Mr. Liakatali Hasham

Crest Lodge

Inspection report

Churt Road
Hindhead
Surrey
GU26 6PS

Tel: 01428605577
Website: www.chdliving.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 April 2018 and was unannounced.

The last inspection was on 27 April 2017 and we rated the service Requires Improvement in the key questions of Safe, Responsive, Well-led and overall. We asked the provider to complete an action plan to show what they would do and by when to improve these key questions to at least 'Good'.

Crest Lodge is a 'care home'. People in care homes receive accommodation with nursing and personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to accommodate up to 47 people with mental health needs. The main building has three floors of accommodation and there is additionally a two bedroom bungalow in the grounds. Communal rooms are situated on the ground floor of the main building. The provider employs registered mental health nurses and general nurses who work at the service 24 hours a day. At the time of our inspection 43 people were living at the service. Everybody had a diagnosis associated with a long term mental health need, although people had a range of different needs including psychosis, brain injuries, anxiety, depression, Schizoaffective disorders, Huntington's disease and dementia. Some people needed support with aggression, self-harm or self-neglect. A small number of people were supported with rehabilitation with a view to moving to a more independent setting, although this was not the case for the majority of people who required on-going long term care and treatment. Some people also had a physical disability.

Crest Lodge was the only location for the provider who was an individual. The management of the service was overseen by the CHD Living Group who employed the staff and developed policies and procedures. The CHD Living Group is a provider of care homes and home care services in London and South East England.

The registered manager left the service at the beginning of 2018. The provider had employed another manager who had previously been the clinical lead at the service. They had been in post since February 2018. They had applied to be registered with the Care Quality Commission and this application was being processed at the time of the inspection. 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 and associated Regulations about how the service is run.

People were happy living at the service. They felt well cared for and supported. They liked the staff and said that they had good relationships with them. We saw evidence of this and saw that interactions between staff and people who lived at the service were kind, friendly and positive. People felt their needs were being met. They were involved in planning and reviewing their care. We saw that they had been consulted and their opinions had been recorded.

The staff were happy working at the service. They felt well supported and they liked the manager. They told

us they had the training and information they needed to carry out their roles and responsibilities. They demonstrated a sound knowledge of essential policies and procedures and about the people who they were caring for. There were enough staff to keep people safe and meet their needs. There were effective systems for communication so that the staff had a consistent approach.

The provider had assessed whether people had the mental capacity to make decisions about their care and asked them to consent to this. Where people lacked the mental capacity the provider had acted within accordance of the Mental Capacity Act 2005 and had made decisions in their best interests alongside people's representatives.

People had enough to eat and drink from a varied menu of freshly prepared food. The staff supported people with their mental and physical healthcare needs. People were encouraged to take responsibility for staying healthy and were provided with support and guidance about this. The provider employed a mental health specialist who oversaw how people's needs were being met. They provided individual and group support, reviewed care plans and risks assessments and trained the staff so they understood people's needs.

People were safely cared for. They received their medicines as prescribed and in a safe way. There were procedures designed to protect people from abuse and the provider had responded appropriately when people had been placed at risk of harm. The environment was safely maintained and people had unrestricted access around the home and grounds.

People were able to make complaints or suggestions for improvements and the provider listened to them. There were effective systems for monitoring the quality of the service. Records were up to date, accurate and appropriately maintained. There was evidence the provider had made significant improvements to the service since 2016. There were plans for further improvements. The provider had a team of senior managers who offered support and regularly visited the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe.

There were procedures designed to safeguard people from the risk of abuse.

The risks to people had been assessed and were safely monitored and managed.

There were sufficient numbers of suitable staff to support people and meet their needs.

People received their medicines as prescribed and in a safe way.

People were protected by the prevention and control of infection.

The provider learnt from when things went wrong and made improvements as a result of these.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed so that care and treatment could be provided to meet these needs.

People were cared for by staff who had the skills, knowledge and experience to deliver effective care.

The environment was designed and decorated so that it met the needs of people who lived there.

People had consented to their care and treatment where they were able. For people who lacked the mental capacity to consent, the provider had acted in their best interests in accordance with the Mental Capacity Act 2005.

People were supported to live healthier lives and had access to

healthcare services and received ongoing healthcare support.

People were supported to eat and drink enough to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion.

People were able to express their views and be actively involved in making decisions about their care and treatment.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People's concerns and complaints were listened to and used to help improve the quality of care.

There were appropriate plans to ensure that people would receive the right care and support at the end of their lives.

Is the service well-led?

Good

The service was well-led.

There was a clear, visible and credible strategy to deliver effective care and support in a person centred way.

The provider's governance framework was effective so that improvements were ongoing and risks had been identified and mitigated.

People using the service and other stakeholders were given opportunities to share their views on the service and these were used to help make improvements.

Crest 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 comprehensive inspection took place on 4 April 2018 and was unannounced.

The inspection team consisted of two inspectors, two members of the medicines inspection team 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 visit we looked at all the information we held about the service. We looked at the last inspection report. We spoke with the local authority quality monitoring team and viewed a report from a visit they undertook to the service in February 2018. We looked at information we had received from members of the public, such as complaints. We also considered notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The provider had completed a Provider Information Return (PIR) in February 2018. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the planning for the inspection we also looked at public information about the service, such as care home review websites and the Food Standards Agency website.

During the inspection we spoke with nine people who used the service and one visiting relative. We observed how people were being cared for and supported. We looked at the environment and equipment being used. We spoke with the staff on duty, who included the mental health specialist, nurses, care workers, domestic and catering staff, the activities coordinator and the administrator. Two regional managers were at the service throughout the inspection and we spoke with them. We examined records used by the provider which included the care records of six people who used the service, six staff recruitment and training files, meeting minutes, records of complaints and other records such as audits and quality

monitoring. The medicines team inspectors witnessed the administration of medicines and looked at storage, records and information around the management of medicines.

At the end of the inspection we gave feedback to the nominated individual and the regional managers.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. Some of their comments included, ''I feel safe, there are always staff around'' and ''There is no discrimination here, everyone respects one another.''

The provider supported the majority of people to look after their money to different degrees. In some cases the staff prompted people, some people had made agreements for the staff to hold small sums of cash to help them with budgeting and in some cases the provider had access to people's bank accounts. The provider had selected a small number of staff who could access and support people with their money. There were systems for recording this. However, the provider did not carry out any additional audits of reconciliation of people's money and the responsibility for this was left to a small number of staff. We discussed this with the provider who told us they had already identified risks associated with this and had introduced a new procedure which would minimise these risks.

The provider had procedures regarding safeguarding adults and whistle blowing. The staff received training in these. The subjects were also discussed at team and individual staff meetings. They demonstrated a good knowledge of the procedures and what to do if they suspected abuse. The provider had responded appropriately to allegations of abuse by protecting people from further harm, investigating allegations and liaising with other agencies such as the local safeguarding authority.

The risks to individual people had been assessed and planned for. We saw examples of risk assessments including those associated with people's mental and physical health, self-neglect, assisted moving, skin integrity, nutrition, smoking and aggression. These were appropriately recorded and there were clear actions to help keep people safe and prevent harm. The assessments had been regularly reviewed and updated following incidents, such as a fall or changes in people's needs.

The provider had ensured that the building was safely maintained. Equipment was regularly serviced and maintained. The staff carried out checks regarding health and safety, including fire safety. There was emergency evacuation information available in the foyer and personal evacuation plans were created for each person describing how they should be supported to leave the building in the event of an emergency.

There were enough suitable staff to keep people safe and meet their needs. People told us they did not usually have to wait for care, that there were always staff available and that call bells were answered promptly. The staff told us they felt there were enough of them with comments which included, "There's enough staff generally – it can be very busy in the mornings but its ok" and "There's enough staff – there's someone in the TV lounge at all times so people aren't left unsupervised."

The provider had suitable procedures for the recruitment of staff which included formal interviews, a record of their employment history, checks on their eligibility to work in the United Kingdom, references from previous employers and checks on any criminal records from the Disclosure and Barring Service.

People's medicines were managed so that they received them safely. Cupboards and rooms were available

to store medicines securely. All medicines that required stricter controls by law were stored securely and accurately documented. Most liquid medicines had the date of opening recorded on the label. The service kept medicines to treat minor illnesses like headaches and colds. The GP had agreed that these were safe for people to use should they need them. Temperature records for the medicine fridges and areas where medicines were stored showed that medicines were kept within their recommended temperatures.

People living at the home were encouraged to maintain their independence by asking the nurses for their medicines when they were due. Nurses signed medicine administration records (MARs) to show when they had given medicines. The MARs we reviewed were complete including supporting information about a person's medicines needs, such as allergies, and "when required" or "variable dose" protocols. The protocols contain additional information for staff about the medicines. MARs were mostly printed. Best practice guidance had been followed when they had to be hand written. A care worker explained how they applied creams to people as part of their personal care. We reviewed cream administration records for two people. These records included the product name and when and where they were to be applied. Once applied the care worker signed the administration record.

The home received external safety alerts. Staff reviewed these alerts and recorded any actions taken on the copy of the alert.

The effectiveness of medicines was safety monitored. We reviewed the records and spoke with a nurse about two people prescribed a medicine that required blood monitoring. Their records contained subsequent scheduled test dates. We reviewed the care plans and MAR charts for two people who could become agitated. Whilst one person's care plan clearly described the de-escalation steps to take prior to administering the medicine, the other person's care plan lacked this level of detail. A mental health specialist was available three days a week to support people living at the home. Support they offered included additional information about their medicines.

We reviewed the three most recent medicines audits. An action plan was developed where an area for improvement was identified and improvements were tracked via subsequent audits.

The environment was clean and well maintained. People told us that they found it was regularly cleaned. We noted that some of the shower heads would benefit from limescale removal, although the problem was not enough to cause a risk of infection. The provider had procedures relating the prevention and control of infections. These included the staff wearing protective equipment such as gloves and aprons, schedules for cleaning and regular audits of infection control and cleanliness. The service had recently received the maximum rating of five stars from the Food Standards Agency when they inspected the systems and processes for infection control in the kitchen.

The provider had systems for recording and responding to accidents and incidents. The staff kept reports of all accidents and these included information on the immediate action and learning from the incident. The manager viewed all accident and incident reports and commented on these. Each month the provider analysed all accidents, incidents and complaints. Themes or repeated incidents were identified and the provider recorded the action they would take as a result of these. The regional managers worked closely with the manager to monitor incidents at the service. The organisation shared information across the services so that managers could learn from incidents in other services and share this learning with their staff team.

Good

Is the service effective?

Our findings

The provider undertook assessments of people's needs and preferences before they moved to the service. They used recognised good practice tools for assessing specific needs such as skin integrity, mental capacity and nutritional needs. They also met with the person and their representatives to discuss their needs. There was evidence of consultation with healthcare professionals involved in people's care as part of these assessments. Information was recorded in care plans so that people received care which met these assessed needs. The provider carried out reassessments following changes in people's needs and circumstances.

New staff employed by the provider undertook three days (four days for senior staff) induction training before they started working at the service. The training was classroom based and included assessments of their competency. Following this they shadowed experienced staff working at the service. The length of time they shadowed staff was dependent on their skills and experience. The provider assessed their competencies in key areas before they were able to work independently. All staff completed training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The provider had a programme of training updates in all subjects associated with the Care Certificate. Experienced staff were able to request additional training when they wanted. In addition, the provider carried out annual appraisals for all staff regularly where their knowledge of key subjects was assessed. If they failed to show sufficient knowledge or how this was applied to their role then they were asked to attend further training.

The nurses had opportunities for training in specific clinical interventions. The provider employed a clinical lead who oversaw this area of training and development for nurses. They also employed a mental health specialist who trained and supported the staff so that they had a better understanding about how to meet people's mental health needs.

There was a range of written information available for the staff on key subjects including fire safety, dementia care, end of life care and hydration.

There were effective systems for the staff to work together and communicate to deliver care and treatment. These included daily handovers of information where the staff discussed people's current needs. We observed handover on the day of our inspection. The staff used this as an opportunity to share ideas about how to support people with specific needs and resolve problems. There were also regular heads of departments meetings for all senior staff at the service, team meetings and meetings for each department. The minutes of these were recorded. There were other systems for information sharing and communication and we saw how the staff had recorded a brain storm of ideas about improving the service on a white board in the office.

The staff told us they felt well supported and trained. Some of their comments included, "We have lots of training here – now it's all done face to face which is much better than e learning'', "We have training in all the basics plus the option to do additional training if we want" and "They won't let you work on your own if someone needs a particular type of assistance until you're familiar with what the needs are."

The building was suitable and met people's individual needs. There were a number of different communal areas including lounges with games, books, music, TVs and computers, an exercise room, comfortable seating in the main foyer and two dining rooms. Everyone living at the service had their own room which they had personalised. Bathrooms were spacious and there were facilities to support people who had physical disabilities to take a shower or bath. The building was decorated with different styles and features chosen by the people who lived at the service. There was a large communal garden which included an accessible patio area.

Information about the service, such as planned activities, the complaints procedure and menus were displayed throughout the home. There were leaflets about advocacy services and other external services available in the foyer.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.

The provider had undertaken assessments of people's mental capacity with regards to making decisions about their care and treatment. People who had mental capacity had been asked to consent to their care and treatment. This was recorded along with information about choices which were explained to them. People told us that the staff asked for their consent when providing care and that they were involved in making decisions and reviewing their care. Where people lacked the mental capacity to understand or make decisions, the provider had liaised with others to make decisions in their best interests. This process was recorded. The provider had made applications for DoLS where appropriate and had systems to monitor when these were due for renewal. Conditions relating to DoLS were included within care plans and were appropriately documented.

Some people had restrictions which formed part of their plans of care. For example, some people smoked and they could only afford a certain amount of tobacco. They had made agreements with the staff so that their tobacco consumption was limited to an amount they could afford. Other people accessed the community independently, but had signed agreements regarding the time they would return home so that staff knew when to expect them. These agreements were made with people's consent and the restrictions were imposed to help keep people safe and meet their needs. They were able to discuss these restrictions so that they understood why they were in place.

People's healthcare needs were recorded within their care plans. Information was appropriately detailed and included how they should be cared for. There was evidence that the staff worked closely with other healthcare professionals. Referrals were made in a timely manner and the guidance from these professionals had been recorded in care plans. The GP visited once a week and there were effective systems to make sure they were aware of changes in anybody's health conditions. Daily care notes included observations of people's health and any changes in their needs. The staff worked closely with the community mental health teams who also visited regularly. One person had become unwell shortly before our inspection. We saw that the staff made sure the person was comfortable and safe. The staff told us they had called the doctor who was due to visit the person.

The provider had introduced a new initiative to support healthier living within the service. The staff and people using the service had helped to think about ideas to improve people's health and lifestyle. As part of this one of the communal rooms had been furnished with gym equipment. The regional manager told us the provider was purchasing additional equipment which could be accessed by people using a wheelchair. People were being supported to take part in exercise regimes. There had also been a change to the smoking policy at the service. Everyone, including smokers, had been consulted about where smokers should be allowed to smoke. As a result there was a reduction in the number of inside smoking rooms. The provider had created a sheltered outdoor space with the aim that during the better weather people would not be permitted to smoke anywhere inside the building. People were also being supported to stop smoking, with the staff providing information and resources for this. The staff had provided people with information about healthier eating and there was a focus for the whole community to talk about this. The provider had arranged for more fruit and vegetables to be available for snacks and had started to review their menu in order to develop healthier options.

People told us they liked the food. They said that there was a variety of meals. Menus were displayed and we saw that people were offered choices during mealtimes. There were snacks and drinks available when people wanted these. We saw that people were offered regular drinks. Some people had been assessed as at nutritional risk. The staff monitored their food and fluid intake, recorded this and had taken appropriate action when people had not eaten or drank enough. The kitchen staff had information about people's special diets and nutritional needs so were able to make sure the food they prepared was suitable.

Some people using the service used a Percutaneous Endoscopic Gastrostomy (PEG) feeding system. They received the right support with these. The staff had a good knowledge about the system and how to care for people who used these. There was detailed information about individual nutritional regimes within care plans. Records of the support people received showed that these care plans were followed.

Good

Is the service caring?

Our findings

People told us that the staff were caring, respectful and compassionate. Some of their comments included, ''They are all very kind'', ''They never shout, and we do not have to wait for assistance; they are always helpful'', ''The staff are good and look after me because I don't have anyone else'', ''They are kind and caring and they are very helpful'' and ''If you are feeling low, they help you and are there for you.''

We saw the staff supported people in a kind and caring way. They took the time to think about people's needs and respond to their requests. We saw that staff entering communal rooms sat and spoke with individuals asking about their wellbeing and checking if they needed anything. They encouraged people to join in with social activities or to find something they wanted to do. For example, one person was seated so they could not see the social activities taking part in the room. A member of staff sat with them and encouraged to reposition themselves and join in with the activity. During the lunch time service there was good interactions between the staff and the people who they were serving. They offered choices, asked people about their enjoyment of the meal and talked with them about things that interested them. Throughout the home we overheard the staff encouraging people and being positive. For example, we heard the staff complimenting people and people responding well with one person telling a member of staff, ''Being with the lovely people here makes me happy.''

People told us that they were involved in decisions about their care. One person said, ''Everything is discussed.'' We saw evidence of this in people's care plans. Their preferences were recorded. We observed the staff offering people choices throughout the day on our inspection. People were given information about the service and had opportunities to discuss their care, and the service in general, during regular meetings, through use of suggestion boxes and by taking part in therapy sessions. The provider's visions and values, information about equality and diversity and supporting people with dignity were displayed through the service.

People explained that they were able to maintain their independence. One person said, ''I can come and go as I like.'' Another person commented, ''I can do anything I want for myself, I am not restricted.'' People using the service were supported to develop skills, take responsibilities for their own care and be independent where they were able. This was reflected in people's care plans. People's skills and abilities were recorded and we saw that staff encouraged people to use these. Some people accessed the community independently, using local shops and amenities. People were encouraged to take a lead in an area of interest at the service. For example, some people acted as 'champions' for particular aspects of life within the home, such as cleaning, knitting, computer/IT skills, a book club and karaoke sessions. One member of staff explained, "They're really trying to promote independence here." The provider supported people who wished to manage their own medicines. Although no one was fully independent with their medicines at the time of our inspection, some people were expected to take responsibility for asking for medicines rather than waiting for the staff to approach them.

People told us that their privacy was respected. They said that staff knocked on bedroom doors and provided care behind closed doors. People had been asked whether they had preferences regarding the

gender of staff who supported them with personal care needs.

Good

Is the service responsive?

Our findings

At the inspection of 27 April 2017 we found that there was not always detailed information regarding people's mental health care. At this inspection on 4 April 2018 we found that improvements had been made. Care plans contained extensive details about people's mental health needs and how they should be cared for. The provider had employed a mental health specialist whose role included regular review of care plans and risk assessments to make sure people's needs were adequately recorded and planned for. They also provided guidance and training for the staff so that they understood about people's different needs.

The care plans also included information about people's life before they moved to the service, how they communicated and other needs. The information was clearly recorded and had been regularly reviewed and updated. The provider had a system of ''resident of the day.'' Each person had an assigned day where their individual needs were reviewed by all departments, such as the catering team, activities coordinators, nurses and care workers. People were involved in these reviews and had opportunities to ask for changes to their care plan.

People using the service told us that the staff met their needs. They said that they were able to make choices about their care and the staff respected these. Where people were unable to verbally communicate their needs, care plans included a wide range of information about how the person would express their needs and preferences. The staff had a comprehensive understanding about people's needs, personalities, likes and dislikes. They were able to speak about individual people who they cared for and the way in which they supported people showed they felt confident and knowledgeable about people's needs. During discussions between the staff they talked about how they would respond to specific changes in people's needs and shared ideas about how best to support different people.

People told us they had enough things to do and liked organised social activities. One person said, ''I would like to do more in the garden, planting some fruit and vegetables, but I like the things they do organise too.'' Another person told us, ''I get involved in most of the activities.''

Activities were appropriately advertised on notice boards around the service. There was a full and varied programme of planned social activities which included regular trips, entertainment, craft sessions and exercise. The provider employed an activities coordinator who planned different events. People were also supported to pursue individual interests and small group activities. For example, one person enjoyed computer work. The provider had purchased a package to help them develop their computer programming skills. The person had also taken on a role of supporting other people to use the computers for on line shopping and to meet their needs. Another person enjoyed knitting and had started to make blankets for a local neonatal unit. There was a book group for a small number of people who enjoyed reading and discussing books. Another person ran their own discos for others.

In addition to organised social activities, the provider ran therapy sessions and group discussions facilitated by the mental health specialist. These were led by people who used the service to discuss topics of shared

interest or needs. For example, people could talk about how they were feeling, express frustrations and work together to resolve issues.

An independent member of the local church community visited the home each month to chair meetings with people who lived at the service. Minutes of these showed that people had opportunities to discuss any concerns or changes they wanted. People were well informed about the service and able to contribute their ideas regarding plans, such as the changes in arrangements for people who wanted to smoke.

People told us they knew how to make a complaint or raise a concern. They said that they felt confident these would be listened to and acted on. We saw that the provider kept a record of complaints. These included information about how the complaint was investigated and any learning from this, as well as evidence that the complainant was given an explanation and response.

The provider had discussed people's wishes and needs for being cared for at the end of their lives. They had liaised with the local commissioning groups and family members to make sure suitable plans were in place for those people who may not be able to communicate their needs regarding this. We saw evidence of the involvement of palliative care teams to help plan for pain relief so that this would be available when people needed.

Good

Is the service well-led?

Our findings

People told us that they were happy living at the service and thought it was well managed. Some of their comments included, ''I am quite happy here, everything is perfect and there is very good staff'', ''I have lots of friends here, everyone is friendly'', ''It is a good place and there are always plenty of people about which is nice'' and ''They all seem very professional.'' The staff also spoke positively about the service. They told us that they thought it was a good place to work and they felt supported. One member of staff said, "Everything is good here. The home is decorated well and people are always safe."

At the inspection of 27 April 2017 we found that there were aspects to the management of records that required improvement. At this inspection on 4 April 2018 we found that these improvements had been made. Records were accurate and up to date. The staff recorded the care they had provided and also monitored specific needs for individuals, such as food and fluid intake, repositioning and wound care management. These records were all completed accurately and could be used to track how people were being cared for and any changes in their conditions or needs. Records were stored securely. The provider used an electronic system for care plans and risk assessments. This could be accessed remotely by senior managers within the organisation so they could identify any areas of concern. The system flagged up when reviews of care plans or risk assessments were due. Paper records were held within locked offices. The provider had systems to make sure temporary staff had access to the information they needed, such as summaries of care plans.

The provider kept a record of comments from people who used the service and other stakeholders, these included thank you cards and written compliments. Some of the comments which had been made in 2018 included, ''Your work and the care which you offer to residents is impressive and deeply appreciated'', ''Thank you for the love, passion and commitment – it is really appreciated – it is down to [the staff] that Crest Lodge is a fun and loving place to be'', ''Staff treat everyone beyond [their illness]'', ''I feel [my relative] has come a long way'', ''It makes me feel better that [my relative] is in safe hands'' and ''Thank you for being there to listen, comfort and reassure.'' There were also comments from staff. One member of staff had written to the manager, ''I am very happy that you are the manager – Crest Lodge has improved so much he home has an amazing feel and I is a pleasure and honour to work for such a wonderful person.''

The manager had previously worked at the service as the clinical lead and knew the service well. They had been in post since February 2018 and had applied to be registered with the Care Quality Commission. They were supported by a team of other senior staff including a clinical lead and mental health specialist. The provider's regional managers told us they regularly visited the service. They said they had seen improvements there and felt that it was well managed. One regional manager told us that Crest Lodge was a ''Unique home.'' They explained this by saying that even though there was a diverse range of needs they felt people there received personalised care.

The staff carried out a range of monthly audits and checks on the service. These included health and safety audits, checks on infection prevention and control and medicines audits. Where problems had been

identified the manager had created an action plan to state how improvements would be made. There were also regular audits of care plans and other records.

The manager undertook a daily audit of the service looking at the environment, how people were being cared for and how staff were conducting themselves. These were recorded. In addition they carried out spot checks where they observed the staff caring for people to make sure they did this appropriately. Any concerns and areas of good practice were identified and discussed with the staff members.

The provider asked people using the service, staff and other stakeholders to complete quality satisfaction surveys about their experiences. We viewed surveys which had been completed since October 2017. These showed that people were happy with the service. Where people had raised specific concerns these had been discussed with the person and the provider had taken action to improve the person's experience. There was evidence they had analysed the results of surveys to identify any themes. The majority of surveys showed that people were happy with most or all of the service. Comments from people using the service included, ''The staff are very friendly and caring'' and ''I am happy to live here and am very well looked after.'' Some of the comments from visitors included, ''Staff are always welcoming'', ''Crest Lodge always feels relaxed and friendly'', ''The standard of care has improved over the last year and is more professional'', ''I have always been most impressed by the care, love and attention given to residents'', ''Staff at this home work incredibly hard'' and ''The home has a warmth about it and the residents look well cared for.''

The regional managers carried out regular audits of the service. These included audits based of the key lines of enquiry and whether the service was meeting Regulations and also themed audits looking at specific areas of care, such as supporting people with dementia. The manager had created action plans for any areas where concerns were identified and had regularly updated these.

The manager recorded information regarding falls, incidents, wounds, infections, complaints and safeguarding alerts each month. This information, along with information about the action taken, was shared with the provider's representatives each month. This meant that the provider had an effective overview of how the service was being managed and any areas of concern.

The provider worked closely with the local mental health community teams and commissioning groups to make sure people received care and support to access the services they needed. The local authority quality monitoring teams visited the service to carry out their own audits. There was evidence the provider had responded to their comments and taken action to make the improvements which they had requested.