Benjamin Lodge Ltd

Benjamin Lodge

Inspection report

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Date of inspection visit:
14 January 2016
05 February 2016

Date of publication:
18 March 2016

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

We carried out this inspection on 14 January and 5 February 2016. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Benjamin Lodge is situated in the village of Cottingham and is within walking distance of local shops, churches and other amenities. The home is registered to provide care to a maximum of 17 people who require support with mental health needs. Each room is single occupancy and there are sufficient communal areas. There is a car park to the rear of the building. The home is owned by Benjamin Lodge Limited.

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

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes and we found that the recording and administration of medicines was being managed appropriately in the service.

We found assessments of risk had been completed for each person and plans had been put in place. Incidents and accidents in the home were accurately recorded and monitored monthly.

The home was mostly clean, tidy and free from odour and cleaning schedules were in place. However, we found that the downstairs shower room and WC required improvements. We saw plans were in place to address this.

We saw that staff completed an induction process and they had received a wide range of training, which covered courses the home deemed essential, such as safeguarding, moving and handling and infection control and also home specific training such as mental health awareness.

The registered provider's management team understood the Deprivation of Liberty Safeguards (DoLS) and we found that Mental Capacity Act (MCA) (2005) guidelines had been fully followed. The home did not use restraint but the registered manager understood the process to ensure that any restraint was lawful.

People's nutritional needs were met. People enjoyed a good choice of food and drink and were provided with regular snacks and refreshments throughout the day. People told us they enjoyed the food and that they had enough to eat and drink. People were supported to maintain good health and had access to

healthcare professionals and specialist Mental Health services.

We found that staff were knowledgeable about the people they supported and saw they interacted positively with people living in the home. People were able to make choices and staff actively encouraged them to maintain their independence.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported on day to day basis and also during a 'Crisis'.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were appropriately actioned. We found the provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support.

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.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Risk assessments were in place and reviewed regularly which meant they reflected the needs of people living in the home. The registered provider had established links with the community to help keep people safe.

The home had a robust system in place for ordering, administering and disposing of medicines.

Is the service effective?

Good

The service was effective.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role.

The registered manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act (MCA) (2005) legislation was being followed.

People enjoyed a good choice of food and drink and were provided with regular snacks and refreshments throughout the day. People told us they enjoyed the food and that they had enough to eat and drink.

People who used the service received, where required, additional treatment from healthcare professionals and specialist Mental Health services in the community.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs. People's independence was actively encouraged.

People were offered choices about their care, daily routines and food and drink whenever possible.

Is the service responsive?

Good

The service was responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

We saw people were encouraged and supported to take part in activities and hobbies that were important to them.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Good

The service was well led.

The service had effective systems in place to monitor and improve the quality of the service.

Staff and people who visited the service told us they found the management team to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Benjamin 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 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 was carried out on 14 January 2016 and 5 February 2016 and was unannounced. The inspection team consisted of one Adult Social Care (ACS) inspector.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The registered provider was not asked to submit a Provider Information Return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three members of staff, the area manager, the assistant manager, the proprietor and three people who lived at the home. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for four people, handover records, the incident / accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

People living in the home told us they felt safe and said the staff were there to help them if needed. One person said "I get on with people here" and "Yes I feel safe" and "I can't think of anything I'd like to change." Another said "The staff look after me, they make sure I take my medication."

Staff told us they had systems in place to ensure that people remained safe. They had established links within the local community and this enabled them to be able to telephone people directly to check on the whereabouts of people who lived in the home if they need to, for example, when people had not returned by the time they stated. We saw that the registered provider recognised that people living in the home had the right to live in an environment that was safe, conducive to their needs and free from aggression or the threat of aggression.

We saw care plans contained risk assessments that were individual to each person's specific needs. This included, for example, an assessment of risk to the individual for nutrition, hygiene, medication, mobility, physical aggression, health and relationships. We also saw room assessments for the kitchen, bedrooms and bathrooms had been completed. This ensured that risks were managed in a way that enabled people to maintain their independence. We saw Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This showed the registered manager had taken steps to reduce the level of risk people were exposed to.

When accidents and incidents had occurred we found these were accurately recorded and detailed information of the incident and what action had been taken was logged. These were audited on a monthly basis, which provided opportunity to determine whether any patterns were developing and put in appropriate interventions to minimise the risk of them occurring again. There had been no accidents or incidents in the previous 12 months that required reporting to either the local authority safeguarding team or to the CQC as part of the registered provider's registration requirements.

We spoke with staff about safeguarding. They were able to describe the different types of abuse, how they could be identified and also what action they would take should they witness any abuse. One staff member told us "If I saw anything I was not happy with I would speak to the manager or take it higher if needed." Another said "I'd talk to the manager or just go straight to the owner or the safeguarding team if I needed to." We looked at the home's training record and found that all but one member of staff had completed training in Safeguarding Vulnerable Adults.
On the day of the inspection we found the morning shift was covered by the assistant manager, two care staff and a member of domestic staff. Staff told us that as people were mostly independent with day to day activities they felt there was sufficient numbers of staff on duty to safely and effectively meet the needs of the people living in the home. Our observations supported this, although, we did note that during the medication round in the morning and the evening there were only two members of staff on duty. As both members of staff were need to administer medication this meant that people did have to wait a short while

for non-urgent requests.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). 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 ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions of employment. Staff were also issued with guidance on how their approach to their role could impact on the people they supported. They were told to approach work in a positive manner and it was evident from our observations that staff adhered to this guidance

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the gas installations, electrical circuits, fire extinguishers and emergency lighting. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency and that a full evacuation of the building was carried out every six months. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We looked at how medicines were managed within the home. We saw that medicines were obtained in a timely way so that people did not run out of them. The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken and when.

We checked a selection of medication administration records (MARs) and found that medication was administered on time, recorded correctly and there were satisfactory arrangements in place for the disposal of unwanted or unused medication. We did note that body maps were not always used to record where topical ointments such as creams, needed to be administered or which part of the body patches were placed. This was discussed with the staff on duty who informed us they would begin this process immediately.

All medicines were stored in the medication room. The medication room door was kept locked at all times and could only be accessed through the staff room. Medication was administered from the medication room and this meant the medication trolley was not taken from the room. The temperature of the medication fridge and medication room were monitored regularly and recorded; this evidenced that medicines were stored securely and at the correct temperature.

As the home operated with a small number of staff we found that all but one member of staff had completed training in the safe handling and administering of medication. This ensured that people living in the home received their medication when required, including during the night. We observed a medication round and saw that the majority of people waited in the lounge for their medication. People who did not come down to the lounge to receive their medication had their medication taken to them. This meant people had a choice on when and where their medication was administered. All of the people we spoke with told us they were happy with this arrangement.

On the day of the inspection we found the home to be clean and free from odour. We saw that there was a member of domestic staff employed to help support the people living in the home to keep their personal space clean and tidy and also to assist with carrying out laundry tasks. The domestic staff employed also ensured that communal living areas and bathrooms were kept clean. We saw that cleaning rota's were in place to ensure areas including the kitchens and communal bathroom were kept clean and tidy. We found the home was awarded a Food Hygiene Rating of 5 (Very Good) by East Riding of Yorkshire Council in August 2015.

However the downstairs shower room and adjacent WC were not in a satisfactory condition. We saw that black mould was present in the grout and sealant in the shower and this was also seen under the rubber shower mat. In the WC we saw that the toilet seat was broken and there was no lock on the door. We discussed this with the registered provider and area manager and they agreed that both rooms would benefit from refurbishment. When we returned for the second day of the inspection we found that a full refurbishment of the two rooms was planned to start the following day.

Good

Is the service effective?

Our findings

The staff we spoke with told us that they felt suitably trained to carry out their roles. They told us that prior to starting to work in the home they were required to complete an induction. This covered a variety of topics including values, the worker relationship, communication, confidentiality, role of the worker, needs of the client, emergency first aid, effect of stress on client / worker and policies and procedures. The induction also required the staff member to understand the home's protocol, which set out how they should approach work, acknowledged that some behaviour they may witness may not always be appropriate and also how to manage any complaints. Staff were also required to complete the Care Certificate as part of the induction process. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working lives.

We looked at the home's training records and saw that staff had received training in areas the registered provider deemed as important. This included health and safety, food hygiene, safeguarding adults, fire training, mental health awareness, moving and handling, medication, infection control, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Additional training in areas including epilepsy, diabetes, dementia care, pressure care and vision and dental awareness had also been completed. A small number of staff had yet to complete some elements of the training. However, we saw that training was already booked for them to complete at the next opportunity. This meant staff had the skills and knowledge to effectively support people living in the home.

Staff told us they felt well supported, received regular supervision and also attended staff meetings. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's support needs, identify any training or development opportunities and address any concerns or issues regarding practice. We looked at supervision records and we saw the issues discussed were specific to each member of staff. This meant that staff had opportunity to discuss those issues that were most relevant to them.

We saw that staff had completed training in MCA and DoLS and were able to explain what this meant for people living in the home. Staff told us that people's capacity to make decisions could fluctuate dependent on the state of their mental health. They told us that when people living in the home were 'well' all had capacity to make decisions for themselves. However, when their mental health deteriorated they may require more support to make some decisions. We found that people's consent to the care and support they were receiving was recorded throughout the person's care plan. This included consent for the home to manage their medication where this was necessary to help maintain the person's health.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

The 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 homes 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. We found that one person was subject to an emergency DoLS authorisation due to deterioration in their health. We saw this had been granted for an initial period of six weeks. We found that the service had made no other applications to the local authority at the time of the inspection.

We discussed the use of restraint within the home and were told that they had a no restraint policy. There were clear guidelines to follow should people become physically aggressive and these involved 'distraction techniques' to diffuse any behaviour that may challenge the service. We saw that the last recorded incident of this type was in 2013.

People living in the home had access to a choice of foods which were prepared in the home by the care staff. As people were largely independent they also had access to a variety of foods that they could access themselves when out of the home. People told us they were asked in the morning what they would like for their lunch and evening meal and they also said staff would make them something different if they changed their mind. One person said "I enjoy the food and there is always a choice."

We saw that people collected their own meal from the kitchen and then took it through to the dining room to eat. We discussed this with the staff and they told us that this was to promote independence in relation to mealtimes. We saw that the dining area of the home was an informal café style environment and was used throughout the day by people who were able to help themselves to tea and coffee in this area of the home. This meant that people had access to refreshments throughout the day.

We saw that nutritional risk assessments were in place for all people living in the home and that they were weighed on a regular basis. This enabled the care staff to quickly identify whether people had experienced significant weight loss or weight gain and put appropriate plans in place. We saw that where necessary referrals had been made to the GP and dietician to address any dietary concerns. One person was cared for in bed and we saw that they had a specific risk assessment in place to minimise the risk of them choking on their food whilst eating.

Peoples health needs were supported and were kept under review. We saw evidence that individuals had input from their GP's, community psychiatric nurses (CPN), district nurses, opticians and dentist. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). We saw that people were actively involved in the management of their own health. For example, one person had requested that the strength of one of their medications be reduced. This request was actioned by the person's psychiatrist and the medication was reduced for a trial period.

Good

Is the service caring?

Our findings

The people we spoke with told us they got on well with the staff team. One person who lived in the home told us "I get on with all the staff, but I have my favourites." The relationship between people living in the home and staff was a friendly one and although they knew they could go to them for help and support when needed people did not recognise the staff as carers. This meant that people were very relaxed and comfortable in the company of staff. We saw that staff often took themselves away to allow people to have time to themselves without continual supervision. This showed that staff respected people's right for privacy.

We found that the approach from staff was professional, but friendly and caring. Staff were competent in their roles and knowledgeable about the care and support that people required from them. We saw they were able to assess people's mood and quickly intervene when people needed support to help alleviate signs of anxiety or distress. They were also able to predict how other people's behaviour would impact on the rest of the people living in the home. They understood when to offer higher levels of support or increase observations to ensure that any issues did not escalate. The actions of the staff, their ability to foresee events within the home and their level of understanding in relation to each person's needs meant that the home had not recorded any incidents of physical aggression since 2013.

We observed staff interacting with people in a manner appropriate to each person, they knew who they could have a laugh and a joke with and who would respond better to a more discreet approach. They knew to always ensure that people were given privacy if they wanted to discuss any issues and also to ensure that other people would not be upset by the content of the conversation. People were welcomed into the staff office if they wanted to have a conversation in private, which we saw happen throughout the inspection. One member of staff told us "I enjoy working here, staff and residents all click, we're like a big family and all get on. We can have a laugh and a joke with residents, I love it."

The promotion of people's independence was the focus of the service provided and 'move on' was encouraged if people were well enough to return to living independently. We saw that some people who lived in the home were highly independent and would spend time away from the home with friends, partners or visiting members of their family. Other people liked to access the facilities available to them in the local community.
There was an expectation that people were responsible for ensuring that their own rooms were kept clean and tidy, that their laundry was done on a regular basis and that they addressed their own personal care needs. Some people achieved this with minimal staff influence whereas others required repeated prompting or physical assistance from staff. We saw that tea and coffee making facilities were also available for people to help themselves throughout the day. This showed that staff recognised that providing people with basic living skills was important to the people living in the home.

We were told that two people self-medicated and saw that risk assessments were in place to ensure that this was closely monitored by the home's staff. Some people also held responsibility for their own finances and we saw people were able to withdraw money from the bank and also spent time shopping either in the

village or in nearby Hull City Centre. People either used public transport or arranged their own taxi's to take them to their chosen destination. All people who lived in the home had a risk assessment in place for accessing the kitchen and this allowed those who wanted to prepare their own meals to do so with the support of the staff team. We saw that the role of advocates was promoted in the service. An advocate is an independent person who will support people to have their say. Staff told us that some people arranged this for themselves and other people had support with this.

We saw that visitors were made welcome when they visited the home. One person living in the home had a partner who visited them on an almost daily basis and they told us they were always offered a meal if they were visiting across mealtimes and would on some occasions have both lunch and an evening meal in at the home. We only saw one family member visit during the inspection and although we did not speak with them they appeared to be relaxed in the home's environment and spent time with their relative in the communal lounge, joining in with conversation and watching TV.

We saw that the people living in the home were from diverse backgrounds. Discussion with the staff revealed there were people living at the service who had different needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that people from all backgrounds were welcome at the home and that steps were taken to ensure that all people were treated with dignity, respect and without discrimination. We saw that people were able to express themselves as they chose and that the home offered a safe environment for this to happen.

Good

Is the service responsive?

Our findings

We found that prior to people moving to live in the home pre-admission admission assessments were completed by one of the management team. This ensured that the home was able to safely meet the needs of the person and also assessed whether there would be any impact on other people living in the home and also on staffing levels. We saw that people had been given the opportunity to visit the home, to see their room, meet other people living in the home and also familiarise themselves with the staff team. Following the visit they completed a feedback form to inform the registered manager what their thoughts were about the home and whether they wanted to accept the room that was offered. During this visit the homes expectations were explained to the person, this ensured people were aware of where they were moving to, what to expect from the service and also what the service expected from them.

We spoke to the staff and the area manager regarding care planning and they told us that allocated key workers were responsible for ensuring that the care plans were kept up to date and reflected the person's needs. The area manager explained that key workers had developed good relationships with the people they supported and therefore were most knowledge about a person's requirements. This enabled them to quickly assess if a person's level of need within one of the aspects of care planning had changed. This meant people's needs were continually assessed and care plans could be updated regularly to reflect this.

We saw that the care plans were individual to people's needs. They contained a one page profile that explained people's likes and dislikes, favourite foods, hobbies and past times and also information regarding places they previously lived and the people in their lives that were most important to them. Care plans incorporated 24 different aspects of a person's care including, for example, Hygiene, Activities / Social, health, weight, reviews, visitors, what makes you happy / sad, and aims for the future. We found that where a care need was identified a tailored care plan had been developed to ensure that their needs were met in a manner the person was happy with. Risk assessments were also completed and where risk were identified plans were put in place to minimise this. People living in the home also had risk and relapse plans within their care plans and we saw that these were incorporated into the homes care planning to ensure all involved knew how best to respond when peoples mental health deteriorated.

People living in the home came from a diverse background and as a result had a variety of interests and chose to spend their time in different ways. Some people enjoyed spending time away from the home either with their friends and families or by pursuing their own interests or hobbies. We saw that people liked to go out shopping into the local village or into nearby Hull City Centre. One person told us they liked to attend church every Sunday and this was something they were able to do by themselves and it gave them chance to meet up with their friends within the church community. We observed other people spending time watching TV, listening to music or talking with other people who live in the home or with staff if they chose to.

We spoke to the area manager and the staff regarding whether any activities were offered within the home. They told us that activities including bowling, cinema, meals out, bingo and day trips out were offered in addition to seasonal activities including events such as bonfire night, Halloween, Hull Fair, Easter and

Christmas. They also tried to offer more formal activities but found that people generally refused to join. The area manager informed us that they were in the process of improving the Wi-Fi signal in the home to ensure that all people living there were able to access the internet. This would provide opportunity for people to complete on line courses, manage their finances and communicate with their families.

We found that there were opportunities for people living in the home to raise concerns or provide feedback regarding the home to the staff and management team. Regular meetings for people living in the home were held and were used to discuss different issues for example the homes food menu, activities that had been arranged and any issues people had with their rooms. People living in the home were also allocated a key worker who was responsible for providing some designated one-to-one time at least once per month. This time was often used to have a general catch up and find out how the person was, however it also provided another opportunity for people to inform staff of any issues they had.

People told us they knew how to make a compliant if they wanted to and one person said "I would just speak to a member of staff." There was a complaints procedure in place and we saw this was on display in peoples care files and also in the homes entrance. We looked at the complaints file and found that the complaints the home had received were audited on a monthly basis. We saw that when complaints had been received they were investigated and responded to in writing by a member of the management team to the satisfaction of the complainant. For example, We saw that that three people had complained about the conduct of another person living in the home. This was addressed by the homes staff and the person accused made an apology to all of the complainants. We did note however that the contact details for the local safeguarding team and the CQC were both out of date. The area manager told us this would be updated immediately.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager in post. At this inspection there was a registered manager in post who registered with the Care Quality Commission (CQC) in July 2011. The registered manager was not at the home on either day of the inspection as they were providing support at another of the registered provider's homes, however, managerial support was provided across the week by either the registered manager, area manager, assistant manager and if needed the proprietor.
We asked staff if they felt well supported even when the registered manager was not present. Staff told us that having different managers working within the home provided them with a greater choice of people they could talk with and actually considered this to be a positive arrangement. All of the people we spoke with told us the management team were approachable and said they operated an open door policy. We saw that the area manager clearly had a good relationship with both the staff team and people living in the home and this enabled them to freely discuss any issues they had at the earliest opportunity. One member of staff said "The management are spot on, I can go to them with anything" and "They are easy going and this creates a relaxed atmosphere to work in. I love it here."
The area manager was aware of the needs of people living in the home and knew what measures to take to ensure that minor issues did not escalate. We observed them providing staff with clear instructions on how to manage people's safety during periods of heightened stress or anxiety. For example, we saw that one person living in the home had recently experienced deterioration in their mental health. We saw that the area manager advised the staff to increase the frequency of observations and also to encourage the person to follow the plan the plan of care that had been agreed with the person. This ensured staff had clear guidance regarding the type of intervention required and this helped to provide the support people needed and maintain the smooth running of the home.
In addition to the supervision staff received, staff meetings were also held on a monthly basis. Staff told us they found these meetings useful and that they provided a good overview of any changes that had occurred in relation to any of the people living in the home. It also provided a forum to discuss any concerns or issues that staff may currently be experiencing and ensured that these did not escalate. We saw that staff meetings were also an opportunity for the management team to feedback any of the issues raised during their management meetings and to also provide staff with a comprehensive description of any new admissions into the home. This helped ensure that staff were aware of any changes to the service and also had a thorough understanding of the needs of people they supported.

We saw that the registered manager completed a number of 'manager's checks' to ensure that systems in place within the home were working and had been adhered to by staff. These checks included, for example, audits on medications, infection control, night staff duties, bedrooms, the kitchen, food quality spot checks, water temperatures, staff files and care plans. We saw that when issues had been identified, action had been taken to address these. For example bedroom audits had found that some of the furniture in people's rooms had become worn out and where necessary the registered provider had ensured these were replaced. This showed that the audit systems in place were working.
Quality assurance questionnaires had been distributed to people living in the home (including an easy read version), the staff and also to people's relatives. We found that the feedback received was largely positive. However, we did note that the information gathered needed collating and summarising and reporting for it

to be a more worthwhile process. This would enable the registered manager to compare results with previous years and assess the impact of any changes that had been made.
The registered provider had taken to steps to ensure that the approach of the management and staff team created a positive culture within the home. Staff were provided with the homes protocol which contained guidance on how the they should prepare for work. This included arriving at work in a relaxed mood, speaking to people in a pleasant manner and ensuring that they knocked on people's doors before entering. There was an emphasis on developing people's skills to enable them to live as independently as they were able. The registered provider was continually pushing for people who had the necessary skills and support to 'move on' and return to living independently in the community. It was hoped that more people would achieve this in the future.
Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The CQC had not received any notifications from the home since 2013. We discussed this with the area manager and found they had a good understanding of when notifications would need to be submitted and they explained they had very few incidents that required reporting. We checked the accident and incidents and safeguarding logs and found that all incidents recorded were low level and would not require a notification. This meant that registered provider was aware of the requirement to inform CQC of important events within the home.
We found the records held on people that lived in the home, staff and the running of the business were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held. This meant that people's personal and private information remained confidential.