Maria Mallaband Limited

Skell Lodge

Inspection report

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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

This inspection was unannounced and was carried out on 12 May 2016.

Skell Lodge is a large, detached house situated in a quiet area, within walking distance of Ripon city centre. The registered provider is Maria Mallaband Care Group Ltd and is registered to provide accommodation and personal care for up to twenty-three older people. On the day of the inspection there were eighteen (18) people living at the service.

This service was registered by Care Quality Commission (CQC) on 12 October 2015 and this was the first comprehensive inspection for this location.

The registered provider is required to have a registered manager in post and on the day of this inspection there was a registered manager registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 spoke positively about the service and those we spoke with said they felt safe. Staff recruitment processes included carrying out appropriate checks to reduce the risk of employing unsuitable people. Staff had received training with regard to safeguarding adults and were able to demonstrate they knew what to do in the event of suspected abuse. Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were enough staff on duty to make sure people's needs were met. Staff recruitment processes included carrying out appropriate checks to reduce the risk of employing unsuitable people. Staff had received relevant training which was targeted and focussed on improving outcomes for people who used the service. This helped to ensure that the staff team had a good balance of skills, knowledge and experience to meet the needs of people who used the service.

People received their medicines at the times they needed them. The systems in place meant medicines were administered and recorded properly and this was audited regularly by the service and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was re-assessed regularly.

People had their nutritional needs met. There was a variety of choices available on the menus, snacks were freely available throughout the home and people were supported to have sufficient food and drinks to meet their dietary needs.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

People told us that they were well cared for and happy with the support they received. People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had a knowledge and understanding of people's needs and worked together well as a team. The service had a relaxed and comfortable atmosphere.

People were involved in decisions about their care and their care plans provided information about how to assist and support them in meeting their needs. People's needs were regularly reviewed and, where necessary, appropriate changes were made to the support people received. People were supported to maintain their health and had access to health services if needed.

The provider actively sought the views of people using and visiting the service. People using the service, their relatives and other professionals involved with the service completed an annual survey. This enabled the provider to address any shortfalls and improve the service.

Staff told us they were clear about their roles and responsibilities. Staff had a good understanding of the ethos of the home and the quality assurance systems in place. This helped to ensure that people received a good quality service. They told us the registered manager was supportive and promoted positive team working.

The registered provider completed a range of audits in order to monitor and improve service delivery. Where improvements were needed or lessons learnt, action was taken.

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 had undertaken training with regard to safeguarding adults and were able to demonstrate what to do if they suspected abuse was happening.

Care and support was planned and delivered in a way that reduced risks to people's safety and welfare. Staff knew how to minimise risks whilst supporting people to live their life as independently as possible.

Appropriate checks were completed as part of staff recruitment this helped reduce the risk of employing unsuitable people. There was enough staff to provide the support people needed.

People's medicines were managed safely and they received them as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

People received the assistance they needed with eating and drinking and the support they needed to maintain good health and wellbeing. External professionals were involved in people's care so that each person's health and social care needs were monitored and met.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005. Staff obtained people's consent before they delivered care and support and knew what action to take if someone was being deprived of their liberty.

Is the service caring?

Good

The service was caring.

People were comfortable and relaxed in the company of the staff supporting them.

The relationships between staff and the people they cared for were friendly and positive. Staff spoke about people in a respectful way and supported their privacy and dignity.

People's end of life wishes were documented and respected. Guidance was provided to care staff on how to best support people.

Is the service responsive?

Good

The service was responsive.

People using the service had personalised care plans and their needs were
regularly reviewed to make sure they received the right care and support.

Staff responded when people's needs changed, which ensured their individual
needs were met. Relevant professionals were involved where needed.

We saw people were encouraged and supported to take part in a range of activities.

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

The provider actively sought the views of people and collated them in the form of an action plan to improve the service.

Is the service well-led?

Good

The service was well led.

Staff and people using the service; their relatives and representatives expressed confidence in the registered manager's abilities to provide good quality care.

There were effective quality assurance systems in place to monitor the service and drive forward improvements. This included internal audits and provider lead audits which provided positive feedback about the service.

People were encouraged to routinely share their experiences of

the service and the provider used this information to make improvements.

Skell 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 took place on 12 May 2016 and was unannounced. The inspection was carried out by a single inspector.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. The registered manager had also completed a Provider Information Return (PIR).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.

We spoke with nine people who used the service, four relatives, the registered manager, operations manager and six members of staff during the course of our visit.

We looked at five people's care records to see how their care was assessed and planned. We reviewed how medicines were managed and the records relating to this. We checked three staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

We contacted the local authority commissioners and Healthwatch to ask for their views and we have incorporated their feedback in our report. Healthwatch provided their report for their Enter and View Visit carried out on 30 October 2014.

Good

Is the service safe?

Our findings

People we spoke with told us they felt there were enough staff on duty. One person said, "I never have to wait, staff have plenty of time for you." A relative told us they visited every day and they had not witnessed any time where there seemed to be a lack of staff available.

The service had policies and procedures with regard to safeguarding adults and whistleblowing. When we spoke with staff about their responsibilities for keeping people safe they referred to safeguarding polices and confirmed they had received training about safeguarding adults. They were clear of the procedure to follow and said they would have no hesitation whistle blowing (telling someone) if they saw or heard anything inappropriate. One member of staff told us that they "Would have no hesitation in reporting a safeguarding issue." The registered manager told us all staff had received updated safeguarding training and this corresponded to the training records we looked at. Information the CQC had received demonstrated the registered manager was committed to working in partnership with the local authority safeguarding teams. The registered manager said, "We have a good working relationship with the local safeguarding team; we all need to be open and honest because we can sometimes learn and improve things as a result." The service had made and responded to safeguarding alerts appropriately.

We looked at the recruitment records for three staff and found they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. All of them had attended an interview and two references and Disclosure and Barring (DBS) checks had been obtained prior to the member of staff starting work.

The registered manager told us staffing levels were determined according to the numbers and individual needs of people. They said they had the authority to increase staffing levels if required and gave examples of instances where people required additional support, such as if people became ill or needed support to attend medical appointments. In addition to the registered manager, and ancillary staff, such as domestic and maintenance staff, there were three care staff on duty during the morning and early afternoon, with two care staff for the late afternoon and evening, although we were told this increased if occupancy increased. There were two members of staff on duty and awake overnight. Staff we spoke said that although they were busy they felt there were sufficient staff on duty. They said the good team work meant they supported each other and worked effectively together.

Where people were at risk, there were assessments which described the actions staff were to take to reduce the possibility of harm. We found that risk assessments were in place, as identified through the assessment and care planning process, which meant that risks had been identified and minimised to keep people safe. These included measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to keep people safe. Standard supporting tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments to ensure people's nutritional requirements and pressure sore risks were minimised.

There were risk assessments in place relating to the safety of the environment and equipment used in the home. For example, hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly. The service had in place emergency contingency plans, for example in the event of power failure. Staff told us on call support was always available through the registered manager or senior staff. Staff were trained in first aid to deal with medical emergencies and appropriate arrangements were in place for fire safety. There was an up to date fire risk assessment for the home and practice evacuation drills were regularly held involving both people using the service and staff. People had specific risk plans in place, which gave guidance to staff on how they should support them to leave the building in the event of a fire.

The electronic recording system meant that accidents and incidents were analysed for trends and patterns. These were automatically sent to senior managers within the organisation to review and formed part of the registered provider's monthly visits. This meant action could be taken to prevent further occurrence.

We walked around the building and saw grab and handrails to support people and chairs located so people could move around independently, but with places to stop and rest. Communal areas and corridors although homely, were free from trip hazards.

The home was clean. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

We spoke with the senior care worker responsible for handling medicines on the day of our visit about the safe management of medicines, including creams and nutritional supplements within the home. They explained that an electronic recording system was used which they found to be effective. They said since it had been installed there had been no medication errors. We observed medicines being administered, and staff explained that the system monitored each step in the process of administering medicines so that they were completed in the correct order. The system recorded the time of giving medicines and for instance if pain relief was attempted to be given outside of the recommended interval, the system would not allow completion of the administration record. The senior member of staff giving out the medicines said they had been 'wary' of the new system but found it very easy to use and would not want to return to a manual system. We saw that trained, senior care workers supported people living in the home to take their medicines in ways that maintained people's individual needs and preferences as much as possible.

Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines.

Regular audits (checks) were carried out to determine how well the service managed medicines. We discussed how these audits had been developed and improved in order to make the auditing process more robust and effective. We saw evidence that where concerns or discrepancies had been highlighted, the senior care workers and registered manager had taken appropriate action straightaway in order to address those concerns and further improve the way medicines were managed within the home.

Good

Is the service effective?

Our findings

People we spoke with were complimentary about the staff. When we asked people if they thought staff had appropriate skills and knowledge they commented, "I hear staff talking about the training they are doing." And "They certainly know what they are doing, well that's my experience." A relative said, "The staff understand my relative's needs and I know they have consulted the district nurses about certain things to help them."

We spoke with the registered manager about the training and support staff received. They explained the registered provider had a training programme which all staff completed. They told us newly appointed staff completed a twelve week induction based on the new care certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. It assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. In addition we saw induction documentation that indicated new staff were orientated to the home and that training covered information such as accident reporting, emergency situations, call bell system, and corporate policies and procedures. Staff also completed a period of working alongside more experienced staff before they worked unsupervised. This demonstrated how staff were supported to understand the fundamentals of care at the start of their employment.

The registered manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Training completed included mandatory training such as moving and handling, first aid, safe administration of medication, infection control and safeguarding adults. In addition the registered manager told us they had arranged specific training in order that staff had the skills and knowledge to support service user living at the service for example staff told they had completed training with regard to Parkinson's disease.

The registered provider was implementing an accreditation scheme based on the work of Professor Dawn Brooker called LIFE (Living In Fulfilling Environments.) This scheme focusses on meeting the needs of people living with dementia. The registered manager explained that although Skell Lodge did not provide a specialist service for people living with dementia, the accreditation process would further enhance staff skills and enhance the lives of people generally living at Skell Lodge. Prior to our inspection visit the registered manager had arranged a staff meeting to begin to look at the accreditation facilitated by the operations manager. We observed some of this session and heard staff challenge each other and participate in lively debate. This demonstrated that the staff team were open to challenge about their practice and enhance their skills and knowledge.

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 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. The registered manager told us they had made one DoLS application but had yet to receive an outcome. We looked at the records for this person and saw documentation was completed appropriately by the registered manager, who displayed a good understanding of their role and responsibility in relation to the MCA/DoLS.

Staff we spoke with were able to demonstrate an awareness of the principles of the MCA and DoLS procedures. We found examples of best interest meetings being held where people were unable to make decisions for themselves. A best interest meeting is a meeting of those who know the person well, such as relatives, or professionals involved in their care. A decision is then made based on what is felt to be in the best interest of the person. Where best interest meetings had taken place there was information in care plans about the decisions made and the reason the person lacked capacity for that decision. For example, we saw a best interest meeting had been held with regard to a 'Do not attempt cardio-pulmonary resuscitation' decision.

We also saw additional 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. This meant people's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

When we spoke with staff they demonstrated a good understanding of the MCA and supporting people to consent with particular regard to day to day care practice ensuring people's liberty was not unduly restricted. During the inspection we saw staff consulting with people and gaining their consent before supporting them with tasks. For example, in carrying out personal care tasks or assisting people to move about the home.

We reviewed one person's care records who had been identified as being a risk of malnutrition. We could see that a Malnutrition Universal Screening Tool (MUST) assessment completed (including swallowing and hydration) had been completed which had prompted the completion of additional care plans which contained clear guidance about the support required and any monitoring charts to be filled in. We saw this had been completed and the person had been weighed regularly to monitor further weight loss. We saw in another person's care plan that a referral had been made to the local Speech and Language Therapy (SALT) Team and dietician. The chef told how they added items such as cream and butter to foods to increase the calorie content of food and made high calorie smoothies to supplement people's diet where they were at risk of weight loss.

One person had significant sight impairment. We spoke to staff about this as we saw they were using a red plate. They told us the person had requested this as it made is easier for them to see their food. They also said they changed the colour depending on the meal to ensure a colour contrast. This meant people were supported to have their individual needs met.

We saw that people enjoyed their food and that there was a variety of food available to them. During lunch and tea time the atmosphere was relaxed and there was quiet music playing in the background. We saw people smile and chat with each other making lunch an enjoyable experience. Tables were set appropriately, with table cloths, cutlery, and crockery. People had been asked about their choice of meal

during the morning but this was again clarified with them before the meal was served. Everyone was given the choice, of eating in the dining room, or if they preferred having their meal in their bedroom. One person told us, "The food is lovely, I usually spend most of my day in my bedroom but come down to eat my meals." And another person said, "The food is lovely, good old fashioned home cooked." We saw that people were assisted to eat at their own pace and in a manner that promoted their dignity. People were discreetly offered clothes protectors.

Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

The service had achieved a level 5 food hygiene rating which meant that the level of food hygiene had been assessed as very good.

People were supported to have their health needs met. The registered manager told us they had good relationships with the local GP and this was reflected in the feedback we gathered from them. The GP had a regularly 'in house surgery' but was readily available at people's requests. People were supported to ensure their chiropody, optical and hearing needs were met either through home visits or staff supporting people to attend community appointments.

The home was an adapted property with a purpose built extension. Some parts of the home were less accessible than others. The registered manager explained consideration was given to this during the preadmission assessment to ensure people's mobility meant they were able to access their bedrooms. We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms. There were appropriately placed chairs throughout the building for people to stop and rest if they needed. This meant people could remain as active and independent as possible.

Good

Is the service caring?

Our findings

People who used the service told us they were happy with the standard of care and support they received and all the staff were kind. Comments included, "I am very well cared for here, the staff are marvellous." And "Staff do anything for you, I have everything I need and would recommend it [the service] to anyone." A relative told us, "They go the extra mile; they even made sure the pictures in his room related to his past work life which is what he lived for."

We spent time in the lounge areas of the home. Staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. We observed a member staff kneeling down to be on the same level as someone and chatted to them in order that they could have good eye contact with the person. They also held their hand in an easy and relaxed manner. We observed there was a relaxed and sometimes jovial atmosphere.

We observed that staff approached people with respect and concern for their dignity. Staff told us that they respected people's right to privacy and dignity and spoke about using a kind tone of voice, listening to people and being sure to support people discreetly and in a way which made them feel comfortable. We saw care been taken to ensure people's dignity was maintained for example covering people's knees with a blanket. We saw staff knocked on bedroom doors and awaited for a response before they entered.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. We heard one member of staff say to someone, "You usually have a cup of tea in the afternoon or would you like coffee instead today?" This demonstrated that staff didn't make assumptions about people's choices and recognised the right people had to change their mind. When we asked one member of staff if they enjoyed working at Skell Lodge they said, "You have to have both a passion to work here and show compassion towards people, it's the only way."

People told us about special events and made particular reference to the Christmas tree memorial service stating it is; "very special" and "so kind and thoughtful." The registered manager told us during one particular year a number of very long standing residents had died. The staff team decided to invite back relatives and hold a service around a Christmas Tree in the garden. This has since become an annual event. As is the communal Christmas cake making. People also talked to us about 'cream teas', explaining they were traditional cream teas served from a trolley and cake stands. The service held a monthly luncheon club inviting members of the local community and people living in a supported housing scheme nearby.

We noted a comment from a recent survey stated written, "Every effort is made to make things memorable for the residents when there is something to celebrate."

We saw that visitors came to the home throughout the day and that they were made welcome by staff. They chatted to other people who lived at the home as well as their relative or friend. Family members told us that they were made to feel welcome at all times and that they were well looked after. People's confidential

information was kept private and secure and their records were stored appropriately. Staff knew the importance of maintaining confidentiality and had received training on the principles of privacy and dignity and person centred care.

We were told people had access to an external advocacy service if required and details were included in the service's welcome pack and were seen on the noticeboard.

People told us they valued that staff were local and many people living at the service and their relatives spoke of knowing staff and their families prior to coming to the service.

We noted on the activities programme that local ministers visited to attend to people's religious and spiritual needs.

Staff talked to us about caring for people at the end of their lives. They told us about the support they provided and the close liaison they had with district nurses and palliative care team to ensure people received appropriate care and medication to reduce any distress and pain. They said additional staffing was always available to ensure people were not alone and also the importance of supporting relatives, the people who lived at the home and each other at that difficult time. We saw in compliments cards written, "[name] was tended to with great compassion and empathy and afforded their dignity."

Good

Is the service responsive?

Our findings

People and relatives we spoke with told us they had been consulted about their needs prior to moving into the service. They also said they had been involved in developing their plan of care. One person said, "The manager came to visit me and we discussed what I needed, once I'd moved in she came to check everything was ok." Another person said, "I like to be independent; and that's what's happened they [staff] only help me where I want them too." A relative said, "The staff discussed with me why my husband became restless at a certain time of day. Once we'd talked it through we came up with an idea to distract him and he is more settled now."

The registered manager explained that people's care records were all stored on an electronic system which was accessed by staff via a unique password and user name. The date, time and author of the record was automatically saved and cannot be amended. The registered manager said this ensured the most accurate record and although there had been some resistance to moving away from a paper hand written record this system had proved to be more effective in terms of a readable record which could not be amended. The programme also generated prompts for staff to take specific action, for example where an accident had been recorded the computer programme would prompt that a review was required or completion of a corresponding risk assessment.

We looked at five people's electronic records and found them comprehensive and easy to follow. We saw the care plans covered areas such as personal care, mobility, nutrition, daily and social preferences and health conditions. Where we saw an area of risk identified there was an easy to follow risk assessment.

We saw care plans were written in a person centred way. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what is important to the person. For example, we saw recorded that one person liked to carry a handkerchief with them and for another person they enjoyed a cup of tea and a chat with night staff if they could not sleep. This was helpful to ensure that care and support was delivered in the way the person wanted. From our discussions with staff it was evident they knew the individual care and support needs of people.

People's care plans were reviewed monthly or when any changes had occurred. For example, one person was recovering from an infection which had affected their mobility. The care plan had been amended to reflect additional support this person needed. This meant that the person's changing needs had been monitored.

Staff completed a daily record and we saw the detail in these meant people's needs could be monitored and any changes picked up at an early stage. Staff told us they had a handover meeting at every shift change where any changes to people's needs were made known so they were able to provide appropriate care.

Although the service employed an activities organiser, the responsibility for ensuring people were offered meaningful activities and occupation was shared with the care staff. We saw a programme of activities displayed on the noticeboard and spoke with people about what was on offer. Activities included attending

Holy Communion, chair exercises, rope games and memory games. People told us there was always plenty on offer or to do and in addition we saw magazines, books and puzzles around the home for people to access. Two people we spoke with said they preferred to spend time in their rooms. One person said, "I like to stay in my room, I'm happy with my own company but staff pop in regularly to see me and have a chat." Another person told us they enjoyed reading and jigsaw puzzles, "I am kept supplied with a good book to read and I enjoy my jigsaws."

The service had a complaints procedure which we saw displayed in the reception area of the service and again on the noticeboard. People we spoke with told us they had not needed to make a complaint but would feel confident that any issues would be addressed and resolved. The registered manager said there had been no formal complaints since 2005. The registered manager said she felt this was because she encouraged people to come and speak with her at an early stage therefore any concerns were resolved quickly.

There were other opportunities for people living at Skell Lodge and their families to raise concerns or provide feedback to the registered manager. These included monthly resident and relatives meetings and an annual questionnaire, the results of which were published and were available in the entrance hall. We saw the minutes from some of these meetings and could see where issues had been raised and resolved. For example there had been some comments about a decline in the standard of cleanliness at the service during a period when there had been a lack of domestic staff. We could see from the minutes that people had been updated on the recruitment of new staff and people had been asked for their opinion on improvements once they had started work.

The service was also registered with Your Care Rating. Your Care Rating is conducted on behalf of care home providers by a market research organisation. The results are analysed and scored out of a potential 1000 points. The 2015 survey results from the 19 people who completed the survey with regard to Skell Lodge scored 965.

Good

Is the service well-led?

Our findings

People living at the service and their relatives with were very complimentary towards the registered manager. We saw recorded in a complimentary letter, "[name] is a conscientious, hardworking and emphatically caring manager who is totally dedicated to the job."

We sent the registered provider a 'provider information return' (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned within the given timescales. The information within the PIR told us about changes in the service, improvements being made and enabled us to contact health and social care professionals prior to the inspection to gain their views about the service. Without exception the feedback we received was positive. One professional told us, "This is a lovely, homely service where people are treated very well, but it also very professional and the registered manager is well aware of and takes her responsibilities seriously."

The registered manager had worked at Skell Lodge for over 25 years and had been the registered manager for 12 years. She had relevant skills, experience and qualifications for this role. Staff told us they had great respect for her. From evidence gathered through this inspection we could see they placed a lot of emphasis on people receiving high quality care which was personalised. They were able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening with staff and people who used the service. They told us they were proactive in developing good working relationships with partner agencies in health and social care and they hoped staff felt valued and supported.

Staff told us they found the registered manager supportive and they respected that she 'rolled her sleeves up' and worked alongside them, knew people well and had a visual presence in the service. Staff meetings had been held at regular intervals, which had given staff the opportunity to share their views and to receive information about the service. Staff told us that they felt able to voice their opinions, share their views and felt there was a two way communication process with managers and we saw this reflected in the meeting minutes we looked at.

The registered manager was supported by senior care staff who had also worked at the service for many years. Senior staff told us the staff team had a shared ethos for the home which was to provide the best care they could. They also shared with us a desire to maintain a homely and intimate environment. When we spoke with relatives and people who lived at the service they told us the attitude of staff and the small homely feel of the home had influenced their decision to move there.

The registered manager was also supported by an operations manager and other registered managers within the registered provider group. The registered provider had an established governance programme which required the registered manager and operations manager to complete audits in order to evaluate the quality of the service and identify any shortfalls. Results of the audits were analysed and action points with time scales developed. We viewed audits and saw they included regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, firefighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and

develop.

Monthly audits and monitoring undertaken by the operations manager helped learning from events such as accidents and incidents, complaints, concerns and whistleblowing. The results of audits helped reduce the risks to people and helped the service to continuously improve.

The registered manager had sent us statutory notifications about important events at the home, in accordance with their legal obligations. They kept us regularly informed of the progress and outcome of investigations they completed when issues or concerns were raised.