Milkwood Care Ltd

Castleford Lodge

Inspection report

Castleford Hill
Tutshill
Chepstow
Monmouthshire
NP16 7LE

Tel: 01291408151
Website: www.milkwoodcare.co.uk

Date of inspection visit:
17 October 2017
18 October 2017

Date of publication:
13 December 2017

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 took place on 17 and 18 October 2017 and was unannounced. It was the service's first inspection since its new registration with the Care Quality Commission in June 2016

The service was on the same site as one of the provider's nursing homes but was managed separately. It had its own secure grounds. The service provided care and rehabilitation to a maximum of nine people who lived with acquired brain injuries. It did not provide nursing care.

It was managed by an experienced registered manager. 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 lived in a safe environment and risks which could have an impact on people's health, safety and welfare were assessed and managed. People were also supported to recognise their own personal risks and taught to manage these as part their rehabilitation. People were looked after by staff who received appropriate training and support to be able to meet people's very specific and diverse needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and ethos of the service supported this practice. Where people were unable to make their own decisions about where they lived and about their care and treatment, these were made in their best interests and according to the principles of the Mental Capacity Act. Authorisations under Deprivation of Liberty Safeguards were met. People were supported to eat and drink in a healthy way and they had access to health care professionals when needed.

People's care was delivered in a caring and thoughtful way. People had good relationships with the staff who afforded them respect and maintained their dignity. People's human rights were upheld and their preferences in life were supported. Family members were encouraged to be fully involved and to support their relative, where this was appropriate and where the person wanted this to happen. People were involved in the planning of their care and were able to discuss this with staff on a daily basis if needed. Opportunities for people to be involved in social and therapeutic activities had increased over the last year. If people want to commit to some form of work they were supported to do so. People were taught new life skills with the aim of them living more independently where this was possible. People were supported to go on holiday.

The service had a strong leader who valued staffs' ideas and commitment. There were good communication arrangements in place with relatives and their suggestions and involvement was also valued. Quality monitoring arrangements were in place to ensure the standard of care and service provided remained in line with people's expectations. These arrangements also ensured the service complied with relevant regulations. Improvements had been made to the service and these were continuing to be made when we

visited.

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 were protected against risks that may affect them. Environmental risks were also monitored, identified and managed.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

People were supported to receive their medicines safely.

People lived in a clean environment where there were measures in place to prevent the spread of infection.

Is the service effective?

Good

The service was effective.

People received care and treatment from staff who had been trained to provide this. Staff received appropriate support to understand how to care for people living with acquired brain injuries.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's short-term and long-term health needs were met.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff. Staff worked in a flexible way and had adopted a personalised approach to care.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and their care planned around their needs, goals and aspirations.

People had opportunities to socialise and take part in activities which were meaningful and which also had a therapeutic value.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led.

People and staff had benefited from the registered manager's strong and experienced leadership.

People, relatives and staff were communicated with in a way which suited them. Their ideas and feedback was valued and acted on.

There were arrangements in place to monitor the service and to ensure it provided a high standard of care and met with necessary regulations. Improvements had been made to the service and continued to be made.

Castleford 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 17 and 18 October 2017 and was unannounced. The inspection was carried out by one inspector. This was the service's first inspection since its new registration with the Care Quality Commission in June 2016.

Prior to the inspection we reviewed the information we held about the service. This included a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted to the Care Quality Commission on 29 March 2017. We reviewed statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events. We reviewed a report produced by 'Inclusion Gloucestershire' (Gloucestershire Voices) who reviewed the service in December 2016 and again in July 2017.

During our visit we were introduced to eight people who lived at 'the Lodge' as it is known to them. We spoke with three people in more detail to gather their view of the services provided. We spoke with two relatives. We spoke with the registered manager, acting deputy manager and a senior operations manager. We also spoke with two support workers, the activities support worker, maintenance person and a visiting professional who delivers training to staff. We sought the views of those who commission with the service and of health and adult social care professionals.

We reviewed two people's care records which included care plans, risk assessments and records relating to their mental capacity. We observed medicines administered to five people and reviewed their medicine records. We also reviewed other records relating to the overall management of medicines in the service. We reviewed three staff recruitment records, staff training certificates and the service's training record. We reviewed maintenance records which included the service's Fire and Legionella risk assessments and Emergency Contingency Plan. We reviewed a selection of audits and reports completed by the registered

manager and the operations manager.

Good

Is the service safe?

Our findings

People told us they felt safe. One person went on to explain how the staff gave good explanations and how this personally helped them to feel safe. They said, "Explanations are given. I need to know how it works so that I can then feel safe." Explanations for this person included reminders of why they needed support, why they were at Castleford Lodge and why they may be feeling anxious. Another person who was dependent on staff to keep them safe, said, "They always make sure I'm safe, I feel totally safe."

The service's goal was to rehabilitate people and support them to live as independently as possible. The registered manager told us staff therefore supported and educated people to be aware of potential risks and they helped them to manage these. They told us that by not educating people about risks, not offering people choices and opportunities for independence in life "takes more away from them than their condition." The registered manager had improved people's opportunities in life but had done this in a safe way. People who were unable to recognise risks and manage them, because of a lack of mental capacity, were supported by staff to remain safe but in the least restrictive way possible. For example, one person required more supervision and intervention from staff when the weather was warm, to ensure they drank enough fluid to remain hydrated, than when the weather was cooler.

People's care records, the people we spoke with and the staff told us that for some areas of daily living, some people were fairly independent, but for other areas, they were vulnerable and required support. There were therefore risk management processes in place which staff followed in order to reduce risks to people. The visiting trainer told us staff were provided with training which taught them how to implement these processes. Staff had received risk management training on one of the days we visited. They were also taught to carry out "on the spot" risk assessments. For example, to mentally risk assess a situation or their environment before they provided the support or care required. For example, prior to physically supporting a person to move or when supporting behaviour which could potentially have an impact on others.

Staff had been trained to recognise potential abuse, to report any concerns they may have and help support people to be aware of potential abusive situations. Staff were able to tell us what their responsibilities were and what they needed to be aware of in order to protect people. The trainer told us that the safeguarding training referred to the service's policy and procedures and that of the local authority. This meant that the staff at The Lodge appropriately shared relevant information or concerns with other professionals and agencies in order to safeguard people.

There were enough staff employed and on duty to ensure people remained safe both in their daily living and social activities. One relative said, "It's always well staffed." One professional commented, "There appears to be sufficient staff on duty to ensure residents are supported to attend community based activities." Staff recruitment records showed that staff were recruited safely in order to protect people from those who may not be suitable.

All staff had received training on for example, how to transport people safely in a wheelchair or how to transport them safely in the care home's transport. People also lived in a building which was kept safe and

where safe working systems were followed. Risks relating to fire and Legionella had been assessed and control measures were in place. For example, the water system was monitored and steps taken to keep it healthy. All fire safety systems, the alarm system, door closures and firefighting equipment were regularly checked and serviced. The trainer told us that fire training had included how to evacuate people safely and had been specific to The Lodge's environment and the people who lived in it. People who lived in apartment like accommodation, slightly detached from the main building, had also received fire awareness training. An Emergency Contingency Plan was in place and in an emergency, the provider's nursing home, situated on the same site, would provide support.

The maintenance person showed us records which demonstrated that all areas of health and safety were maintained. For example, window restrictors were checked to ensure people were not at risk of falls from a window, call bells were checked on a regular basis to ensure these operated when pressed, security arrangements were checked and the safety of all exits and pathways were maintained. The provider had specialist contracts in place for the maintenance and servicing of equipment such as the passenger lift and equipment used to move and transport people.

The environment was kept clean by the day and night support workers. Staff had received training in how to reduce the spread of infection and how to therefore clean safely. All staff cooked at various times so all staff had completed training in how to handle food safely and hygienically. The member of staff, predominantly responsible for the management of the kitchen, ensured safe systems of working, recognised by the Food Standards Agency, were implemented and maintained. The registered manager explained the service had not yet been inspected by this agency. The kitchen area looked clean and tidy and the member of staff preparing the food wore protective clothing and had their hair tied back. We observed frequent hand-washing taking place by this member of staff when we observed them. Hand washing was also seen completed by the member of staff when administering people's medicines. There were arrangements in place to safely handle the service's laundry and any clinical waste.

Good

Is the service effective?

Our findings

People were cared for by staff who received appropriate training and support. One member of staff said, "Oh we receive loads of training." Another told us the training was "very good". We saw a large group of staff receiving training during the inspection. They were both animated and engaged. One member of staff told us the training provided was always made relevant to the people they looked after or the work they completed. They said, "It then makes sense."

All new staff completed induction training. We saw records of this in staff recruitment files. This included an awareness of the provider's policies and procedures as well as other employee information. All staff completed training on fire safety, safeguarding adults, dementia care, first aid and food hygiene. The services training record also recorded training completed on equality and diversity, behaviours which challenge, diabetes and epilepsy. Staff who administered medicines completed relevant training. Training had also been delivered by health care professionals and had included specific stretch exercises and how to administer insulin.

Staff new to care completed modules from the Care Certificate. The certificate provides a framework of training and support which aims to enable staff new to care to be able to deliver safe and effective care, to a recognised standard. Some staff were ambassadors. Their role was to support staff following their training and to check their competencies. For example, one member of staff was an ambassador for safe moving and handling. They could refer staff back for more training if this was needed.

Training specific to working with people with an acquired brain injury (ABI) had been completed by a few staff. The latest report by Inclusion Gloucestershire dated July 2017 had raised the need for training specifically related to ABI. The Operations Manager told us further training was planned and would be repeated as there were now some new staff since this training had been provided. We spoke with one member of staff who had attended the original training session. They explained the benefits of this specialised training and how they had a better understanding of people's needs following this.

The Provider Information Return (PIR) stated that the registered manager worked with staff so they were aware of the standard of staffs' practice and levels of competency. During our visit we saw this to be the case. A member of staff who administered medicines told us staffs' competencies in this task were reviewed annually with observations of practice carried out in- between. Staff spoken with confirmed they received regular supervision sessions. These provided an opportunity to discuss with the registered manager any areas for further learning and reflection. Records of these sessions were kept and the staff member's overall performance reviewed during an annual appraisal.

A training need was identified during our visit. This was around the correct completion of the records in use to record mental capacity assessments and best interests decisions. All the necessary information was present, so we could see that the principles of the Act were being followed, but the variation of records were causing confusion in what needed to be recorded where. We fed this back to both the registered manager and the operations manager. The operations manager told us there was a learning need in what forms

needed to be used. They told us this would be organised.

We checked to see if the service was working within the principles of the Mental Capacity Act (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to lawfully deprive a person of their liberty. We also checked to see if the provider had properly trained and prepared their staff in understanding the requirements of the MCA in general, and the specific requirements of the DoLS.

Two people had authorised DoLS in place and one DoLS had additional conditions. We reviewed the authorisation paperwork and then asked staff if they were aware of the MCA DoLS and if these applied to anyone in the service. They were able to tell us who had DoLS, what the additional conditions were and how they ensured these were met. Staff told us how they applied the principles of the Act in practice. People were supported to make individual decisions and we observed this throughout our visit. One person confirmed they were involved in making decisions which they found hard, but staff supported them to do this. They also said, "I do not feel overtly restricted, I can go out when I want to." This person told us that when they wanted to go out, but felt they needed support to do this, this was always provided, so at those times they also did not feel restricted. Another person who was dependent on support to go out said, "Staff will take me out when I want to go out."

Staff were aware of the processes that had to be followed if people were not able to make independent decisions. Where decisions had been made on behalf of people these had been made through best interests decision processes as required by the MCA. Relevant and appropriate people had been involved in these decisions, such as health care professionals, care home staff. People's representatives had also been consulted. Where people were unable to give permission for their day to day care this was delivered in their best interests and a care plan explained what had been agreed and how this would be done. Where appropriate people's representatives had been consulted with this care planning.

Both relatives spoken with confirmed they did not hold power of attorney for health and welfare, (only for finances) but told us they were consulted and kept well informed about their relative's care, with their relative's permission. One relative confirmed their relative had mental capacity to make most other decisions and that the staff supported them to do this. The PIR stated that people were at different stages of their rehabilitation journey and what might be the right decision or the right way to come to decisions one day, may not be on another day or into the future. This demonstrated that there was an understanding that the support people needed to make decisions could change.

People were supported to have a healthy and appropriate diet to maintain their individual nutritional well-being. Potential nutritional risks and other dietary needs were assessed and managed. People's appetites, weight and blood sugar (for people who were diabetic) were monitored. Any concerns relating to these or with a person's ability to swallow safely were referred to their GP. Specific health care professionals were involved when needed to support people's health, for example, a diabetic specialist nurse or a speech and language therapist. Meals could be taken with others around the kitchen table or on a tray in people's bedrooms for example. We saw people doing both. People were able to make themselves a drink or have

one made for them when they wanted. We saw people and staff sitting around the kitchen table and conversing over a cup of tea or coffee. People could choose what they wanted to eat. One person had said "There is no real choice, but [name's] cooking is fantastic." We later observed this person eating a lunch which they had specifically requested and at the time they wanted to eat it, which was early afternoon. The main meal of the day was late afternoon/early evening and if people did not want the planned option they could have an alternative. This showed that staff were able to be flexible around people's eating and drinking preferences.

People were also involved in planning the menu, the shopping list and in some cases, doing the shopping, so their food and drink preferences could be met. We observed people's different needs, for example, some people required a drinking vessel with a top, some with a top and a straw. Whatever the need staff met this. Some people required more space for example, to access the dining table, so this was all accounted for.

People had access to health care support when needed. One person said, "Yes, I'm able to see my doctor when I need to." Care records confirmed that appointments had been held with, for example, GPs, a practice nurse, dentist and optician. If people wanted or required staff support to attend a health appointment this was provided. Apart from access to NHS Physiotherapy services the service employed a personal trainer who visited on a regular basis. They supported and helped people to maintain strengthening and conditioning treatment programs put into place by a physiotherapist. They also worked independently with people on a particular goal. For example, one person wanted to visit family and this had to involve the use of public transport. In order to do this the person worked on improving their strength and muscle condition to be able to stand from their wheelchair and transfer into a seat on the public transport. Professional support and reviews were also organised with regard to people's mental health.

Good

Is the service caring?

Our findings

People told us staff were caring and understanding. One person said, "The staff are great. I'm able to talk with them about anything." Another person told us the care home was "a wonderful place" and they put this down to the staff who worked there. Another person said, "All the staff are very kind." We observed staff interacting with people in a relaxed, respectful and thoughtful way. Staff obviously knew people well and they were able to appropriately alter their type of interaction as the situation required. For example, we observed gentle banter but also moments of compassion and kindness. One professional who had visited the service commented, "Residents seem happy and relaxed. Staff were friendly and able to joke appropriately with residents without seeming overly familiar or unprofessional." Both relatives told us the staff were "very good" and "very supportive".

Staff had completed equality and diversity training and the management promoted a zero tolerance of any form of discrimination. By talking with staff and managers and by looking at how they supported people it was clear that they believed equal opportunities applied to everyone they cared for, irrespective of their disability or age. We talked with one member of staff who told us people had spoken to them about their personal relationship/sexual needs and wishes. They said, "I and others here just talk to people as individuals." When telling us about how they supported one person, they said, "I see [name] for [name], not the injury." They went onto say, "I want people to see these people for who they are." In talking with other staff and during our observations this sentiment was mirrored throughout our visit.

People received personalised care tailored to their needs. The Provider Information Return (PIR) stated, "The client dictates what happens, and when. There is a very flexible routine which operates 24 hours a day." People's specific wishes, goals and aspirations were explored and staff tailored people's care and support around these. The manager explained that she was also able to work the staffing rotas as flexibly as needed to ensure staff could meet people's individual preferences. One person described their preferred daily routine and told us the staff worked around this to make it happen. One professional commented that the service "seemed client focussed." The PIR stated that the registered manager wanted to develop the personalised care approach further. It stated, "We will make our care as person centred as possible in order to make their [people's] lives as meaningful as possible."

People's right not to be treated in a degrading way was upheld. We observed how one person's needs were responded to immediately. This was done in a quiet and respectful way so they were protected from potential embarrassment. People's privacy and dignity was maintained. We observed, for example, staff knocking on people's bedroom doors before entering and any form of intimate personal care was delivered in private. Staff spoke respectfully to each other and were supportive of each other. The registered manager told us that any behaviour other than this, either in work or for example through social media was not tolerated.

People's right to private family life and correspondence was supported and maintained. Relatives confirmed they were able to visit the care home when they chose to, or when their relative preferred them to. The registered manager explained that many relatives lived some distance away but they were always supported

to make contact with their relative or staff when they wanted to. People received their own personal post. People had access to WIFI and could use their communication devices freely. Where there were legal restrictions in place, through safeguarding processes for example, these were maintained by the staff in order to protect people. People were provided with support and opportunities to maintain relationships with those who mattered to them.

Where people had thought about their end of life preferences and wishes, these were known to the staff. One person for example, had made a Living Will which the relative told us staff were aware of.

Good

Is the service responsive?

Our findings

People told us they were involved in the planning of their care. Relatives confirmed they had been given opportunities to speak on behalf of their relative. A practice encouraged by the staff, if appropriate and with the person's permission. In regard to their care, one person said, "I'm able to put ideas forward and these are facilitated."

People's needs were assessed before they moved into the Lodge, to ensure staff were able to meet these. The registered manager described the service as predominantly a rehabilitation service. Some people had stayed at the Lodge for relatively short periods of time and, after a period of successful rehabilitation, had been able to return home or live in a more independent setting. The registered manager told us people were at different stages of their rehabilitation journey and had different needs which the staff adapted their support to meet. They told us there were people who were on a longer journey but whose ultimate goal was to live more independently. Care and support for these people was therefore aimed at acquiring a new set of life skills and improved physical and mental health in order to achieve that. They also explained that there were people who wanted to be able to have more opportunities but who also wanted to remain at the Lodge. In these cases they would be supported to achieve what they want to achieve and the Lodge would remain their home. One relative who had explored other services before their relative lived at The Lodge said, "It's a brilliant half-way house for people with really complex needs." The Provider Information Return (PIR) stated, "The ethos of the Lodge is not to let the client's diagnosis define them, rather it is something that they live alongside on a day to day basis. Clients are encouraged to live in the moment, and not to focus on what has happened."

People's care was recorded in care plans which recorded the area of support required and how this was to be given. These were then evaluated on a regular basis to ensure they remained relevant. One person we spoke with was not aware records called care plans/support plans existed and they said they would be interested in seeing these. We therefore advised them to tell the registered manager about this. Another person was aware of their care plans and their relative confirmed they had been shown their relative's care plans during a care review. The PIR stated, "Families are encouraged to attend all reviews if that is what the client wishes, although there has been little uptake." During our visit the registered manager told us relatives had requested a more spontaneous update or review as and when things altered. Care records showed good communication in place with family members [where this was appropriate].

Staff had been provided with support over the last year to get more involved with these documents. Staff confirmed they had access to these on a daily basis. One member of staff said, "Everything we need to know is all in the care plans." This member of staff told us about a situation which had arisen and where they had referred to the person's care plan to help them manage what was happening. The member of staff said, "They give good guidance and so they do work." The care records we reviewed contained numerous care plans and other pieces of relevant information for staff. They gave detailed information about what the people could do independently, what they needed support with and their preferences had been recorded.

People were supported to take part in activities of their choice and which were meaningful to them. We

spoke with the member of staff who took a lead on supporting people's activities. This person was passionate about finding out from people what was important to them and what they enjoyed doing and then helping them do this. There were times when this member of staff had gone over and above what was expected of them to support people. This had involved being flexible in their working hours and working at weekends to accommodate people's wishes. The registered manager had made a comment in the PIR about the staff team generally, which stated, "I am very fortunate that staff will often go above and beyond their duty to support the client. All attempts are made to make the most simple outing an occasion." One person told us about what they enjoyed doing outside of the Lodge and how staff supported them to do this. They said, "I will always have a laugh when I go out."

At the time of our visit one person was celebrating their birthday and they had wanted to go out for a drink and something to eat. This was supported by the activities co-ordinator by them returning to work later in order to accompany the person. They said, "[Name] wants to do what people of [name's] age do so that's what we will do." We spoke with this person the next day and they had clearly enjoyed their evening out. People had also been supported to go on holiday, something the registered manager wanted to see more of in the future.

The provider had a complaints procedure and since the service had been newly registered (June 2016) two complaints had been formally recorded in the complaints file. These had been from the same person and the registered manager told us how these had been addressed. The registered manager told us she liked to "nip things in the bud" in relation to any "grumbles" received so people felt listened to and their issues addressed. The registered manager worked proactively to minimise any dissatisfaction about the service provided.

Good

Is the service well-led?

Our findings

People, relatives and staff considered the service to be well-led. Comments about the registered manager included, "approachable and very supportive", "always on hand to talk to," "I trust her, she is a very experienced manager", "wants a quality of life for the people here" and "makes us [staff] feel valued." The registered manager had previously been the registered manager of the nursing home which shared the same site. She had over 20 years of care home management experience and was a registered nurse. She had become the registered manager of the Lodge in June 2016 when the Lodge registered with the Care Quality Commission as a separate service in its own right.

Since being in post the registered manager had made several changes to the service and there had also been some staff changes. One member of staff said, "We are a team" and another staff member said that the changes had been "good". The registered manager had a clear vision and shared their expectations and values with the staff team. The staff we spoke with were totally committed to these. One member of staff said, "As far as [name of registered manager] is concerned they [the people] totally come first and that's fine with me." There was evidence to show, by way of minutes of meetings and discussions held with staff, that their ideas and suggestions were valued. One member of staff said, "If you have a suggestion you can put it forward and she [registered manager] will listen." One professional's comment about the service was, "Leadership seems strong."

Some of the changes made by the registered manager had made a significant difference to people's quality of life. One area of improvement had been the improved links with community based services and businesses in order to increase people's work and social opportunities. This had partly been in response to feedback from people and relatives when the registered manager first joined the care home. The registered manager also said, "Everyone has a right to be involved and be part of the community." If people wanted support to find employment or voluntary work they were supported to do so. For one person links with a voluntary organisation had therefore been made and the option was there as and when this person felt able to commit to joining them. In the meantime, involvement with other activities was helping to build up the person's confidence and help them acquire new life skills.

People had opportunities to make suggestions and to have their ideas heard. One person told us there were not many "collective group meetings" but they confirmed people were able to contribute to decisions made in the care home. The Provider Information Return (PIR) stated, that clients had been asked about having 'residents meetings' and their view had been that if they had any issues they would tell the registered manager or the staff on the day. We observed staff and the registered manager spending a lot of time around people, talking with them, going out with them and at times meeting collectively around the kitchen table. Relationships were observed to be relaxed and it was clear that people were able to informally discuss things with the staff. The registered manager also told us that they had organised relatives meetings which had not been attended. We were told that relatives preferred to be contacted individually when any information needed to be passed on. The PIR stated, "We have introduced a system of communication which works for them [relatives]." The registered manager told us she had regular communication with all relatives either by telephone, email or face to face. A news magazine called the 'Chronicle' was written and

printed four times a year and was available to people and sent to relatives. This provided general news from the provider, updates on events having taken place and those planned.

The provider formally sought the views of relatives and people once a year. The last customer survey had been sent out with the latest issue of the 'Chronical' so information was not yet available for collation. The previous survey had been in 2016 had highlighted the need for improved activities which we have reported on above.

There were quality monitoring processes in place to monitor the standard of care provided and to ensure the service met with all necessary regulations. We reviewed a selection of audits completed by the registered manager. These included for example, accident and incidents, health and safety and medicine audits. The findings of which, along with any actions for improvement were shared with the provider. A weekly business report, which included an update of what was happening in the service, was produced for the provider each week by the registered manager. The operations manager explained they also visited the service every other week. They were in contact by telephone and email on a regular basis in-between these visits. These arrangements ensured the provider was fully aware of what was happening in the Lodge at any given time. The registered manager told us they felt well supported. The operations manager completed a general audit of the service every three months. We saw examples of these and of how actions from previous audits or visits were followed up. A record was kept of what was followed up and when actions had been evidenced as completed.

Staff and people knew who the operations manager was and we observed them moving around the service during our visit, talking with staff and people.