Borough Care Ltd

Bruce 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

The inspection took place on 22 September 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting.

Bruce Lodge is a purpose build care home situated in Stockport. The service can provider care and accommodation for up to 47 older people. At the time of our inspection 46 people were living at the service. The service has communal lounges, dining rooms and bathing facilities available. Accommodation is provided over two floors which can be accessed by a lift. To the front of the building is a large secure landscaped garden and car parking is available.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Emergency procedures were in place for staff to follow and personal emergency plans were in place for everyone, however these lacked details. Fire drills had not taken place; discussion on what to do in the event of a fire had taken place but these were not practical fire drills.

Medicines were not always managed appropriately. The registered provider had policies and procedures in place to ensure that medicines were handled safely. Medication administration records were completed fully to show when oral medicines had been administered and disposed of. People we spoke with confirmed they received their oral medicines when they needed them. However, topical medication, such as creams, was not always recorded when it had been administered and we saw gaps in these records.

People and their relatives told us they felt safe. Risk assessments were in place for people who needed these. Risk assessments had been regularly reviewed and updated when required.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce the risks.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place and the registered provider had a policy in place to minimise the risk of abuse occurring.

Certificates were in place to ensure the safety of the service and the equipment. Maintenance and fire checks had been carried out regularly.

A recruitment process was followed to reduce the risk of unsuitable staff being employed. All new staff completed a thorough induction process with the registered provider.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal. Staff had received training to support them to carry out their roles safely.

People were supported to maintain their health. People spoke positively about the food and drink provided at the service. Staff understood the procedures they needed to follow if people became at risk of malnutrition or dehydration.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew what action they would take if they suspected a person lacked capacity. We saw that documentation was in place to show best interest decisions being made appropriately.

Each person was involved with a range of health professionals and this had been documented within each person's care records. From speaking with staff we could see that they had a good relationship with health professionals involved in people's care. People's care records contained evidence of appropriate referrals to professionals such as falls team, SALT and tissue viability nurses.

The service was clean and neutrally decorated throughout but was adapted to support people living with a dementia. People were able to bring their own furniture and personalise their bedrooms.

People spoke highly of the service and the staff. People said they were treated with dignity and respect.

People, and where appropriate their relatives, were actively involved in care planning and decision making. This was evident in signed care plans and consent forms. Information on advocacy was available.

Care plans detailed people's needs, wishes and preferences and some were person-centred, however some areas of the care plans lacked person centred information. Care plans had been regularly reviewed and we saw evidence that relatives had been invited to these reviews. Relatives we spoke with confirmed this.

The service did not currently have an Activity Lifestyle Facilitator who managed activities, but there were plans to recruit a person for this position. Staff spent time preparing and conducting activities with people and we saw a variety of activities on offer. Some people felt activities could be improved and more stimulation was needed.

The service had a clear process for handling complaints. There had been two complaints received in the past twelve months which had been managed appropriately. People we spoke with confirmed they knew how to make a complaint.

Staff told us they enjoyed working at the service, felt supported by the management and were confident any concerns would be dealt with appropriately. We could see from our observations and speaking with people that the registered manager had a visible presence at the service.

Quality assurance audits were completed by the registered manager and action plans were generated. However, effective monitoring systems were not in place and the issues we found during inspection had not been identified such as care plans were not always person centred, activities were not accurately recorded and practical fire drills had not taken place.

Feedback was sought from people, relatives, and staff. 'Comment cards' were regularly given to people and relatives to complete. The manager told us this information was evaluated and action plans produced

where needed.

Staff worked with various healthcare and social care agencies and sough professional advice to ensure that people's individual needs were being met.

The registered manager understood their role and responsibilities and was able to describe when they would be required to submit notifications to CQC.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were in place for people who needed these.

Fire drills had not taken place. Personal emergency evacuation plans lacked details on how to evacuate a person safely.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place. Safeguarding alerts had been raised with the Local Authority when required.

A recruitment process was followed to reduce the risk of unsuitable staff being employed.

Medicines were not always managed appropriately. The administrations of topical medication was not recorded accurately. The registered provider had policies and procedures in place to ensure that medicines were handled safely.

Is the service effective?

Good

The service was effective.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal.

Staff had received training to support them to carry out their roles safely and training had been refreshed when required.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to maintain their health. People spoke positively about the food and drink provided at the service.

Is the service caring?

Good

The service was caring

People spoke highly of the staff and said they were treated with dignity and respect.

Staff were knowledgeable about the likes, dislikes and preferences of people who used the service.

People had choice about how they spent their time. People told us they enjoyed living at the service.

Is the service responsive?

Good

The service was responsive

People, and where appropriate their relatives, were actively involved in care planning and decision making.

People were able to tell us about the activities on offer and told us they enjoyed the activities provided.

The service had a clear process for handling complaints. People we spoke with confirmed they knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led

Effective monitoring systems were not in place. Quality assurance audits had been carried out to monitor the quality of the service but failed to identify some of the issues we found on inspection.

Feedback from people who used the service, relatives and staff was sought.

Regular staff meetings had taken place and staff told us they were supported and included in the service.

Bruce Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 22 September 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting the service. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all the information we held about the service which included recent notifications submitted to the Care Quality Commission (CQC). We spoke with the local authority contracts and commissioning teams. The registered provider had competed and submitted a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to plan our inspection.

During the inspection we reviewed a range of records. This included four people's care records and ten people's medication administration records. We also looked at four staff files including recruitment, four staff files relating to training records and four staff files relating to supervision and appraisal. We also looked at records relating to the management of the service and a variety of policies and procedures.

We spoke with six staff members including the registered manager, training manager, operations manager, deputy manager and two care staff. We spoke with three people who used the service and three relatives.

Requires Improvement

Is the service safe?

Our findings

Personal emergency evacuation plans (PEEPs) were in place for each person who used the service. PEEPs provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. However, the PEEPs only contained information around people's mobility and aids they used to mobilise. It did not indicate what level of assistance would be required in an emergency or the person's ability to understand the emergency evacuation procedure. It did not clearly indicate the level of risk for each person in the event of an emergency. This meant that staff and emergency services did not have the information they needed to safely evacuate people.

Records showed that discussions around fire drills and what action to take should a fire occur had taken place. However, these were not practical fire drills and they were not accurately recorded. There was no information to show the time the discussed evacuation had taken place and some recording did not inform the number of participants. This meant staff had not demonstrated their competency in this area. We discussed this with the registered manager who told us they would take action to correct this immediately.

Systems were in place for the safe management of medicines. The home had a medication policy in place which staff understood and followed. People's use of medicines was recorded using a medicine administration record (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. All of the MARs we looked at contained a current photo of the persons. A photo helps staff to ensure they are administering medicines to the right person.

We reviewed ten people's MAR's and saw there were no gaps in administration. Where medicines had not been administered the reason for this had been recorded. A list of staff signatures for those staff administering medicines was stored in the front of the MARs. This helped create a clear record of who was administering medicines. However, topical medication such as prescribed creams had not been accurately documented and we saw several gaps on the topical medication administration records (TMAR). It was not clear from the records, if the creams had been administered and staff had failed to record. This meant, that potentially, there was a risk that people may not have received prescribed creams as intended by their doctor, which could result in unnecessary discomfort for the person. We spoke with the registered manager about this who told us they would address the issues and speak with staff.

This is a breach of regulation 12 (1) (2) (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We asked people if they felt safe living at the service. Everyone we spoke with confirmed they felt safe. One person said, "Yes, I do feel safe. I suppose I have never really thought about it before but yes, I feel safe." A relative we spoke with told us, "Oh yes, I am confident [relative] is safe. They treat me very well when I visit too."

We looked at arrangements for managing risk to ensure people were protected from harm. Risks to people were assessed and care plans put in place to reduce the risk of them occurring. Where a risk was identified,

further assessments took place to assist in taking remedial action. For example, a risk assessment for one person showed they were at risk of falls. This led to a moving and handling care plan being produced. Another risk assessment detailed a person who was at risk of pressure sores. A skin integrity care plan had been produced as a result and we could see that action had been taken, such as twice weekly visits from the tissue viability nurse, purchase of a pressure mattress and cushion and two hourly turns implemented when the person was resting in bed.

We looked at arrangements in place for managing accidents and incidents and what actions were taken to prevent the risk of reoccurrence. Appropriate forms were completed for each accident or incident that had occurred. Records were in place to show that accidents and incident were reviewed on a monthly basis and details were submitted to Head Office so the information could be collated and any action plans needed, developed. We spoke with staff that were knowledgeable about what action they would take if a person was suffering regular accidents. For example, making referrals to other professionals such as the falls team.

Risk assessments were in place associated with the day to day running of the service. Regular checks were made by the maintenance staff in areas such as water temperature, emergency lighting, window restrictors and fire alarms. Required test certificates in areas such as electrical testing, controlled waste, legionella and fire fighting equipment were in place.

All staff we spoke with had a good level of knowledge and understanding of safeguarding and the different types of abuse. They were able to tell us procedures they would follow should they suspect abuse had occurred. An up to date safeguarding policy was available. We looked at records relating to safeguarding. We could see that the registered manager had recorded all safeguarding concerns and these had been shared with the Local Authority. On occasions, when the registered manager had been requested to investigate a safeguarding concern by the Local Authority, this had been accurately recorded.

Staff told us they would not hesitate to whistle blow (tell someone) regarding any concerns they had. One staff member told us, "I would not hesitate to report anything to my manager or senior. I know it would be dealt with in confidence". Another staff member told us, "I think all staff here would whistle blow and I would have no problem doing it if I had concerns."

Medicines were stored securely in a locked medicines trolley. When they were not being used for medicine rounds, they were stored securely in a locked cupboard. Room and fridge temperatures were recorded twice each day to make sure medicines were stored at the correct temperature. Regular audits had been completed to ensure room and fridge temperatures were recorded.

Stock checks of medicines were carried out every month to ensure people always had access to the medicines they needed. Surplus medicines were securely stored until they could be returned to the pharmacist for safe disposal. Some people were prescribed controlled drugs. These come under the Misuse of Drugs Legislation and have strict control over administration and storage. We could see that they were securely stored and were audited on a daily basis.

We looked at arrangements for ensuring safe staffing levels. During the day, there was two senior and six carers on duty. At night there was one senior and two carers. The registered manager and deputy manager were also present most days and were not included in staffing numbers. A member of the management team was on call outside of normal working hours should staff need assistance or guidance when the registered manager was not present. The registered manager was also available outside of normal working hours if further assistance was needed.

People we spoke with confirmed there was enough staff on duty day and night. One person we spoke with told us, "They always seems to be enough staff. I can't say I have had any problems." A relative we spoke with told us, "I have wandered around a few times and struggled to find staff, but overall staffing levels seem ok. My [relative] has never raised any concerns." We asked staff about staffing levels. They told us they felt there was enough staff on duty. One person said, "Staffing levels are fine. You always wish there was more staff but we do manage on the staffing levels we have now."

During the inspection we looked at four staff files relating to recruitment. Records we looked at evidence that safe recruitment procedures were followed. Applications and interview questions had been completed. Two checked references and a Disclosure and Barring Service (DBS) check had been sought prior to staff starting employment at the service. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people from working with children and vulnerable adults.

Communal areas and bathrooms were clean and tidy. Cleaning equipment was securely stored when not in use in a locked room. Throughout the day we saw housekeeping staff cleaning communal areas, bathrooms and people's rooms.

Good

Is the service effective?

Our findings

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "We have done more training recently and I know there is a lot of training planned. I feel I have the training I need to do my job correctly." Another staff member told us, "I did an induction when I first started. It covered lots of things. Training is good, I quite enjoy it. I have done some recently." We spoke with the training manager about training. They told us that lots of training was planned in the next couple of months and the registered provider and the training manager had worked hard to improve the current training and the overall number of staff that had completed training.

We looked at a training matrix which confirmed that mandatory training for staff was up to date Mandatory training is training the registered provider thinks is necessary to support people safely. We looked at four staff files to evidence training that had been completed. Certificates were available to view on a computer system. The training manager was able to show a detailed over view of all the training that staff had completed as well as evidence the overall training achievement score for the service, which at the time of inspection was 98%. This showed that training for staff was up to date.

People we spoke with told us they thought staff were suitably trained to look after them. One person told us, "I have never had a problem. They all seem to know what they are doing." A relative we spoke with told us, "I have no complaints at all about the staff, I am sure they have all the skills they need."

Staff were supported with regular supervision and appraisal. Supervision is a process, usually a meeting, by which organisation provides guidance and support to staff. From the records we looked at we could see that these meetings were used to discuss any support needs the staff member had, as well as confirming their knowledge and performance over a period of time. Records confirmed regular supervisions and appraisals were taking place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and 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 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.

One care plan that we looked at provided details of a best interest decision that had been made with regards to the covert administration of medication. We could see that a GP had completed a best interest assessment and this was documented in the care plan. There was evidence of other professions and relatives being involved in the best interest decision.

Staff we spoke with had a good understanding of the MCA and were able to explain what action they would take if they suspected a person lacked capacity.

Staff had a good understanding with respect to people's choices and consent. We could see that consent to care had been given by people or, where appropriate, their relatives, and signed documentation was present in care plans to evidence this. These documents covered areas such as consent to treatment, sharing information, medication being administered and photographs being taken.

Some people who used the service had made advanced decisions on care and treatment and 'do not attempt cardio-pulmonary resuscitation' orders(DNACPR) were in place. These DNACPR documents had been completed by relevant professionals and were in date.

People were supported to maintain a balanced diet. People's weights were monitored and recorded on a monthly basis when required. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals if needed. Staff were able to tell us whether the people they supported had specific dietary needs and, if so, what they were. The registered manager described how information was relayed to the cook with regards to people's nutritional needs and preferences and described how the menu could be adapted to meet people's needs. This included adapting dishes to meet people's requirements (such as soft diets or diabetic diets) and ensuring alternatives were available if people did not want what was on the daily menu.

We looked at a menu plan. We could see that there was a six weekly rolling menu. There were three meal options available at lunch time and four options available at tea time. Pictures of the meal options available were also displayed on the menus, which meant it was easier for people living with a dementia to understand the meal options available. People were able to choose what they would like for lunch and tea on the morning. The registered manager told us that people often changed their minds about what meal they would like and this was not a problem and was accommodated. The registered provider used an outside catering company to provide all meals. The catering company was based on site in a large purpose built kitchen. The catering company had been provided with details of people's nutritional needs so they could adapt meals accordingly.

We saw that people were able to eat at flexible times. There was an allocated time for lunch and tea meals, but these could be changed to accommodate people's wishes. Arrangements were in place to ensure that there was enough staff to support people who required help with feeding. Refreshments and snacks were provided throughout the day. People told us they enjoyed the food at the service. One person told us, "The food is good and always nicely presented." A relative told us, "The food always looks very good, my [relative] certainly seems to enjoy it."

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, district nurses, social workers and dieticians. We could see that referrals to these professionals had been made in a timely manner and these visits were recorded in people's care records.

The service was clean and neutrally decorated throughout. Each section of the home had a theme, such as a royal theme and an 'Old Stockport' theme, with pictures and items around the service which people appeared to enjoy. The service had also developed an old style sweet shop, which was open on specific days

and people could buy items of their choice. Throughout the service there was old toys, food packaging and household item which were used as reminiscence. Each person had a memory box located outside their bedroom doors, which helped people who may be living with a dementia navigate to their room.

Good

Is the service caring?

Our findings

People who used the service told us they were very happy and staff were caring. One person said, "I love all the staff. They are always there when I need them" and "I am so well looked after here." A relative told us, "Staff are always very caring and we feel part of a family. They know [relative] very well." This relative continued to tell us how the service had gone the extra mile when it was their relative's birthday, explaining, "They had cake, wine and [relative] was given a present. [Relative] was made to feel very special."

During the inspection, we spent time observing staff and people who used the service. We saw people approaching staff for chats and to ask for assistance. One person approached the registered manager as they were unable to find a hearing aid. The registered manager assisted the person and offered reassurance. It was clear from this observation that the registered manager knew the person's needs. We also saw staff spending one to one time with people, chatting about general topics and sharing jokes as they moved around the building. This helped to create a relaxed and homely atmosphere throughout the service.

We saw staff were respectful and called people by their preferred names. Staff were patient with people when speaking with them and took time to ensure people understood what was being said. Staff members often approached people who used the service to check they were ok and had general conversations about the person's day and what their plans were for the coming week.

Staff explained to us how they respected a person's privacy and dignity, by keeping curtains and doors closed when assisting people with personal care and by respecting people's choices and decisions. We saw staff seeking permission before any care and treatment was provided to people and people we spoke with confirmed this. One person said, "I can go to my room when I wish and staff always knock before entering. Sometimes I see them passing and invite them in for a chat" and "They make sure people know what they are doing." We observed staff discreetly seeking permission from one person to assist them to the toilet. The staff member asked the person if they would like assistance to get to the toilet and only when permission was given did they assist.

Care plans detailed people's wishes and preferences around the care and treatment that was provided. We could see evidence, such as signatures in care plans, that people were being involved in care planning and, in some situations, relatives had also been involved. Relatives we spoke with confirmed they were involved in their relatives care. One relative told us, "They do tell me if anything has changed or if they have any concerns. I am here most days and the staff treat me well too."

People spent their recreational time as they wanted to and had access to communal areas as well as private space if they wished. We saw people were able to go to their rooms, as they wished, throughout the day. People chose when they wished to rise on a morning and retire on an evening and people we spoke with confirmed this. This helped ensure people received care and support in the way that they wanted.

It was evident from discussions with staff and the registered manager that all staff knew people well, including their personal history, preferences and likes and dislikes which was also documented in people's

care plans. One staff member said, "This is their homes and we all respect that. I for one treat them as if they were family. We spend a lot of time with these people and you build up relationships." A relative we spoke with told us, "The staff always have time for people and seem to know everyone really well."

People who used the service had access to independent advocates. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. The registered manager told us that people had used advocates in the past and information was available and displayed in the reception area of the service. Staff were aware of the process and action to take should an advocate be needed.

At the time of this inspection, there was no one receiving end of life care, however, information on people's wishes and preferences was documented in their care files.

Good

Is the service responsive?

Our findings

During our inspection we looked at four care plans. Care plans began with a one page profile which included people's name, previous address, birthday, family and friends, regular visitors, likes and dislikes and places of interest.

Care plans were produced to meet individual's supports needs in areas such as communication, mobility, nutrition, personal hygiene and sociability. Some care plans were detailed and focused on the person's preferences and were reviewed on a monthly basis. The care plans that we looked at were all up to date and some were person centred. For example, one care plan detailed what the person need support with regards to their hairstyle. This provided staff with details that '[person] should be taken to a mirror and brush placed in hand, then [person] will brush own hair into preferred style'. Another care plan detailed that a person liked to have jewellery to match their clothing and also liked a squirt of their favourite perfume each morning. However, some care plans lacked person centred information. For example, a night care personal plan for one person detailed 'things I may need help with', but this information was very basic, such as personal care, but did not provided details of how this support was to be provided.

We spoke with staff that were extremely knowledgeable about the care people received. Although some person centred information was not recorded in care plans, staff knew what care was to be provided.

Staff were responsive to the needs of people who used the service and people and relatives that we spoke with confirmed this. One person told us, "They [staff] are all great. I don't know what I would do without them. They know me inside out." A relative we spoke with said, "They know [relative] as well as I do and they have wonderful relationships."

People were supported to access activities which they enjoyed. The service did not currently employ an activities coordinator, but the registered manager told us this was something they were addressing. Staff were responsible for arranging and providing activities such as movie afternoons, coffee mornings, board games, ball games and sing-alongs. Outside entertainers also visited the service, which included singing entertainment, gospel hymns and 'movement to music'.

The deputy manager told us of church groups that visited the service to provide support with activities as well as relatives who assisted with gardening and beauty therapy days. We looked at records of activities that had taken place. We could see that trips to the local community had been arranged and attended by some of the people who use the service. Trips included visits to the 'airport pub' and afternoon tea at 'The Plaza'. Some people had been supported on a one to one basis with visit to the local church for holy communion and church services. However, recordings of some of these activities did not provided sufficient details. There was no clear indication as to if people had enjoyed the trip and weekly planners for activities taking place were not completed.

We asked people who used the service about activities on offer. People told us, "There is always something to do" and that staff "Keep them busy." A relative we spoke with told us, "There are activities but I think

people need more stimulation. I think more activities could be done." We spoke with the registered manager about this who told us this was one of the reasons they were looking to recruit a full time activities coordinator for the service.

We were given a copy of the registered provider's complaints procedure. The procedure gave people details about who to contact should they wish to make a complaint and timescales for actions. The deputy manager told us that both them, and the registered manager, spoke with people on a daily basis so people who used the service would generally express any concerns they had to them and this was encouraged by management. One person told us, "I would speak to [registered manager] if I had any problems. To be honest I could speak to any of the staff. I can't say I have any complaints at the moment." Another person told us, "I don't need to complain, I am happy here."

We looked at the record of complaints. Two complaints had been received in the past 12 months. The registered manager told us that complaints were submitted to Head Office and they would instruct if further action needed to be taken. We could see that complaints had been dealt with appropriately and full responses given to the complainant. The registered manager was knowledgeable about the procedure that was to be used when managing complaints

Requires Improvement

Is the service well-led?

Our findings

The registered manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services, ensuring they provide people with good services and meet the appropriate quality standards and legal obligations. Monthly audits were carried out in areas such as health and safety, infection control, nutrition, medication, care plans, and pressure relieving equipment. From the records we looked at, we could see action plans had been developed, where issues had been identified, to ensure remedial action was taken. For example, a care plan audit had identified that a risk assessment required updating. Action had been taken to update the risk assessment as a result. However, these audits were not an effective monitoring systems. The quality audits completed by the registered manager had failed to identify that practical fire drills were not taking place so staff had not demonstrated their competencies in this area.

During the inspection we identified that inadequate information was contained in PEEPS which meant that staff and emergency services did not have the information they needed to safely evacuate people in the event of an emergency. Quality audits that had been completed had failed to identify this. Topical medication administrations was not always being recorded for prescribed creams which meant that people could be at risk of not receiving prescribed medication. The monthly medicines audit that was completed had failed to identify this.

Recordings of some of these activities that had taken place did not provided sufficient details. There was no clear indication as to if people had enjoyed the trip and weekly planners for activities taking place were not completed. Quality audits had failed to identify this. We spoke with the registered manager about this who told us that they 'were aware' recordings were poor but no action had been taken to address this.

This is a breach of regulation 17 (1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The registered manager had been in post since March 2008. The registered manager had a clear vision of the culture of the service and told us, "We aim to continuously improve. We are always looking for ways to develop the service. We recently developed and opened an 'old style sweet shop' within the service which people have responded well to. We have plans to develop a pub and we already have a café area that we plan to develop further."

People who used the service spoke positively about the registered manager and told us they were "caring" and "[registered manager] is lovely." We could see the registered manager had a visible presence at the service and regularly interacted with people and relatives. There was a management office located on the ground floor of the service and throughout the day of inspection we saw people coming into the office to speak to management. The registered manager and deputy manager spent a lot of time with people who used the service and staff, having conversations with people about their health, any plans they had for the coming week and observing practice around the service.

We asked staff about the management of the service. All staff we spoke with confirmed they were supported by management. One staff member told us, "[Registered manager] is a great manager. I have never had any reason to complain and the home runs smoothly." Another staff member told us, "I have worked in other homes and this one is different. The manager is approachable and I for one feel listened to."

Regular staff meetings had taken place with the most recent in June 2016. Meeting were arranged for senior staff, care staff, night staff and housekeeping staff. Minutes of the meeting showed that staff were given the opportunity to share their views and management used the meeting to keep staff updated with any changes within the service. From the records we looked at we could see that these meeting were well attended by staff.

Questionnaires were not sent to people who used the service to gain their views. However, feedback was sought through 'comment cards' that were given to people and relatives on a regular basis. This allowed people to express any concerns or areas of the service that could be improved and also the opportunity to comment on positive aspects of the service. A box was available in the reception area of the service so 'comment cards' could be submitted anonymously if people chose. The comments cards were then evaluated by the registered manager and submitted to the Head Office where actions plans would be developed if required. The registered manager told us they had received no negative feedback or concerns that required action to be taken. People we spoke with confirmed they had the opportunity to complete 'comment cards'.

The manager also completed 'spot checks' around the service, which included observations of the lunch time routine and checks on night staff. Where concerns had been identified, an action plan had been developed and we could see action had been taken as a result.

From discussions with the registered manager, we could see that continuous improvements were being made to the service to met the needs of people living with a dementia, such as the 'old style sweet shop' and the café area that was in development. People who used the service were at the centre of this. The registered manager had plans to develop the service further to meet the needs of people living with a dementia. The registered provider had recently recruited an 'ambassador' for dementia care and there were plans in place for the 'ambassador' to visit the service and have discussions with relatives and people who use the service to allow them to gain further knowledge of dementia. The service had also begun a process to ensure all staff were 'dementia friends' which would increase their knowledge and understanding of dementia.

The manager understood their roles and responsibilities and was able to describe the notification they were required to make to CQC. Safeguarding alerts had been submitted to the local authority when required.

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 PEEPS contained insufficient information regarding how to safely evacuate people in an emergency. Fire drills had not taken place. Topical administration records were not appropriately used to record when prescribed topical medication had been administered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance audits failed to identify that PEEPS did not recording appropriate information on how to evacuate people safely. People's activity records did not providing sufficient details. Fire drills had not taking place so staff competencies had not been assessed. Topical medication administration records did not record medication administered.