

R Bonomaully Stonesby 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?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 26 June 2018 and was unannounced. We last inspected this service in April 2016 and rated the service as Good. We found the provider was meeting the regulations, but improvements were needed in the management of medicines and risk assessments lacked the detail required to mitigate risks.

Stonesby Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Stonesby Lodge accommodates up to 12 people who have mental health needs. The accommodation is an adapted residential property and is provided over two floors. At the time of our inspection, there were nine people using the service.

There was a registered manager in post. 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 provider had not alerted potential safeguarding incidents to relevant agencies or made appropriate notifications. This meant external agencies were unable to take action to assess and evaluate potential or actual risks in order to ensure appropriate action was taken to keep people safe.

There was a lack of effective systems and processes to monitor the quality of the service and identify where improvements were needed. Informal systems were in place but were not effective in making improvements in the service.

Risk assessments were not sufficiently detailed to demonstrate effective assessment and evaluation of risks. Records did not provide the guidance and information on the actions staff needed to take to mitigate potential risks for people.

Medicines were in the main managed safely. However, further improvements were needed to ensure records relating to stock management were completed accurately and correctly.

There was a system in place to monitor accidents and incidents. However we found no analysis of these was done which would identify any trends to prevent further re-occurrences.

The people we spoke with said they felt safe as a result of the care and support they received and trusted staff who looked after them.

Staff were trained in safeguarding and knew what to do if they had concerns about the well-being of any of the people using the service.

There were sufficient numbers of staff available to meet people's needs. Most staff had worked in the service for many years and knew people well, which supported consistent care.

Recruitment files did not demonstrate staff had always been recruited safely as key documents, such as employment references, had been archived and could not be located. The registered manager was in the process of updating these files.

People told us staff were well trained and provided effective care and support. We observed staff were confident and skilful in their interactions with people. The provider's training matrix, a central record of staff training, had not been kept up to date and there were gaps in records showing what training staff had undertaken. Staff told us they had completed a range of training which gave them the skills and knowledge they needed.

People were supported to eat a balanced diet and specific dietary needs were met. Staff encouraged people to make drinks and snacks if they were able. Staff ensured people had enough to eat and drink.

People were supported to access a range of health professionals to maintain their health and well-being. The service worked in partnership with other agencies and was pro-active in ensuring people had the care and treatment they needed.

People were supported to make decisions and choices about their care. Staff understood the principles of the Mental Capacity Act 2005 (MCA) and sought consent before providing care and support. At the time of the inspection, there was nobody using the service who was subject to a Deprivation of Liberty Safeguard (DoLS) authorisation.

People were treated with kindness, respect and compassion. Staff encouraged people to be as independent as possible. Staff supported people to express their views and be involved in making decisions about their care.

Staff were knowledgeable about the people they supported and knew their likes, dislikes, hobbies and interests. Care plans included information about people's life history, preferred routines and people or item that were important to them. This information supported staff to provide personalised care.

Care plans were reviewed and these were signed by people. People had been supported to write down their key aims and objectives and staff ensured care was provided to support people to achieve these. Improvements were needed to ensure care plans were updated in a timely way to reflect changes in people's needs and information in daily handovers supported effective monitoring of people's wellbeing.

There were opportunities for people to be involved in interesting activities, both inside and outside the service. People were able to choose how they spent their time and supported to be involved and a part of their local community.

The provider had an appropriate complaints procedure in place and people were confident to raise concerns or make complaints if they needed to.

People were supported to share their experiences of the service and discuss ideas and suggestions to

improve the service. People, a relative and staff spoke highly of the leadership and support of the registered manager and the registered provider.

We found two 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 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 consistently safe.

The provider had not always followed safeguarding procedures in making appropriate, timely notifications to external agencies.

Risk assessments did not always provide clear instruction to staff to mitigate known risks.

Medicines were in the main managed safely but there were areas which required improvement.

People received care from a consistent team of staff who were deployed in sufficient numbers to meet people's needs.

Is the service effective?

Good 

The service was effective.

Staff were supported through training and supervision, although there were gaps in training records.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). People were supported to make decisions and choices and staff sought consent before providing care and support.

People were supported to access appropriate health care professionals when required and staff were committed to achieving positive outcomes to maintain people's health and well-being.

Is the service caring?

Good 

The service was caring.

People were supported by staff who respected them as individuals.

People were provided with opportunities to be involved in making decisions about their care and support.

Staff upheld people's rights, including their right to privacy and

dignity.

Is the service responsive?

Good ●

The service was responsive.

People were involved in the planning of their care. Care plans supported staff to provide personalised care.

People were supported to pursue meaningful hobbies and interests in the service and in the local community and could choose how they spent their time.

People felt confident to raise concerns and complaints if they needed to.

People were supported to plan and make choices about their end of life care.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There was a lack of systems and process to monitor and assess the quality of the service to identify where improvements were required and implement action to keep people safe.

There was a registered manager in place who promoted an open culture in the service. The provider's values were embedded in staff working practices.

People were supported to share their experiences of the service and the care provided.

Stonesby 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 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.

This inspection took place on 26 June 2018 and was unannounced.

The inspection was carried out 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.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make. We reviewed information we held about the service, including notifications of incidents that had occurred in the service, which the provider is required to send us by law. We contacted commissioners, responsible for funding some of the people using the service, to gain their views about the care provided.

During this inspection we spoke with seven people and telephoned one relative of a person using the service. We met with the registered provider, the registered manager, a member of care staff and a domestic staff. We also observed care and support and staff interactions in communal areas. We sampled three people's care plans and records to see if people were receiving the care they needed. We looked at recruitment files for three staff, staff training records, and other records pertaining to the day-to-day management of the service including quality assurance.

Is the service safe?

Our findings

We found that the provider had not discussed potential safeguarding incidents with relevant agencies or made appropriate notifications. For example, one person was known to leave the premises without reference to staff. There was a risk assessment in place advising staff on likely places the person would visit, how the person may put themselves at risk of harm and actions to take in the event the person did not return at a given time. However, records did not include any assessment of the person's understanding of the potential risk of abuse from others as a result of their actions in the community. On a recent occasion, the person had returned to the service with unexplained bruising. Staff had recorded the incident and discussed this with the person, but had not completed a body map of the injuries and had not alerted external agencies. The registered manager explained that staff had investigated the incident to assure themselves the person had not experienced harm. However, records did not reflect these actions. A second person had experienced a number of falls, one of which had resulted in a head injury. Although staff had taken appropriate action in seeking medical assistance and assessment, they had not alerted the local authority or notified the CQC. This meant external agencies had not been able to evaluate the potential impact for the people and decide the level of intervention required to keep them safe.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes must be established and operated effectively to prevent abuse of service users.

The registered manager told us they would ensure records were more robust and detailed and appropriate notifications made to external agencies.

Records showed staff had undertaken safeguarding training and demonstrated they understood how to identify if someone was at risk of abuse. The provider's policy provided staff with information and guidance they needed based on current best practice, including contact details for external agencies.

We looked at how staff managed risk to people, including risks associated with behaviours that may challenge. Care plans contained risk assessments for areas such as daily living tasks, mobility and risks associated with people's health conditions, including mental health. For example, where a person was at risk of falling, the equipment and measures staff needed to take to reduce this risk were included in their risk assessment. A change in another person's health condition had been assessed and included measures staff needed to take if the person's health condition deteriorated.

In other care plans, risk assessments did not include the detail and guidance staff needed to keep people safe. For example, where people demonstrated behaviours that could challenge, assessments lacked details of possible triggers for behaviours, suggested interventions and measures staff needed to take to keep people safe. Risk assessments were not always in place where people left the service to go out unsupervised. Records did not demonstrate risk assessments had been reviewed following incidents, such as falls or incidents of challenging behaviour. Staff had supported people for many years and were able to describe people's individual needs in detail including steps taken to ensure the person's safety. The registered

manager told us they would review and update risk assessments and develop behaviour management strategies to ensure records reflected people's current needs.

Regular maintenance and equipment audits relating to fire safety records, maintenance of safety equipment, gas safety and portable appliance testing (PAT) were undertaken. Records showed processes were in place and followed to reduce serious risks to people's health, such as legionella. Fire drills were undertaken on a regular basis to ensure people knew what was required of them in the event of an evacuation. The provider had a policy regarding personal emergency evacuation plans (PEEPS) for people, however no assessments had been completed. There were very few risk assessments relating to the premises. These are important to ensure the premises are maintained to be safe and suitable for people, staff and visitors.

At our last inspection in April 2016, we found improvements were needed in the management of medicines. This was because records lacked the detail and guidance staff needed to administer medicines safely and accurate stock checks of medicines were not maintained. At this inspection we found improvements had been made but further improvements were needed to ensure records were completed accurately.

Temperatures of storage areas were monitored and recorded. Some people were prescribed additional medicines on an as required basis (PRN). Information was in place that detailed when and why people might require additional medicines in order to identify trends. The registered manager carried out stock checks and medicines that were no longer required were recorded and safely disposed of.

People told us they received their medicines on time and in line with their preferences. Comments included, "Staff administer our medicines, always on time," "My medicines are explained to me and I know the side effects," and "I could get a paracetamol if I had a headache." We looked at a sample of medicine administration records (MARs). These had, in the main, been completed correctly to confirm people had taken their medicines. We found one record where staff had not signed for a topical medicine.

Records relating to the amount of medicines in stock were not always completed correctly. For example, we found stock recorded for one person's medicines did not match the actual amount of medicines in stock. Staff were not consistently recording medicine stock which had been carried over from the previous month. Staff maintained a 'homely remedies' book, where 'over the counter' medicines were available to treat minor ailments, such as headaches. Records showed staff had not recorded the reason why these medicines had been given. These records are important to demonstrate people had received their medicines safely and as prescribed. The registered manager told us they would review records and staff practices to ensure these were completed correctly.

People told us they felt safe using the service. Comments included, "I do feel very safe; there are night staff on all night," "I can lock my door at night but nobody would harm me here," and "If we go out somewhere we have to tell them (staff) in case there is a fire which makes us feel safer." A relative told us, "[Name] feels secure. [Name] can do what [name] wants but there is always someone there to keep an eye on [name]."

People told us there were enough staff to meet their needs. Staffing rotas we saw showed the staffing levels we found on the day of our inspection were the usual ones. The registered manager explained staffing levels were flexible to respond to individual activities and events.

People were supported by a consistent team of staff who had supported them for some time. We reviewed a sample of staff recruitment files and found some files did not include evidence that appropriate checks had been made to establish the person's employment history. The registered manager explained this

information could not be located in the archives as staff had worked at the service for many years. They were in the process of ensuring all staff completed an updated check with the Disclosure and Barring Service (DBS). The DBS carry out criminal and barring checks on individual who intend to work with people using care services and helps employers to make safer recruitment decisions.

People told us they were happy with the hygiene standards in the service. Comments included, "Very clean, spotless," "It's all very clean. The cleaner [name] does a great job," and "It's the cleanest home I have been to." A member of staff was responsible for domestic tasks and we observed them cleaning communal areas whilst following safe infection control practices. We saw areas of the service were clean and free from malodours. Staff were provided with personal protective equipment, such as gloves and aprons and used these when supporting people with personal care. The kitchen had a five star rating awarded by the Food Standards Agency.

There were arrangements in place for reporting and reviewing accidents and incidents, although there was no formal analysis of these to identify trends and prevent re-occurrence. Records showed staff took action to prevent further harm. For example, one person had experienced a number of falls and near misses in recent months. Staff had liaised with health professionals to determine possible reasons for the increase in falls and to support in identifying actions to reduce the risk of further falls. The provider had made improvements to the rear gardens to reduce the risk of people tripping or falling whilst accessing these areas.

Is the service effective?

Our findings

People told us they thought staff had the skills and knowledge they needed to meet their needs. One person told us, "They [staff] know what they are doing." Another person said, "They [staff] are well trained." Staff we spoke with felt they had undertaken the training they needed in their roles. One staff member told us, "I have completed a lot of training. Most recent training is health and safety, safeguarding and manual handling."

We looked at the provider's training matrix, which was a central record of training staff had undertaken. This showed gaps and anomalies. For example, the matrix showed only two staff had completed manual handling training. Food safety training had not been undertaken since 2010. Information from staff training certificates, which showed staff had completed a range of essential and specific training, had not been added to the matrix in a timely manner. The training matrix was not effective in providing the information the provider needed to ensure staff retained their skills and knowledge through regular training. The registered manager was in the process of updating the training matrix.

The provider had not recently employed any new staff to the service but had in place an induction programme to support staff to develop the skills and knowledge they needed.

Staff told us they felt supported by the registered manager and the registered provider and received regular supervision, which included observations of their working practices. The registered manager frequently worked alongside staff which enabled them to guide staff in best practice.

People told us that staff supported them to eat and drink a balanced diet. One person told us, "The food is very good, you have a choice as well. Food (portions) is a good size, home cooked and get plenty of it. We are able to get plenty of drinks as well." A second person told us, "I like the meals, they are varied. We have what is on offer that day but we get two choices."

During our inspection visit, we observed people being served drinks and a light meal for lunch. Staff explained that most people were out at lunchtime, so the main meal was served at dinner time because this suited everyone. We saw people were consulted about what they wanted to eat and some people helped themselves to cold and hot drinks from the kitchen throughout the day. Care plans included people's specific dietary needs and staff demonstrated they were aware of these. For example, one person required a diet low in sugar. Staff provided the person with the same menu choices, but ensured foods served were suitably low in sugar. This helped to ensure the person did not feel excluded at meal times, particularly when desserts were served.

People's needs were assessed prior to them moving to the service. Assessments included details about people's health and well-being. People told us they had been involved in developing their care plan and staff supported them to maintain their health and well-being. Staff worked in partnership with a range of health professionals to support people to access routine appointments, such as GP, dentist and opticians. In addition, staff supported people to attend specialist appointments to ensure they had the support they needed to manage their mental health needs.

Care plans included the impact people's mental health had on their well-being and this supported staff to identify any changes in people's behaviour and responses and make timely referrals to appropriate health professionals. People were enabled to attend health screening to support early detection of health conditions. Staff support helped to ensure people had fair access to health services and were not discriminated against because of their mental health needs or behaviours. This effective management and intervention helped to avoid people reaching a 'crisis' point in their mental health wellbeing and prevented the need for re-admission or more invasive treatment.

Records showed staff acted upon concerns relating to people's health and welfare. For example, one person had recently been diagnosed with a life-threatening illness. Staff had supported the person to attend specialist health appointments, liaised with health professionals and ensured, in line with best practice guidance, that the person was supported through best interest processes. This helped them to access the information and advice they needed in order to make decisions about their care and treatment.

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 interest 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 processes for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked that the service was working within the principles of the MCA. Staff demonstrated they sought consent from people before providing care and support, and supported people to make decisions and choices. People using the service had been assessed as having mental capacity to make day to day decisions and choices, including unwise decisions, and this was respected by staff. People told us they were free to choose how they wanted to spend their time and were not prevented from doing what they wanted to unnecessarily. The registered manager and the provider had a good understanding of MCA and were able to discuss actions they would take if they had reason to believe that a person did not have the capacity to consent to anything relating to their care. This included the carrying out of a MCA assessment and making a best interest decision if required. We saw that documentation to assist the provider with this was available.

At the time of our inspection, the provider had completed upgrading some areas of the premises and work was on-going. Improvements included re-decoration of some areas including bathrooms, toilets and corridors and replacement flooring. Further work was in progress, including the replacement of two windows and further re-decoration. We saw people were free to move around the premises and spend time where they chose. They were able to access the rear patio area which included a smoking shelter or a separate smoking room if they wished. People looked at ease with their environment and were able to personalise their rooms with furniture and décor.

Is the service caring?

Our findings

All the people we spoke with were positive about the staff that supported them. Comments included, "They are very caring and look after us well," "They are all good here, smile at us and have time for us," "They are caring. Staff respect me and know me well." A relative who we spoke with told us, "[Name] is cared for very well. Some staff go out of their way to do things, that sort of thing goes on a lot."

Throughout the inspection, we observed staff interacting with people in a kind, pleasant and friendly manner and being respectful of people's choices and opinions. There was a relaxed atmosphere and staff demonstrated a good knowledge of the people they supported. In their PIR the provider told us staff were nominated 'keyworkers' for named people living in the service. A keyworker is a member of staff who, with the person's consent and agreement, takes a key role in the planning and delivery of their care. This supported staff to develop detailed knowledge of the person, their background and establish links with people who were important to them. Staff told us they had time to spend with people and we observed staff spent time supporting people and sitting talking with them.

People told us they were fully involved in the development of their care plans. Care plans included people's preferences, likes and dislikes and how they communicated. There was provision within the assessment and care plan documentation to consider people's individual characteristics. People were supported to identify goals and outcome from their care. For example, pursuing a hobby or interest or achieving a level of independence. Staff provided care in line with people's wishes and objectives which helped to ensure people's needs were met.

The provider informed us in their PIR that they had developed a 'bill of rights' which outlined key points relating to fairness, dignity, respect and autonomy. There was evidence in meetings and records that people were supported to understand their rights through forums and care planning. This helped to ensure people were treated in a dignified manner and their diversity was acknowledged, respected and supported.

There was an advocacy service available if people required this, providing advocates who were skilled in supporting people with mental health needs. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

People told us visitors were welcomed and could visit when they wanted to. One person told us, "Yes, I have a visitor. They [staff] make [name] a cup of tea. [Name] can come whenever." Staff supported people to maintain links with family and friends wherever possible and involved them in people's care.

Staff were aware of the need to ensure people's information was kept confidential and not disclosed to anyone without appropriate consent and authorisation. People's records and information were kept in the office, which was lockable and only accessed by staff.

Staff supported people to develop their independence. During the inspection we observed people taking their laundry to the laundry room, going out to local shops and community activities and making drinks for

themselves. A staff member told us, "We help and advise people but also encourage their independence. We aim to ensure people are not institutionalised and do as much as possible for themselves." One person told us staff worked around people because they all had different routines.

People's privacy and dignity was respected. Each person had a single room with a lock and their own key. Staff were discreet in providing assistance with personal care and supporting people to maintain their dignity. For example, staff discreetly suggested a person change their top because it was soiled. People were supported to maintain their physical appearance which helped to maintain their dignity.

Is the service responsive?

Our findings

Care plans had been written using a personalised approach. Those we saw focused on people as individuals, detailed life history and key events, people who were important to them and hobbies and interests. Care plans included how people communicated and how they preferred to receive information. This information was used to help staff provide personalised care. For example, one person's care plan advised they could be 'shy when meeting people who were new' to them and was able to make 'one decision at a time'. This enabled staff to identify the level of support the person required with new experiences or to communicate with people who were not known to them. Another person's care plan detailed what tasks they were able to complete themselves, and when they needed staff support. This helped staff to provide a level of support that maintained the person's independence.

People's care plans included a history of their mental health, diagnosis and treatments. This supported staff to identify any patterns or trends in people's mental health, known risks and respond to any changes in behaviour or routines, which could be possible indicators of a decline in people's wellbeing.

Records showed care plans were regularly reviewed and were signed by people. Staff supported people to identify their aims and objectives and ensured care was provided to enable them to achieve these. For example, one person wanted to be more independent. Records showed staff had supported the person to achieve this. However, we found some records had not always been updated in a timely manner to reflect changes in people's needs. For example, staff had recorded that one person experienced soreness to their skin and required treatment with a topical medicine. Their care plan had not been updated to reflect that the person was at risk from skin soreness and the actions staff needed to take to manage this.

Staff maintained daily handover records. These commented on people's wellbeing and any significant events which had occurred during the shift. We found records did not always include the information staff needed to respond to any changes in people's behaviour or wellbeing. For instance, one entry referred to a person as 'kicked off this morning' but did not provide any detail or explanation other than this comment. Another entry stated a person had made comments that were unusual and out of the ordinary. A third entry commented that a person's health condition was 'really bad' but did not provide any further information. When we discussed handover records with the registered manager, they explained that a lot of information was passed between staff directly as they were a small team and worked closely together. They told us they would review recordings to ensure these were more detailed and accurate.

People told us staff supported them to access information and helped them to understand it. The provider intended to develop a policy to comply with the Accessible Information Standard (AIS) should they need to support a person to access information in a specific way due to their disability or sensory loss. The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given.

In their PIR, the provider described stimulating and meaningful activities people were able to participate in and how the service was embedded in the local community. During our inspection, people told us they were

able to explore hobbies and interests of their choice and could choose how they spent their time. Comments included, "I go to church. We have a cup of tea, Christian fellowship and talk. We go in the week and on Sundays too. I enjoy it," and "I go to the shops here and there. I am well trusted and I have a key and tell them [staff] when I am likely to be back." One person described how they had organised a trip to London with staff encouragement to visit a place of interest. Another person enjoyed art and proudly showed us their drawings, which they did when they wanted to. We observed people went out locally, to community activities and to pursue hobbies and interests. The provider continued to hold season tickets and regularly supported people to attend matches at the local football club. There was a greenhouse in the garden which supported people to be involved in growing plants and vegetables if they wished. This range of activities in the service and in the local community, provided motivation and stimulation and reduced the risk of people feeling isolated within the service and helped them feel part of the community they lived in.

People felt confident to raise concerns and make complaints if they needed to but told us they had had no need to make any to date. The provider's complaint policy guided people as to how their complaint would be managed and responded to. The policy included contact details of external agencies where people could escalate their complaint if they were unhappy with the outcome, and details of advocacy agencies to support people to make a complaint. The service had not received any complaints since our last inspection.

People had the opportunity to discuss with staff what it meant to be at the end of life. People had expressed their own preferences in how they wanted their care to be provided when they were at end of life, which were recorded in care plans. A relative told us the provider had been very supportive in enabling them to discuss end of life plans with their family member, which had made the whole process easier.

Is the service well-led?

Our findings

Although people described their experience of using the service as positive, we found that there were some parts of the management of the service that needed attention. There was a lack of systems in place to identify where improvements were needed and they had not identified the issues we found needing improvement during our inspection visit. These included not making safeguarding referrals to notify external agencies to ensure people were safe, people's risk assessments did not always provide clear instruction to staff to mitigate known risks, and further improvements were needed medicine records.

The registered manager carried out some checks and audits; these were mainly related to areas around health and safety and the premises. They explained they monitored records, including care plans, and working practices as they were involved in day to day care. They told us they had identified areas that required improvement, such as staff recruitment files, but this information was not recorded anywhere through any formal quality assurance systems. The provider had policies and systems to support quality assurance but these had not been used.

The failure to effectively monitor and assess the quality of the service in order to make necessary improvements is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager and provider told us the shortfalls identified at this inspection would be addressed as a priority.

People were positive about the management of the service. Comments included, "I am happy here, this is the best home I have been in," "It is well run, I like it here," "I can speak to the (registered) manager when I want to," and "[Name of registered manager] is great, always has time for us." A relative told us, "It is well-managed. The place needs a lick of paint but I would rather the money was spent on the care than decoration."

The service had a registered manager in post who had worked at the service and supported people for several years. They were supported by a senior care worker who deputised for them in their absence. Staff were positive about the leadership and management and spoke of strong teamwork, with most staff having worked together for many years. The registered manager encouraged an open line of communication with their team. Regular staff meetings were held. We viewed minutes of the previous staff meetings held in 2018. Issues directly affecting the running of the home were discussed, for example decoration and activities. Best practice was also discussed regarding documentation in care plans. This helped to ensure staff were kept up to date and involved in operational issues.

People were supported to provide feedback on their experience of the service. The registered provider held regular meetings with people where they were able to share their views and participate in discussions about day-to-day issues. For example, minutes of a meeting held in June 2018 showed the provider had discussed 'respect' with people, what this meant to each person and how this could be demonstrated in practice and day-to-day relations. The provider shared best practice with people, for instance NHS alerts about fluids and thickeners to reduce the risk of dehydration.

The provider's values of providing personalised care to individuals living with a mental illness, to enable people to live fulfilled lives and be as independent as possible, were shared by the staff team. Staff spoke of ensuring people were not 'institutionalised' but enabled to make choices and decisions, even if these were unwise. Diversity was recognised and supported within the staff team and staff told us they were treated equally by the registered manager and the provider.

The registered provider was closely involved in the day-to-day running of the service. They demonstrated they were aware of the challenges and limitations of the service. They were working closely with other agencies, including local authority commissioners, to develop the service and ensure best practice in the care provided. Local authority commissioners had recently undertaken quality visits to the service. They told us they had found a number of areas in which the service needed to make improvements.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established or operated effectively to prevent the risk of abuse for service users.

The enforcement action we took:

simple caution

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not followed to effectively monitor and assess the quality of the service in order to make improvements.

The enforcement action we took:

simple caution