Renal Health Limited

Manor Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 2 May 2018. This meant the staff and provider did not know we would be visiting.

We last inspected Manor Lodge in February 2017. At that inspection we found the service was in breach of its legal requirements with regard to Regulations 12, 9 and 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. These related to safe care and treatment, person-centred care and governance. This was because systems were not all in place to keep people safe. Records did not provide an accurate account of the care people received. Robust quality assurance systems were not in place.

We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

We found improvements had been made so the service was no longer in breach of its legal requirements from the findings at the last inspection. However, during this inspection we found breaches of Regulations 18 staffing and regulation15 premises and equipment 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.

Manor Lodge is a care home. People in care homes receive accommodation and 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.

Manor Lodge accommodates a maximum of 22 people. Nursing care is not provided. Care is provided to people who have mental health needs, learning disabilities and/or a physical disability. At the time of inspection 16 people were using the service.

A registered manager was 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.

People said they felt safe and they could speak to staff as they were approachable. We had concerns however, that there were not enough staff on duty to provide safe and effective care to people.

Although a programme of refurbishment was taking place around the home. We considered more timely action was required in some areas to ensure it was safe and fit for purpose.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure

they were suitable to work with people who needed care and support.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interests decision making, when people were unable to make decisions themselves. People were involved in decisions about their care. They were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Staff knew the people they were supporting well. Records reflected the care provided by staff. Staff had developed good relationships with people, were caring in their approach and treated people with respect. Care was provided with patience and kindness. People were positive about the care provided and a camaraderie was observed between people and staff.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. There was a good standard of record keeping and records reflected the care provided by staff.

People had food and drink to meet their needs. Menus were varied and staff were aware of people's likes and dislikes. People were provided with opportunities to follow their interests and hobbies. They were supported to contribute and to be part of the local community.

A range of systems were in place to monitor and review the quality and effectiveness of the service. People had the opportunity to give their views about the service. There was regular consultation with people.

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

Not all aspects of the service were safe.

People told us they felt safe. However, staffing levels were not sufficient to ensure people were looked after in a safe and person-centred way. Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Staff were appropriately recruited.

Checks were carried out regularly to ensure the building was safe and fit for purpose. A programme of refurbishment was taking place around the home. However, some areas of the home required more immediate attention as they were not clean and they were showing signs of wear and tear.

Risk assessments were up-to-date and identified current risks to people's health and safety. Improvements had been made to medicines management so people received their medicines in a safe way.

Is the service effective?

Good

The service was effective.

Staff had a good understanding and knowledge of people's care and support needs. They received the training they needed and regular supervision and support.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected because there was evidence of best interests decision making. This was required when decisions were made on behalf of people and when they were unable to give consent to their care and treatment.

People were supported to eat and drink according to their plan of care.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and they were complimentary about the care and support staff provided.

A range of information and support was provided to help people be involved in daily decision making about their rights and care and support needs.

There was an open and friendly atmosphere. Staff were kind and caring and interacted well with people.

People were supported to maintain contact with their friends and relatives. Staff supported people to access an advocate if required.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. Improvements had been made to records and they reflected people's care and support requirements.

There was a programme of activities and entertainment to occupy and keep people engaged if they chose to participate.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager and provider monitored the quality of the service and had introduced improvements. However, the issues found at this inspection with regard to staffing and the environment had not been not acted upon in a timely way.

A registered manager was in place who encouraged an ethos of involvement amongst staff and people who used the service.

Communication was effective and staff and people who used the service were listened to.

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

Manor Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 May 2018 and was unannounced. The inspection team consisted of one adult social care 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 for people with learning disabilities or mental health needs.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and personnel from health authorities who provided health support to people.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 13 people who lived at Manor Lodge, the registered manager, the cook, three support workers and the housekeeper. We telephoned three relatives, with people's permission, after the inspection. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for four staff, seven people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book,

maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home told us they were safe. One person told us, "I feel safe here." Another person said, "It's alright. I feel safe. The staff make me feel safe." Other people's comments included, "I do feel safe. There are people I can talk to if I need to", "Just knowing that you have the staff around makes you feel safe. I tell them I am going out and they know where I am going" and "I feel secure living here, it's brilliant." During the time we spent with people we saw they appeared comfortable with staff. One relative commented, "[Name] always seems okay when we go down to visit."

Although people told us they felt safe we had concerns that staffing levels were not consistently maintained over seven days of the week. At weekends staff numbers reduced from three support staff members to two support staff members between 8am and 8pm. This was to support 16 people including one person who needed two people for moving and assisting support and some people who displayed distressed behaviours. No other staff support was available on site apart from the cook, who went off duty at 2pm. From 2pm only two staff members were available until night staff came on duty. Support staff also carried out ancillary work across the week and at weekends which reduced their time to provide direct care and support to people. The registered manager told us domestic staff did not work at weekends, they only worked four days of the week and went off duty at 12pm each day. The cook also went off duty at 2pm, relief staff were not available to cover domestic hours when they were not on duty. The support staff were responsible for meals after the cook went off duty and for maintaining a satisfactory level of hygiene around the home as well as providing direct care and support to people. One person told us, "No there aren't enough staff, but it can't be helped, can it?" Another person said, "I suppose there are enough staff", "There could be more staff to bath you", "I would have a bath more often if there were more staff on duty" and "They could have more staff on duty for the amount of people living here."

We were told by the registered manager after the inspection domestic hours had been increased from 16 hours to 30 hours to cover over five days of the week. However, we considered support staffing levels were insufficient to provide direct care and support to people, especially at weekends and we discussed this with the provider who told us it would be addressed. Staffing levels needed to be consistently maintained to ensure they met people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. Staffing.

The registered manager and provider told us about the improvements and refurbishment that was taking place around the home. However, at the time of inspection not all areas of the home were clean. There was a mal-odour on the ground floor of the home. Some bedroom, hallway and lounge carpets and floor coverings were marked. Stair carpet was worn on some treads and presented a trip hazard. Bedroom and hallway door frames, walls and ceilings were marked, some tiles to ceilings around the home were stained or ill-fitting. The dining room wall was damaged, the room was in need of decoration and the floor covering required attention in the interests of infection control as it was damaged. The kitchen was showing signs of wear and tear including the walls by the trolley area. Blinds were not available at the kitchen window to

protect food from direct sunlight and to keep the kitchen at a constant temperature. Some bed bases were soiled. Some areas of the home were showing signs of wear and tear. We were aware a programme of refurbishment was taking place but some areas required more urgent attention. We received an action plan from the registered manager straight after the inspection. This showed the timescale for immediate action and refurbishment, including issues identified, at inspection. However, we considered the refurbishment should be completed in a more timely way.

This was a breach of Regulation 15 of the Health and Social Care Act 2008. (Regulated Activities)Premises and equipment.

Improvements had been made to the management of medicines and accident and incident monitoring since the last inspection and the service was no longer in breach of regulation 12, safe care and treatment.

The pharmacy supplier had been changed. Regular medicines audits were carried out by the home with increased frequencies, daily and monthly to detect if there were any errors. The pharmacist also carried out an annual audit. Staff medicines competency checks had been updated and were carried out annually to check staff understanding and competency to administer medicines. A system had been introduced to check medicines stock to ensure people's prescribed medicines did not run out before the end of the cycle. Medicines were disposed of safely. A book was available that recorded returned and disposed of medicines to the pharmacist and disposed medicines were stored appropriately until collected.

We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records and medicine labels to ensure people were receiving the correct medicine. They explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Appropriate arrangements were in place for the administration, storage and disposal of all medicines and this included the appropriate storage and checks of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. Medicines records were accurate and supported the safe administration of medicines.

Regular analysis of incidents and accidents now took place. The registered manager told us accidents and incidents were monitored. Individual incidents were analysed and a monthly and quarterly analysis was carried out to look for any trends. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to distressed behaviours.

There were personal evacuation plans for each person in the event of an emergency. Regular health and safety checks were carried out by the home staff. Certificates of maintenance for the premises were up-to-date such as for gas and fire safety to ensure the premises were safe.

The provider had a system in place to log and investigate safeguarding concerns. We viewed the safeguarding log and saw 16 alerts had been raised appropriately and investigated by the home where necessary. We discussed with the registered manager an issue we observed during the inspection about a person's care and support needs and they were aware of the procedure and raised a safeguarding alert. Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. One staff member commented, "I'd report any concerns straight away to the manager." Staff told us, and records confirmed they had completed safeguarding training. They were able to tell us about different types of abuse and were aware of potential

warning signs.

Risk assessments were in place that were reviewed monthly and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for alcohol, smoking, refusing personal care intervention, distressed behaviours and moving and assisting. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. At the same time, they gave guidance for staff to support people to take risks to help increase their independence. Our discussions with staff confirmed that guidance had been followed.

Records showed staff had been appropriately recruited. We saw that relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job.

Good

Is the service effective?

Our findings

Staff were positive and enthusiastic about the opportunities for training. One staff member told us, "There are lots of opportunities for training, we do face-to-face training." Another staff member commented, "We've got safeguarding training with the local authority in two weeks' time."

Staff told us when they began work at the service they completed an induction and they had the opportunity to shadow a more experienced member of staff. This made sure they had the basic knowledge needed to begin work.

Staff received regular supervision from the management team to discuss their work performance and training needs. One staff member told us, "I have supervision every two months with the manager." Staff told us they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their work performance.

A staff training matrix showed and staff told us that they were kept up-to-date with safe working practices. They received some training to ensure they had the knowledge and some insight into people's care and support needs. Staff training courses included epilepsy, alcohol misuse, dementia care, positive behaviour support, mental health awareness, diabetes awareness, mental capacity and deprivation of liberty, care planning, hepatitis, team leading, common health conditions and nutrition.

People's nutritional needs were assessed. People's care records included information about their food likes and dislikes and dietary requirements. Meeting minutes showed that people were involved in menu planning and they were asked for suggestions. One person told us, "We have a menu and you get a choice. We have lovely meals." Another person commented, "I like spaghetti bolognese and curry. The chef does a mixture and gives you two choices." Other people's comments included, "The food is really good. I like what the chef does, especially mince and dumplings and cheesecake", "There is always an alternative and a pudding after it", "I have a piece of apple at supper and a yoghurt", "I could ask the chef for juice with my lunch if I wanted it" and "The food is nice you always get a choice."

Care plans were in place for people who required support. There was a kitchen for people and staff to make drinks for people which we noted was well-used during the inspection. We observed the lunchtime meal and saw a drink was not provided unless people made their own and brought it to the dining room. We discussed with the registered manager how positive it was to maintain people's independence. However, as people's hydration was nott being monitored mealtimes should include a drink being served to ensure people were receiving adequate hydration. The registered manager told us that this would be addressed immediately.

People were supported by staff to have their healthcare needs met. One person told us, "I get my eyes tested every two years." People's care records showed that people had access to GPs, occupational therapist, speech and language therapy team, district nurses and other personnel. One health care professional commented, "I have no concerns with the staff or care in Manor Lodge. They attend to the patient with me

and adhere to the advice I give them with feedback on how things are progressing. Staff and manager are very approachable when I speak to them with any concerns."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure 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. One DoLS application had been authorised by the relevant local authority. There was evidence of mental capacity assessments and best interests decisions, if required in people's care plans.

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a handover record and communication book that provided information about people, as well as the daily care entries in people's individual records.

Good

Is the service caring?

Our findings

During the inspection there was a relaxed and pleasant atmosphere in the home. One person commented, "There's a good atmosphere here." People gave positive feedback about the support they received and the caring nature of the staff. They told us the staff and management were supportive and spent time listening and engaging with them. Staff interacted well with people. Camaraderie was observed amongst the people who used the service and they were supportive and caring of each other. One person told us, "The staff are canny (nice). I like it here it's friendly." Another person commented, "The staff are generally very good. If I want something I just ask." A third person said, "I have lived here for years it's brilliant." Other people's comments included, "The staff are kind and caring", "They [staff] are always there if you just need to have a chat", "The staff are brilliant", "I'm very happy here" and "Staff treat you well."

Staff were given training in equality and diversity and person-centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs.

Staff were kind, caring and respectful. They appeared to have a good relationship with people. They asked people's permission before carrying out any tasks and explained what they were doing as they supported them. Some people had been supported by staff from the service for several years. Staff we spoke with showed an in-depth knowledge and understanding of people's care, support needs and routines. Staff understood and interpreted people's non-verbal communication, which enabled people to engage more with those around them. Support plans also provided detailed information to inform staff how a person communicated. The information included signs of discomfort when people were unable to say for example, if they were in pain or unwell. One care record stated, '[Name] is unable to inform staff verbally if they are in pain. If they are in pain staff to look for signs of a grimacing face, upset or crying.'

People's care records contained information about people's likes, dislikes and preferred routines. For example, one care plan stated, '[Name] likes to be seated so they see the full room, so they can see what is happening around them' and '[Name] chooses to bathe rather than shower and prefers female staff to assist.'

People were encouraged to make choices about their day to day lives. They told us they were able to decide for example, when to get up and go to bed, what to eat, what to wear and what they might like to do. One person told us, "If you want to sit in your room you can. I always have my door open during the day." Another person commented, "We just get up when we want. Staff will wake you up but you can stay in bed if you want." A third person said, "You go to bed when you want. Everyone goes at different times."

People's privacy and dignity were respected. One person commented, "The staff won't ask you anything inappropriate, they respect your privacy." Another person said, "When my door is closed, staff knock." We saw staff members asked people's permission and knocked before entering their bedrooms. Care plans also provided information for staff to promote people's privacy and dignity. For example one record stated, '[Name] has specifically asked only female staff are to go into their bedroom.' Records were held securely and policies were available for staff to make them aware of the need to handle information confidentially.

People were actively encouraged and supported to maintain and build relationships with their friends and family. They were also supported to use the telephone to keep in touch.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. A more formal advocacy arrangement was in place where required to assist people with some of their decisions and to promote their views at meetings about their care and support needs. Advocates can represent the views of people who are not able to express their wishes. Information about the use of advocates was displayed in the home.

Good

Is the service responsive?

Our findings

At this inspection we found improvements had been made to people's care records to ensure they received person-centred care. The service was no longer in breach of this legal requirement regulation 9.

People were encouraged to remain independent in aspects of daily living and to retain former skills. One person commented, "I do my bedroom cleaning all myself. The staff hoover the floor." Records showed that information from assessments about people's medical conditions and their daily lives had been transferred to care plans. For example, with regard to nutrition, personal hygiene and mobility. This was necessary to ensure staff could provide support to people in the way they wanted and needed to ensure their health and well-being. One person commented, "Staff help me in the morning and with going out." Staff responded to people's needs and arranged care in line with their current needs and choices. Another person told us, "The staff will help me if I need it but with being independent, I try and do it myself. The staff will help me if I'm not having a good day." The service consulted with healthcare professionals about any changes in people's needs. For example, a speech and language therapist was asked for advice with regard to nutrition for a person with swallowing difficulties.

Care plans were detailed and provided sufficient information for staff to give care and support to people in the way they preferred. For example, one care plan for personal hygiene recorded, '[Name] requires prompting and encouragement from staff to maintain their personal hygiene.' Care plans for personal hygiene also provided guidance and advice for staff to help support people, where people with mental capacity may be at risk of self-neglect. Another care plan stated, '[Name] is able to choose their own daily meal from the choices available from the daily menu.'

Records were in place for the management of distressed behaviours. Care plans showed the care and support requirements when a person became agitated or distressed. The care plans gave staff guidance with regard to supporting people when they became agitated or upset and included triggers and methods to help de-escalate the behaviours. Records showed relevant people were involved to assist staff provide support and guidance to people.

When crises did occur, the home staff approached community and external professionals for support, particularly around mental health and well-being. Records showed that staff liaised with external professionals for advice and support on how to manage any possible issues, to promote the person's well-being.

People said they were supported and involved in planning their care. One person commented, "I have a review with staff every six weeks." Another person told us, "I have seen my care plan." A third person said, "At meetings you can discuss your medicines." Up-to-date written information was available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs were carried out with evidence of regular evaluation that reflected any changes that had taken place.

Staff completed a daily record for each person and recorded their daily routine and progress in order to

monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. We advised the registered manager the monthly evaluation should contain some details of the person's progress and well-being during the month rather than state 'No change'. The registered manager told us that this would be addressed.

People were supported to follow their interests and hobbies. They were positive about the opportunities for activities and outings. They all said they went out and spent time in the community. One person said, "I go to the pub, it's like a restaurant combined pub. It's a nice atmosphere." Another person told us, "Staff took me to Canada to see my sister a couple of years ago. A member of staff came with me and we stayed for a week." Other people's comments included, "The staff take me to the shops", "I go to Whitley Bay with a member of staff", "I go the shops in the wheel chair to do my shopping", "We go shopping by metro to North Shields." Some people accessed the local community independently. One person commented, "I go out myself to Newcastle to the shops. I get a cup of tea in Marks and Spencer". Another person said, "I can go out myself. I like to go for a walk or to the shops." A third person told us, "I go out every morning to get the paper."

People told us there were some activities and entertainment available in the home. People's choices about whether to engage in activities were respected. A programme of activities was on display. Activities included, bingo, board games, armchair aerobics, arts and crafts, quizzes, jigsaws, library and reminiscence. One person commented, "There are activities to do if you want to." Another person said, "You can watch films and I play on my computer in my bedroom." Other people's comments included, "On a day like this I sit in the garden. We have a lovely garden and it's always well-kept", "We have people who visit who do reading and singing, "I like watching television", "I like to do puzzles and play Solitaire on my computer."

People said they knew how to complain. One person said, "I would see the manager to complain." Another person commented, "There is a box in the hallway where you can put a slip in." A third person told us, "If we want to complain we have leaflets and you fill a leaflet in and give it to the manager." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw complaints received were investigated and resolved satisfactorily.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place who had become registered with the Care Quality Commission (CQC) in 2017.

The registered manager had been pro-active in keeping us informed and submitted statutory notifications to the CQC. These included safeguarding notifications, applications for DoLS and any police incidents.

We found that the breaches of Regulation 12, Regulation 9 and Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 had been acted upon and rectified by the registered manager and provider. These related to safe care and treatment, person-centred care and governance

However, at this inspection we found improvements were required with regard to staffing levels and the environment. Although improvements had been made to the quality assurance processes they had not identified the areas of improvement we had identified at inspection. We considered although the environment was being refurbished and an action plan had been submitted the refurbishment and re-decoration of people's bedrooms should be completed sooner than September 2019.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider, whom we spoke with by telephone after the inspection, was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

Improvements had been made to the quality assurance system to ensure it was more robust. Regular analysis of accidents and incidents took place to identify if there were any trends. More effective medicines management audits took place. A formal external audit was carried out by the provider's representative to check the action taken from audits carried out within the home.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of daily, weekly, monthly, quarterly and annual checks. They included catering, health and safety, medicines, finances, incidents and accidents, safeguarding, complaints, personnel documentation and care documentation. Audits identified actions that needed to be taken.

Regular visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits.

The atmosphere in the home was relaxed and friendly. Staff and people we spoke with were positive about their management. One person said, "The manager comes around and sees people. If I need anything I go and see her." Another person told us, "You can go and see the manager if you need anything or sometimes just for a talk." Staff said they felt well supported. One staff member said, "The manager is very

approachable." Another staff member told us, "[Name], the manager will explain how things should be done."

The culture promoted person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

People told us regular meetings took place to ask them their opinions. One person said, "I don't really go to the meetings." Another person told us, "We're asked if our privacy is being kept and if there is anything else you would like for a meal." Records showed regular meetings took place with people. Monthly meetings took place to discuss menus, activities, entertainment, changes in the home and staffing to keep them informed and involved in the running of the service. We noted the registered manager was responsive and listened to people's comments. For example, a daily cleaning schedule had been introduced as a person had commented their bedroom wasn't very clean."

Staff told us staff meetings took place four weekly and minutes of meetings were available for staff who were unable to attend. Staff meeting minutes showed topics discussed included infection control, health and safety, people's well-being, safeguarding, staff performance, complaints and incident reporting. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff meetings also discussed any incidents that may have taken place. The registered manager told us if an incident occurred it was discussed at a staff meeting. Reflective practice took place with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

Feedback was also sought from people through surveys. We saw responses to the provider survey from January 2018 that people had mostly responded positively to service provision apart from for the environment.

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 The registered person had not ensured the premises were being satisfactorily maintained for the safety and comfort of people who used the service, with a suitable level of hygiene. Regulation 15(1)(a)(c)(e).(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe, effective and person-centred care to people at all times. Regulation 18 (1)