. At the last inspection we identified a breach of Regulation 9, person-centred care, as care plans did not fully reflect people's preferences or meet their needs appropriately. At this inspection we found improvements had been made to care plans and the home was now meeting this regulation. However, we have rated this service as 'Requires Improvement' for a second time having identified three further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Alness Lodge Limited is a 'care home' for up to 10 people with mental health needs. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People living at Alness Lodge Limited did not require nursing care.Throughout this report Alness Lodge Limited is referred to as Alness Lodge.

At the time of this inspection there were 10 people living at Alness Lodge, within the age ranges of 33 to 64 years. Alness Lodge is a large, detached house spread over two floors with parking to the front and a large garden area to the rear of the home. The home is situated in the Whalley Range area of Manchester, close to local amenities and public transport routes.

At the time of our inspection the service had a registered manager. 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. The registered manager was absent from the service on the days of inspection however we spoke with them over the telephone and dealt with the deputy manager and the owner, who was at the home carrying out maintenance work and checks.

The cleanliness of the home was a cause for concern. Areas of the home were untidy or cluttered and there were recording gaps in all the cleaning schedules we checked. We saw no use of personal protective equipment by staff, such as aprons or gloves. We were not assured that the home was taking adequate measures to prevent and control the spread of infection.

We saw positive practice around how people were supported to manage their risks and move safely around the home. Examples of identified risks were around mobility, medicines, smoking and finances.

People received their prescribed medication when they needed it and appropriate arrangements were in place for the storage and disposal of medicines. However there was no evidence of any checks in place to ensure medicines were stored at a suitable temperature and there were no protocols for 'as required'

medicines (PRN), as is good practice.

People's health was monitored as required so appropriate referrals to health professionals could be made. People received regular reviews to check their prescribed medicines were suitable and this promoted good health.

There were enough staff to meet people's needs. Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. Staff told us they received training to be able to carry out their role.

People were supported to make their own choices and decisions. Staff sought people's consent before assisting them with support and people had signed to consent to their care. No one living at Alness Lodge had a Deprivation of Liberty Safeguard (DoLS) authorisation in place. People were able to go out independently and we saw people chose to come and go as they wanted to. Staff had received training on the Mental Capacity Act and described how they helped to promote people's choices. Staff demonstrated a good understanding of how to protect vulnerable adults.

People living at Alness Lodge were able to develop and maintain social relationships that were important to them. People living at the home spent time together and appeared relaxed in one another's company. People were treated with care and respect and staff respected the privacy and dignity of individuals.

People engaged in a range of activities, although these were mainly in the community, with no activities being arranged within the home. We observed interactions between staff and people were friendly and staff knew people well. Staff had good relationships with the people living at the home and the atmosphere was happy and relaxed. People were appropriately supported with their nutritional requirements and were encouraged to carry out tasks independently when safe to do so.

People expressed positive views and experiences of the support they received which reflected that their needs had been met. Care plans contained current information about how best to support people and were reviewed every three months, or more frequently if a response to changes in need was required.

There were some checks in place, though these were not always effective when monitoring the quality of service delivery. Policies and procedures were generic and part of a quality management system, therefore not specific to Alness Lodge and practice did not always mirror the policy. We saw the provider had procedures on how complaints should be managed if any were to be received.

People had been consulted about the quality of the service however it was not clear what actions, if any, the service had taken in response to these comments, or if the results of the survey had been communicated back to people living in the home.

Staff spoke highly of the management team and felt well supported by them. Partnership working was evident as the home had established good working relationships with health professionals and local authority representatives. Community links had also been built up and we saw some community ventures advertised around the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe :

The cleanliness of the home was a cause for concern. The home was not taking adequate measures to prevent and control the spread of infection.

Staff showed awareness of how to help manage some people's risks, for example, with money management, mobilising and smoking.

People were protected by the use of appropriate recruitment processes which helped ensure staff were suitable to support them.

There was no evidence of any checks in place to ensure medicines were stored at a suitable temperature and there were no protocols for 'as required' medicines (PRN).

Is the service effective?

Requires Improvement

The service was not consistently effective :

Staff appeared to have a good understanding of the presenting conditions of each service user and how to manage any deterioration in people's mental health.

People were supported to make their own choices and decisions. Staff sought consent before assisting with support and care plans contained signed consent to care documents.

Areas of the home required attention so that it better met people's needs. The physical surroundings detracted from the good work being carried out in order to create a caring and supportive environment.

Is the service caring?

Good

The service was consistently caring :

Practice was consistent to ensure that all people were treated with care and respect.

People were able to develop and maintain social relationships that were important to them.

People's independence was promoted. Staff recognised the importance of giving people the time they needed to do things independently.

Is the service responsive?

Requires Improvement

The service was not consistently responsive:

People expressed positive views and experiences of the support they received which reflected that their needs had been met.

People who were independently mobile were able to access community activities. The same opportunities for activities were not available for those who remained in the home.

There was a complaints process in place. People told us that they would feel comfortable raising complaints if they needed to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led :

Some information on display for people and their relatives was not current. The statement of purpose needed to be revised to reflect the Regulations of 2014.

People had been consulted as the service had issued a residents satisfaction survey during August 2017.

Checks in place to monitor and audit the quality of the service and to help drive improvement were ineffective.

Partnership working was evident as the home had established good working relationships with other health professionals and local authority representatives.

Alness Lodge Limited

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 checked 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 home was last inspected on 6 September 2016 and was rated 'requires improvement.' References throughout this report to the last inspection relate to this inspection.

The inspection of Alness Lodge took place on 13 and 14 December 2017 and the first day of inspection was unannounced. The inspection was conducted by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection, we reviewed the information we already held about the provider, including notifications. Providers are required by law to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

We contacted the local authority that commissions services and the local Healthwatch to seek their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted public health for the most recent infection control visit report, having received a copy of the audit undertaken in November 2016. There had been no further visits since this date.

As part of our inspection, we spoke with eight people living at the home, one visitor and two relatives. We spoke with two care staff members, two senior staff members, the deputy manager and the owner in the absence of the registered manager.

We carried out observations of how people were supported throughout the day. During our visit, we also looked at four people's care records, four staff files and a selection of records maintained by the home regarding the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Alness Lodge. One person we spoke with told us they felt very safe and said, "It's the best home I've lived in." Another person told us about someone who no longer lived at the home as their behaviour had not been appropriate. Staff had managed and monitored the situation closely and the person considered the actions taken by staff had been appropriate and reassuring. They told us, "They made me feel safe."

Whilst people told us that they felt safe, we found the cleanliness of the home was a cause for concern. The infection control audit undertaken in November 2016 gave the home a red rating as there was no documentary evidence of regular mattress audits. Checking mattresses for rips, tears and stains assists in the prevention and control of infection as providers can take action when necessary. At the time of this inspection there were still no records relating to regular mattress checks.

On the first day of inspection we saw dusty, unclean surfaces around the home. Kitchen worktops needed a thorough clean, plastic table coverings in the dining room were sticky to the touch and there was a stained bath mat in the ground floor shower room. Areas of the home were untidy or cluttered, for example, the office and the conservatory. The deputy manager told us that staff were responsible for cleaning communal areas of the home and assisted people to clean their own bedrooms when people were able to do this.

We checked cleaning schedules within the home and found there were gaps in all areas. The kitchen cleaning schedule had not been completed since October 2017. One schedule indicated that a bedroom wash basin should be cleaned on a daily basis however, records indicated this was cleaned on a weekly basis only. It was recorded that a commode in one bedroom had last been cleaned and disinfected on 12 November 2017 and we noted an unpleasant odour in this bedroom on entering. Cleaning schedules reflected when people were able to take responsibility to clean their own rooms but there were gaps in these records too.

We judged that people needed greater supervision and possibly increased support from staff, to ensure that bedrooms were cleaned on a regular basis and to a satisfactory standard. One person told us, 'They really need a better hoover' and we noted that some carpeted areas of the home, for example the stairway, required hoovering. We saw staff preparing food in the kitchen, administering medicines to individuals and stood waiting outside bathrooms in case people who were showering needed help. At no point during our inspection did we see staff wearing any personal protective equipment, such as aprons or gloves. We were not assured that the home was taking adequate measures to prevent and control the spread of infection.

Failure to take adequate measures to prevent and control the spread of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff we spoke with considered there were enough staff on duty to provide the required levels of support. At night there was one waking night staff member on duty to attend to people's needs, with another member of staff on a sleep in shift to provide additional support if required. We asked two visiting relatives if

they thought there were enough staff on duty and they told us," When we're here there always seems to be." People told us staffing levels were safe during the day and at night and that they received the right level of support when they needed it. Our observations supported this as staff were always available to help meet all people's support needs and wishes.

Staff told us they would share any safeguarding concerns with the registered manager. Guidance was displayed around the home to remind staff of safeguarding practices. Systems were in place to help staff raise possible safeguarding concerns to protect people using the service. Processes were in place to report and record accidents and incidents however there was no analysis of these to identify any themes or trends and to prevent re occurrence.

We saw positive practice around how people were supported to manage risks and move safely around the home. Examples of identified risks included mobility, medicines, smoking and finances. The majority of people using the service were independently mobile; however we saw that the registered manager had gathered information and reviewed one person's care plan to identify if they required more support or additional equipment. We saw that the person was still mobilising independently with the use of a walking frame and this helped to promote their safety. This was a relatively new piece of equipment and we heard staff remind the person to use it so they were kept safe. One service user who was relatively new to the service appeared less settled and was being closely monitored by staff in an unobtrusive way so that risks were minimised and the person was kept safe.

We looked at the financial records of two people identified at risk of financial abuse. They had agreed for the home to hold their monies securely in a locked drawer. Records we saw showed us that they withdrew money as and when they needed it to purchase items or to go out and socialise. This meant that they were able to budget better and were protected from financial abuse as they rarely had large amounts of cash on their person.

Regular checks were also in place to promote fire safety and ensure the health and safety of the building. We saw that checks on the fire panel, emergency lighting and portable fire fighting equipment had been carried out within necessary timescales. Fire drills were undertaken twice yearly and training exercises carried out with newly recruited staff. We saw that details relating to everyone participating in the fire drill, residents and staff, and the time taken to evacuate were recorded.. Staff we spoke with were aware of how to respond in the event of a fire and we were assured that people would be kept safe in the event of an emergency.

People were protected by thorough recruitment processes which helped ensure staff were suitable to support them. Processes included checks of staff using the Disclosure and Barring Service (DBS) and obtaining previous employer and character references, prior to staff working at the home. We checked the records of a staff member recently and found that there was only one reference on file. The member of staff had completed their induction and was on shift on the day of inspection, having started on rota from 11 December 2017. The deputy manager was able to evidence that they had approached the last employer on two occasions but had yet not received a response. We discussed this with the deputy manager and highlighted the need for an alternative reference. The deputy manager told us they would follow up the original referee and also ask the employee for an alternative one. We will check on this at our next inspection. The deputy manager told us staff turnover was low and agency staff were not used which meant people were supported by a consistent, familiar staff group.

People were supported to take their medicines safely and told us they received medicines on time. Two people were supported to have regular blood tests as required to ensure a specific medicine dosage was safe and effective. We could see, and people told us, that they received regular reviews, to check their

prescribed medicines were suitable and promoted good health.

At our last inspection we noted that medication administration records (MARs) were handwritten by staff, which is not best practice. At this inspection we saw that MAR charts were now pre-printed by the pharmacy. Information relating to one medicine remained handwritten as this was dispensed by the hospital, with dosages possibly being subject to change. This meant that the likelihood of recording errors was reduced when medicines arrived at the home. Most people's medicines were held in monitored dosage systems. This provided staff with clear guidance about the right medicines people needed at the right times. We conducted a sample stock count of some people's medicines and found these amounts correlated with their records. This supported our judgement that people were receiving their medicines as prescribed and medicines had been given safely. We saw that people's medicines were stored securely within a locked cabinet in the office, with access to keys limited to those staff trained to administer medicines. However we saw no evidence of any checks in place to ensure medicines were stored at a suitable temperature. There were no protocols for 'as required' medicines (PRN), for example paracetemol. Good 'as required' (PRN) protocols help guide staff as to when they should administer these medicines, the maximum doses to be administered within specified timescales, for instance 24 hours, and certain foods to be avoided if relevant to the medicine. We asked the deputy manager why PRN protocols were not in place and they told us everyone using the service was able to request pain relief as and when needed. Staff we spoke with knew residents well, staff turnover was low and the service did not employ agency staff. We were assured that people had not come to any harm as a result of PRN protocols not being in place.

We recommend that PRN protocols are put in place for all PRN medicines so that staff are provided with all information relevant to the medicine requirements for all individuals.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if they considered the care they received at Alness Lodge to be effective and whether they felt staff were trained and competent to carry out their role. Comments included, "It's great here. We all get on together"; and "We're like a big family."

We received positive feedback about the care provided during discussions with people using the service, their relatives and visitors. A visitor we spoke with told us the home was, "Absolutely brilliant." Staff knew people well, how to help meet people's needs and how to minimise risks posed to individuals. The staff team appeared to have a good understanding of the presenting conditions of each service user and how to manage any deterioration. A senior member of staff we spoke with was aware mental health needs were low level and explained individuals' requirements with regards to assistance with memory, cognitive problems and daily living skills. For some people using the service the role of staff was to help them relearn living skills and maximise their independence.

We saw that staff new to the service were signed up to the Care Certificate as part of the induction process. The Care Certificate is a set of 15 occupational standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training for new care workers.

We looked at a new employee's file and saw that they had completed the first five elements of the Care Certificate since their start date in September 2017. These had been signed off by the registered manager and the employee was working on the remaining units. We saw that although the new employee had been provided with information at induction on specific mental health conditions, including schizoaffective disorder, they had not yet completed the mental health element of the care certificate, as this was unit 9. Undertaking this unit earlier will equip new staff with knowledge about mental health conditions, give them an improved understanding and enable them to better support people living in the home.

The majority of staff training was up-to-date in safe working practices such as safeguarding, fire safety, mental capacity, infection control, health and safety and first aid training. The training matrix indicated that two members of staff required medicines training update, as this had last been completed in May 2016. The assistant manager explained why this refresher training had not yet taken place and that they would ensure this training was completed as soon as possible. One new member of staff we spoke with was not yet administering medicines as they had not completed their training and been assessed as competent. We were assured that the service would only allow those members of staff deemed as competent to administer medicines.

Staff told us they felt supported by the management team at the home. A senior staff member told us they attended regular supervision where they discussed their on- going training and development needs. Another staff member told us, "If I need extra training I would ask for it." New members of staff on the team were supported by senior colleagues. We saw competency checks and observations were carried out with new staff during their induction period and these were discussed before being signed off by both members of

staff. The staff supervision scheduler and planner t indicated supervisions that had been completed and those that were due. Staff had also received an annual appraisal and the completed appraisal templates we saw showed that staff had input in this process.

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 authorisation 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.

People told us they were supported to make their own choices and decisions. We saw that staff sought people's consent before assisting them with support and care plans reflected that people had given consent to care. A best interest meeting had been held for an individual during 2017 in connection with a health matter. The home had participated in the decision-making process with other professionals as it was deemed the person did not have the capacity to fully understand how the decision taken might impact on their health and wellbeing.

No one living at Alness Lodge had DoLS authorisations in place that restricted their ability to go outside the home and we saw people chose to come and go independently on the days of our inspection. One staff member told us, "People can come and go as they please as long as they are safe." We saw that people moved freely around parts of the home as they wished. Staff had received MCA training and described how they helped to promote people's choices.

In the event of a vacancy in the service the assistant manager told us the needs of existing residents were taken into consideration before a new person was offered a placement at the home. One person who had started to use the service during the summer had undergone a 'step approach' introduction to the home and other residents. They experienced "taster days" and then a full week's stay, before taking up a permanent placement. This provided the person with an opportunity to meet everyone living at Alness Lodge and to meet the staff providing support. It also allowed the service to judge if the individual gelled with other residents, assess whether their needs could be met and to agree specific outcomes.

We saw this person in the home during our inspection and saw they had settled in well at Alness Lodge. They spent time in their room during the day, as was their preference and joined others in the dining room during meal times.

At the last inspection the home told us that a new kitchen was to be fitted and we saw this had been done. The kitchen was large with two sinks and separate hand washing facilities. There was lots of room for people to access the kitchen, prepare their own snacks and drinks and we saw people doing this during our inspection. There was a four week menu on offer and this was open to change based on people's preferences on the day. As most people shopped for themselves people were offered meals of their choices and preferences to ensure they ate well. Staff had worked at the home for a number of years and were familiar with people's food preferences and dietary requirements.

All of the people we spoke with told us they enjoyed the food served at the home. One person said, "I make my own breakfast" Another said, "I like the food here." A relative told us, "[Name] enjoys the meals. They go out sometimes and always get a cake on their birthday." We heard people asking for drinks and also being offered them during our inspection.

People were supported to access appropriate healthcare when they were unwell and supported to attend regular healthcare appointments. Records showed that referrals to other healthcare professionals had been made to help meet the additional needs of some people living at Alness Lodge. People had annual reviews of their mental health, or more frequent reviews if necessary. Representatives from the home were involved in these reviews, along with relevant health professionals and care managers. People were able to express their views and make decisions about their care and this was documented within support plans and we saw people had signed their consent on care plans.

People told us they were happy living at Alness Lodge, however we identified that areas of the home required attention so that it better met people's needs. The rear garden, although spacious, looked unused and discarded chairs were strewn across the patio. People used this outside area when smoking, but there was no appropriate shelter or seating area provided. There was a conservatory, but it was too cold to use and didn't have any heating. There was a broken lock to the office door on the ground floor and we saw plaster damage on walls in the communal lounge. The home required updating and painting in order to refresh the dark décor of the home. A handwritten schedule of future projects was supplied on inspection and outlined that three service user's bedrooms were earmarked for painting and redecoration along with painting of the dining room, lounge and hall ways. However there were no specific timescales for the completion of this other than the work would be carried out in 2018. Whilst we saw that people had chosen to personalise their rooms there was nothing on bedroom doors to indicate the personality of the person that lived there. The physical surroundings detracted from the good work being carried out in order to create a caring and supportive environment.

Good

Is the service caring?

Our findings

Practice was consistent to ensure that all people were treated with care and respect and people we spoke with told us care staff were very caring. One person told us that the service was really good and said, "In my opinion they [staff] do everything right for you." Another told us, "They don't rush me. I go at my own speed." A relative we spoke with confirmed their family member was happy and told us, "They like it here. They tell us they want to go back home when we take [name] out."

We saw positive aspects of caring and respectful practice which promoted people's independence and dignity, and ensured people were involved in their care decisions. One person was in the bathroom and was showering independently, having chosen to leave the door ajar. We saw the staff member maintained a discreet distance outside the bathroom door in case help was required. We heard the staff member offer verbal prompts, asking the individual at regular intervals if they were ok or if they needed help to reach their towel. They entered the bathroom when asked to do so and we heard positive interactions and words of encouragement from the staff member to the individual. We were assured that people were provided with privacy and had their dignity upheld when being assisted with aspects of personal care.

We saw that some people were able to develop and maintain social relationships that were important to them. There were frequent visitors who had space to spend time with people in their rooms or in the communal lounge. The friend of one service user had been invited to spend Christmas day at the home, with the agreement of the other residents. We asked another person whether visitors were able to access the home and they told us, "You can have visitors when you want, course you can." They went on to tell us about the visitors they were expecting at the weekend. The environment allowed people to mix as much or as little as they liked without question, which appeared to work well for a couple of service users who preferred to spend time alone.

We saw that some people living at the home spent time together and appeared relaxed in one another's company. One person came into the lounge and was greeted by others in the room. We heard one person offer to bring another a glass of water and they were thanked for this.

We asked the deputy manager about access to advocates. They were aware of the role of the Independent Mental Health Advocate (IMHA) and had made referrals for their involvement in the past. At the time of the inspection however no one required the services of an IMHA.

People looked well cared for and were dressed in clothing which reflected their individuality and preferences. People's independence was promoted. Staff we spoke with recognised the importance of giving people the time they needed to do things independently when they were able to. One member of staff told us, "One person likes to have a shower and I have to remind [person] what to do. It can take up to half an hour sometimes but it gives [person] independence."

We saw literature pinned up on the noticeboard in the dining room relating to dignity in care and the F.R.E.D.A. tool. The FREDA principles are underlying principles of the Human Rights Act. They are a useful

guide to ensure that, in practice, organisations are treating individuals with fairness, respect, equality, dignity and autonomy. People told us they were treated with fairness and respect and we saw that people treated staff in the same way. One person told us they were able to continue to follow their faith by being supported to attend Kingdom Hall if they expressed a wish to do so. We were confident that the service treated people equally and did not discriminate on the grounds of the protected characteristics in the Equality Act 2010, for example age, race and religion.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we identified that some information contained in care plans was out of date and reviews had not been undertaken on a regular basis, or when changes in need were identified. At this inspection we saw this had improved and they were now meeting this regulation. Care plans contained current information about how best to support people and old documentation had been archived by the service. We also saw that care plans and risk assessments were reviewed every three months or more frequently when a response to changes in need was required.

For example, we saw one support plan had been reviewed more frequently as the person was prone to falling in the morning. This person was not prescribed any time-specific medicines so these were not a contributory factor to the falls. Staff noted that this person was quite frail in the morning and it took time for them to build up their strength. In agreement with the individual their morning routine was carried out at a slower pace so they were able to 'come round'. The care plan outlined that staff were to give the person options and let the person decide when they were ready. They now took their morning shower at 10 am after breakfast, when they felt stronger and this was documented in the care plan. The home had responded to a change in need, care for this person was now safer and this meant the risk of falls was reduced.

People expressed positive views and experiences of the support they received which reflected that their needs had been met. It was obvious by talking to staff that they recognised the very specific needs and wishes people had. One staff member told us, "People are individuals and have different needs; the care has to be based around that."

The provider information return (PIR) submitted by the service indicated that there was 'continuous evaluation of person-centred care' for people living at Alness Lodge, with service user involvement at all times. Care plans we looked at focused on the individual and reflected the service's ethos to have 'valuable outcomes' for people in their care and we saw that people and relevant professionals were fully involved in the care planning process.

One example of this was helping people to manage behaviours, linking in with their smoking habits. We saw a care plan in place for an individual around the management of smoking, signed by the individual. It was documented that this was a trial, for the home to monitor the person's usage of tobacco or cigarettes. There were four steps on the care plan that the person had agreed to and these were being followed. This smoking management care plan had resulted in positive outcomes for the individual, improving their health, behaviour and finances. The planned outcome of the trial was that the individual would gain responsibility to manage this situation for themselves in the future

We saw that people who were independently mobile were free to leave the home and access the community. There were regular opportunities for them to engage in activities of interest out in the community either alone or with friends. One person using the service used equipment to help them mobilise. The registered manager had identified that this equipment would help them retain some independence around the home. This person did not have the same opportunities as others to access

activities as they could not get out without support and there were no activities arranged within the home. We spoke with the individual and they told us they were happy chatting to others in communal areas and watching the TV. They also spent time in their room which they had personalised with photos and ornaments. Having organised activities available within the home benefits everyone using the service, whether these are group activities or just one to one time spent with individuals doing something they enjoy. The registered provider should ensure that everyone has the opportunity to take part in meaningful activities both inside the home and out in the community where possible.

People told us they used to go out for pub lunches which they enjoyed, however these had not happened for some time. We asked the deputy manager why this activity had stopped. They explained that one person had specific dietary needs and was only able to have fluids. As the service was a small one they felt it unfair visiting a pub for lunch, as it meant that this person was excluded. This showed us that the service took appropriate action to ensure people who had different needs were not discriminated against. As this person no longer lived at Alness Lodge the deputy manager envisaged that outings to the pub for lunch would continue once the weather improved.

People and relatives we spoke with told us that they would feel comfortable raising complaints if they needed to do so. A relative told us they had no problems and said, "I would talk to [management] if I had. They would listen." Some people we spoke with told us they would approach a staff member if they had any complaints or concerns. The registered manager told us no formal complaints had been made at the home and we saw that guidance on how to make a complaint was included in the statement of purpose. We had not received any information of concern about this service since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

On arrival at Alness Lodge on the first day of inspection we did not see a copy of the current Care Quality Commission report on display. Legally this should be displayed in a prominent position in the home and on the company's website, if in existence. We brought this to the registered manager's attention and when we returned for a second day a copy of the inspection report was on display in the office. Alness Lodge does not have a website so we made the deputy manager and provider aware of the need to display the report prominently in the home in our feedback to the service.

The service had a registered manager in post as is it is condition of their registration with the Care Quality Commission (CQC). The registered manager was supported by a deputy manager. On the days of inspection the registered manager was absent however we were supported by the deputy manager who knew both the service and people living there well.

The registered manager had worked at Alness Lodge for a number of years. The home was a family run business with the provider, registered manager and deputy manager all being related and taking on senior roles within the home. Some information on display in the home was out of date. For example, people using the service and their relatives were signposted to the CQC, however the address details given are no longer valid. Information relating to regulation again was not current as the service's statement of purpose refers to the Regulations 2010 of the Care Quality Commission. The service should ensure that information on display is current, that people are provided with correct information and that the service is familiar with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home used a Quality Management System of policies and procedures, so these were generic and not specific to Alness Lodge. One policy stipulated that staff meetings were held every two months, however we saw minutes of only one staff meeting held in July 2017and this mainly concerned the provision of training. No more formal staff meetings had been held by the service, however staff did tell us the lack of these meetings was not detrimental to the service.

There were no records of any formal meetings held with people living at Alness Lodge to gain their views on the service or ask suggestions for any improvements. People we spoke with confirmed there weren't any meetings generally but thought these would be a good idea. One person suggested, "It would be good to have a patio heater." The service was unaware of this as it had not held meetings with residents.

We saw that people had been consulted as the service had issued a resident's satisfaction survey during August 2017. Responses were positive and included comments such as, "Staff are very good and caring"; "I often express my views. Management and staff are of the highest quality" and "The meals are varied." One respondent had suggested more vegetarian food, however it was not clear if the service had added any vegetarian options to the menu as a result of this comment, or if the results of the survey had been communicated back to people living in the home.

The provider carried out checks on the building to ensure compliance with fire safety and identified works

required to improve the environment, for example there was a programme in place for the redecoration of bedrooms. However at the time of our inspection we identified the need for repairs within the home and the need to freshen and update décor in communal areas. There were some systems in place to monitor the cleanliness of the home however we judged that these were inadequate. Systems were in place to report and record incidents but we saw no analysis of these to identify themes or trends and prevent a reoccurrence. We judged that checks in place to monitor and audit the quality of the service and to help drive improvement were ineffective.

Failure to ensure that systems and processes are in place and operating effectively to improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative we spoke with told us that management were very approachable and always visible in the home and said, "I have no problems but if I did I would talk to [registered manager] or [deputy manager.] They would listen."

All staff we spoke with told us that they felt supported in their roles and able to approach the registered manager or the deputy manager with any concerns or queries. A staff member we spoke with told us, "The registered manager does a good job." Another staff member told us, "We know what works and what doesn't. It's a small service and it works." Staff told us managers were always around and would offer support where needed.

Staff we spoke with told us they felt fully involved in the service due to the size and intimacy of the home. They told us they were consulted about aspects of the service on a regular basis and information relating to people's support needs was discussed and shared during daily handover meetings. One staff member said, "They [management] trust us. They ask us for ideas and our opinions. We are loyal staff. We don't leave."

We noted that one person using the service was approaching their 65th birthday in 2018 and would then no longer be eligible to live at Alness Lodge due to the service's current registration criteria. The deputy manager was aware of this and of the need to submit a variation in registration if the person remained at Alness Lodge. They were also aware of the occasions when they might need to send a statutory notification to the Care Quality Commission and understood their responsibilities with regards to this aspect in line with the regulations.

The registered manager had written a business continuity plan and had identified ways that staff and the service should respond in the event of an emergency. This plan also identified to staff those that would need assistance in the event of an emergency.

Partnership working was evident as the home had established good working relationships with other health professionals and local authority representatives. Community links had also been built up and we saw some community ventures advertised around the home. People using the service told us they enjoyed accessing the community, some on a daily basis, to join in with an activity, go shopping or just to meet up with friends.

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 12 HSCA RA Regulations 2014 Safe care and treatment The cleanliness of the home was a cause for concern. The home was failing to take adequate measures to prevent and control the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Checks in place to monitor and audit the quality of the service and to help drive improvement were ineffective.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service was failing to prominently display a CQC rating on the premises.

The enforcement action we took:

Fixed Penalty Notice