Strong Life Care Limited

# Earls Lodge Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Earls Lodge is a care home for up to 50 people. It consists of one building with two floors. The ground floor Dale Unit specialises in residential care for people living with dementia and can accommodate up to 23 people. The first floor Glenn Unit specialises in nursing and palliative care and can accommodate up to 27 people.

All bedrooms are single and include en-suite facilities. Each floor has a communal lounge and dining room, as well as shared bathrooms, toilets and shower rooms. At the time of this inspection there were 44 people living at the home.

Earls Lodge was last inspected in April 2016. At that time it was rated as 'Requires Improvement' overall, with a 'Good' rating in the domains of caring and responsive.

The home did not have a registered manager. The current home manager had been in place since May 2016; they were in the process of applying to be registered manager. 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.

Not all issues with medicines documentation identified at the last inspection had been addressed. The home did not have meaningful protocols for 'when required' medicines and could not evidence people were receiving some of their topical medicines as prescribed. Other aspects of medicines administration and management were done well.

Issues with inconsistency in how risks to people were assessed and managed identified at the last inspection persisted. We saw examples of poor moving and handling practice.

We found numerous instances where people's care plans did not reflect the care and support they needed. This was a finding at the last inspection. We noted this was more of an issue on the first floor. The home manager told us they were aware of this and were already taking action.

A system of audit and monitoring for safety and quality was now in place at the home. There was regular quality monitoring by the registered provider. However, we found issues that had not been identified and addressed by the audit process; some of these had been identified at the last inspection.

People told us there were enough staff; however, two people who use the service felt that it would be unfair to request a bath more than once a week because of the number of people staff had to care for. A dependency tool was in use at the home which showed there were sufficient staff. We observed that whilst staff were busy, people's needs appeared to be met. The home manager said they would encourage people to ask for a bath or shower whenever they wanted one.

We found people's personal emergency evacuation plans were not sufficiently detailed or person-centred to be useful.

However, we found not all people who lacked capacity to consent to care and treatment had assessments and best interest decisions in place for the support they received.

People's care records did not always evidence their relatives who said they had lasting power of attorney, had been granted this by a court. We also noted a person with behaviours that may challenge others did not have a person-centred behavioural management care plan in place.

People enjoyed the food and drinks served at the home; kitchen staff could describe how they accommodated people's specialist dietary requirements. However, we found people's nutrition care plans did not always detail their specific needs and could thereby put people at risk of unsafe care.

People told us they felt safe. Staff could demonstrate they had the knowledge they needed to keep people safe from abuse. Recruitment procedures at the home were robust.

Accidents and incidents had been documented and investigated properly. Regular checks had been made on the home's equipment, utilities and facilities to make sure they were safe.

People and their relatives told us, and we observed, the home was clean and tidy. An intermittent unpleasant odour coming from the sluice on the first floor had been investigated. Further measures had been planned to try and resolve it permanently.

Staff had received the training and supervision they needed to meet people's needs. Annual appraisals were planned. This was an improvement on the last inspection. Staff were very happy with their access to additional courses and the career development opportunities these provided.

People told us, and records evidenced, they had access to a range of healthcare professionals to help maintain and promote their wider health needs. We received positive feedback about the home from healthcare professionals we spoke with during and after the inspection.

Efforts had been made to investigate and implement current evidence-based practice around good dementia care. This included the use of wall and door colours, pictures and memorabilia, activities and signage.

People and their relatives thought the staff at the home were kind and caring. We saw staff respected people's privacy and dignity, and promoted their independence.

People had access to advocacy services if they needed independent help with decision-making. People and their relatives told us they were involved in decisions about their care.

Some staff had received in-depth training around end of life care. Care workers we spoke with could describe what good end of life care involved. Feedback from relatives of people who had received end of life care at Earls Lodge was very positive. The home had purchased a memorial tree so relatives could return to the home and remember their loved ones.

Records showed people were assessed thoroughly before they were admitted to the home to ensure their needs could be met.

People gave us positive feedback about their access to activities. We observed people had lots of opportunities to socialise and have fun.

No formal complaints had been made since the last inspection in April 2016. People and their relatives told us they felt able to raise concerns with the home manager if they needed to.

Statutory notifications had been made by the home manager, when required, and the ratings from the last inspection were displayed at the home and on their website.

People, their relatives and staff at the home received annual questionnaires to feedback about the service. There were regular residents' and relatives' meetings at the home and staff had regular meetings too.

The home manager had nominated employees for awards and highlighted the contribution made by the so-called 'unsung heroes', the kitchen and domestic staff at the home. We saw the registered provider's philosophy of care underpinned the support provided by staff to people at Earls Lodge.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

We found issues with the way medicines were managed and documented. Medicines administration was person-centred.

Some risks had to people not been assessed and managed appropriately. This was a finding at the last inspection.

People felt safe; staff described how they safeguarded people from abuse. Recruitment procedures at the home ensured staff were suitable to work with vulnerable people.

The home was clean and tidy. People and their relatives told us they thought it was clean.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People who needed to have their liberty deprived to keep them safe had the correct authorisations in place. Some people who lacked capacity had not been assessed for their ability to consent to care and treatment.

People liked the food and drinks at the home. We found people's care plans did not always reflect their nutritional needs.

Staff received the training and support they needed to meet people's needs effectively.

People were supported to see a range of healthcare professionals in order to meet their wider health needs.

### Is the service caring?

**Good**

The service was caring.

People and relatives described staff at the home as kind and caring. Interactions we observed were positive and we heard lots of laughter and banter being exchanged.

Staff respected people's privacy and dignity. We also saw them supporting people to remain independent. People had access to advocates if they needed them.

Staff could describe the important aspects of end of life care. Feedback from relatives of people who had received end of life care at the home was extremely positive.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's care plans were not always person-centred. This was an issue at the last inspection.

People had good opportunities to take part in activities at the home. During the inspection we observed people and their relatives having fun together.

People and their relatives told us they would complain to the home manager if they needed to. No formal complaints had been made since the last inspection.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

A system of quality monitoring was now in place at the home. However, issues we identified at this inspection had not been identified and addressed by audit.

People, their relatives and staff were given regular opportunities to feedback about the service. We saw this had led to improvements at the home.

The home manager had used national guidance to implement evidence-based practice at Earls Lodge.

Feedback about the home manager from people and staff was positive. The home manager recognised and valued the contribution of all staff who worked at the home.

# Earls Lodge Care Home

**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 15 and 16 February 2017. The first day was unannounced. The inspection team consisted of two adult social care inspectors and one 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had been a user of healthcare services for many years and had supported adult social care inspectors on other inspections.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This 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 used the information provided by the service to help plan the inspection.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Wakefield, the local authority safeguarding team and the Clinical Commissioning Group. They did not share any concerns with us. During and after the inspection we spoke with a social worker, a podiatrist, a community nurse, an advocate, a MacMillan nurse, a staff member at the local hospice, and a staff member from the local continence team.

During the inspection we spoke with eight people who used the service, six people's relatives, five care workers, the activities coordinator, a unit lead, the home manager, the deputy manager and two cooks. We also spoke with the operations manager and human resources director for the registered provider.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

As part of the inspection we looked at 10 people's care files; this included their risk assessments and care plans. We also inspected five staff members' recruitment and supervision documents, the home's staff training records, five people's medicines administration records, accident and incident forms, and various policies and procedures related to the running of the service.

Requires Improvement

# Is the service safe?

## Our findings

People we spoke with told us they felt safe at Earls Lodge. One person said, "It's nice here and I always feel safe", and a second person told us, "I feel safe." People's relatives also thought their family members were safe.

At the last inspection in April 2016 we identified some issues with medicines management. This included handwritten medicines administration records (MARs) which had not been checked and countersigned by a second member of staff. This helps makes sure medicines information written by staff is correct. In addition, people's MARs did not include information about their allergies, or include a photograph so staff unfamiliar with people could be sure they were administering to the correct person. The MAR folder also lacked a specimen signature sheet so it was clear which member of staff had administered medicines.

At this inspection we found people's MARs included their photograph and any allergies; there was also a staff specimen signature sheet. However, we found four incidences where handwritten MARs had not been checked and countersigned by a second member of staff; one of these MARs had also not been signed by the staff member handwriting the MAR. This meant some poor recording practice identified at the last inspection was ongoing and people may not receive their medicines safely as a result.

We observed a medicines round and checked medicine storage facilities on the first floor nursing unit of the home. We saw medicines were administered to people in a caring and respectful way; each person was asked if they were ready to take their medicines and were not rushed. Medicines were received from the pharmacy in boxes or bottles. The staff member administering medicines used each person's MAR to identify which medicines to give and only signed the MAR when the medicines had been taken. One person was asleep when the staff member went to give them their medicines. The member of staff could explain the procedure for recording when medicines were not taken and the safe disposal of the tablets. We checked five people's MARs for oral medicines and found they were completed properly.

We noted one person was supported to manage some, but not all, of their own medicines. A risk assessment had been undertaken for this and the support the person required was detailed in their medicines care plan. This was a good example of the home supporting a person to retain their independence with the medicines they could manage safely.

The home's training matrix evidenced staff who administered medicines had received the training they needed to do so safely. Staff we spoke with told us they had annual checks on their competency to administer medicines; records we saw supported this.

We reviewed the home's procedure for recording and administering controlled drugs, such as morphine, and found this was done correctly. Medicines we counted tallied against records kept by staff. Medicines were stored securely and at the correct temperature. The deputy manager explained the system for ordering and returning drugs to pharmacy; we saw returned medicines were documented. This meant oral medicines and controlled drugs were administered safely by the home.

We found some oral medicines were prescribed 'when required'; in other words they were to be taken when the person felt they needed them, rather than on a regular basis. According to guidance from the National Institute of Care and Excellence (NICE), information should be available to staff administering medicines prescribed to be taken 'when required.' This should include the reason the medicine is to be given, what the medicine is expected to do and how frequently it can be given. These instructions are often called medicine protocols. For people with problems voicing their need for medicines, such as those living with dementia or receiving end of life care, protocols can provide invaluable information on the signs and symptoms which might indicate a medicine is required.

We saw most 'when required' medicines prescribed for people had protocols, although some were missing. However, the instructions on protocols did not differ from those provided on the MAR and did not contain further information as to when, how and why people's 'when required' medicines were needed. We asked the home manager about the lack of detailed medicines protocols. They told us they had been advised by a pharmacist it was against medicines legislation for the home to create medicines protocols, as they had not prescribed the medicines. This information is incorrect. It is against medicines legislation for home staff to amend GP prescriptions or the instructions on MARs but not to use person-centred information to create individualised medicines protocols. This meant the home was not following national. Shortly after the inspection the home manager confirmed medicines protocols would be put in place as part of a review of all medicines procedures. We will check this at the next inspection.

People's MARs listed the topical creams they were prescribed although we saw their application was not recorded on them. Some creams, such as prescribed barrier creams and moisturisers, were kept in people's rooms where they were applied by care workers when they supported people with personal care. A folder of cream charts for the first floor nursing unit was stored in the medicines room, although none of the six creams we checked had been signed as applied since 09 January 2017. We noted not all cream charts had body maps to show care workers where the creams were to be applied. We also checked daily records on the computer system and found the recording of creams was sporadic and did not specify which creams had been applied or where. By comparing the folder to people's MARs we found the folder did not include cream charts for all the creams that had been prescribed for people on the unit. Care workers we spoke with told us they applied the creams in people's rooms and could describe how and where they were applied. This suggested an issue with recording rather than application, but it still meant records at the home could not evidence people were receiving some of their topical medicines as prescribed.

We asked the home manager how the application of people's prescribed topical creams was recorded and evidenced by the home. They provided evidence of completed cream charts with accompanying body charts from the ground floor of the home and said the plan was for staff downstairs to share their good practice with colleagues upstairs. The home manager and operations manager also planned to add topical medicines to the home's medicines audit and make the topical medicines documentation more fit for purpose.

Issues with medicines recording and documentation were a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in April 2016 we found people who could not weight bear shared slings used for hoisting them; one sling we checked had an odour of urine. At this inspection we found each person had their own sling and a random selection of five slings was found to be clean and odour-free.

At the last inspection we also found the information in people's risk assessments was not always consistent, which could increase their likelihood of harm. At this inspection we checked people's risk assessments and

the care plans in place to manage any risks for aspects such as pressure area care and mobility. We found problems persisted. For example, we saw the frequency of repositioning three people needed to help protect their pressure areas was recorded on a whiteboard in the staff office, but not in their care plans. We also noted one person's risk assessments and care plans did not include how to support them safely to access the bath or shower. The home manager said they were in the process of reviewing people's care plans to make sure they were up to date and person-centred.

During the inspection we observed two examples of good practice when people were encouraged to mobilise with the support of staff. We also witnessed examples of poor moving and handling practice, where people were steadied by staff under their arms or by holding the waistbands of their trousers, both of which can cause discomfort to the person. We also observed staff moving a person using a hoist to a comfortable seat in a lounge area. We noted the wheelchair had a padded cushion on it but not the chair, and asked staff if the person needed a special cushion to protect their pressure areas. Staff told us they did not know, so together we checked the person's skin integrity care plan. The care plan was generic and did not specify whether or not the person needed a pressure cushion, but the care workers noted the person's skin integrity risk was rated as high, so they did need a cushion. They went back to the person and supported them to move onto an airflow pressure cushion, without being sure this was correct cushion type.

We raised the issues of poor moving and handling practice and lack of staff knowledge of people's needs with the home manager and operations manager for the registered provider. They said they would implement an audit to ensure people were receiving the correct pressure relief and provide additional training to staff on moving and handling.

Issues with risk assessment and poor practice to manage people's risk were a breach of Regulation 12 (1) and (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought there were enough staff deployed at the home to meet people's needs. One person told us, "There are a lot of staff on duty", a second said, "Plenty of staff on day and night", and a third commented, "When there's four it's better, but we still get care when there's three because they are so excellent." A relative told us they thought it was more difficult getting time to speak with staff at weekends about their family member who lived at the home; they said, "I am not sure there are enough staff at weekends, I sometimes have to wait a long time."

We also asked people about their access to baths and showers. All the people we spoke with told us they had one bath or shower a week and felt they could not ask for more as the staff were too busy. Comments included, "I would like a bath more often but the staff have so many to see", "I cannot ask for any more as staff are too busy", and, "I've sort of accepted it. It wouldn't be fair on the other residents." Staff we spoke with, including the home manager, were surprised by this; they told us people could ask for a bath or shower more than once a week if they wished to. The home manager said this misconception would be discussed with people living at the home individually and highlighted at the next residents' and relatives' meeting.

We discussed the staffing levels for each floor and for each shift with the home manager, and asked how these were allocated. The home manager showed us a dependency tool which evaluated each person's level of need and from which the number of staff hours required was calculated. We saw people's information was updated regularly; the home manager told us, "According to the dependency (tool) we always have too many staff." We made observations of staffing levels and the responsiveness of staff to call buzzers during our two days' of inspection. We noted staff were busy but people's needs appeared be met in a timely way. We will seek feedback about people's access to baths and showers at the next inspection to establish whether improvements have been made.

Staff we spoke with at the home could describe the different forms of abuse the people they supported might be vulnerable to and said they would report any concerns to a manager. They also told us they had received safeguarding training; the home's training matrix confirmed this. Senior staff knew the process for referring concerns to the local authority safeguarding team or to the Care Quality Commission (CQC). This meant staff at the home understood how to keep people safe.

We looked at records for the accidents and incidents that had occurred at the home in the three months prior to this inspection. We saw each accident or incident had been recorded in detail by the staff who had witnessed or identified the incident, and then investigated and analysed by the home manager. Documentation in the accidents and incidents file showed people's risk assessments and care plans had been reviewed and updated as a result, if required. This meant the home manager had oversight of accidents and incidents at the home and followed up each one individually to ensure prevention measures were put in place, if possible.

We inspected the recruitment records of three staff members who had recently started work at the home. All of the documentation was in order. This included an original application form evidencing any gaps in employment, references from previous employers, and a Disclosure and Barring Service (DBS) check. The DBS helps services make safer recruitment decisions. Evidence of one employee's professional registration had also been sought. This meant the recruitment process at the home was robust and ensured staff employed were suitable to work with vulnerable people.

The home could evidence regular checks were made to ensure the safety of the building, facilities and utilities. These included the testing of water temperatures, servicing of gas appliances, regular checks on moving and handling equipment, and fire alarm and emergency lighting tests. Staff had also received fire safety training, which included the use of evacuation equipment, and could describe how they would respond in an emergency. The home also used an electronic signing in system for relatives and visiting healthcare professionals. This could be used to make sure everyone in the building could be safely evacuated, if required.

We did note, however, that people's personal emergency evacuation plans or PEEPs were not sufficiently detailed for a staff member who did not know a person or the emergency services to assist them to evacuate. This was because the type of support each person needed to mobilise was not recorded. We fed this back to the home manager; they said all PEEPs would be reviewed and updated to ensure they contained the required level of detail as soon as possible.

Requires Improvement

# Is the service effective?

## Our findings

People told us they thought staff had the skills and experience they needed to support them. One person said, "Staff seem trained and are able to help me", and a relative commented, "The staff seem fully trained."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection in April 2016 we identified a breach of the regulation relating to safeguarding service users as it was not clear whether all people who lacked capacity to consent to being at Earls Lodge had a DoLS authorisation in place, or an application for a DoLS under consideration at the local authority. At this inspection we found there had been improvements, as people who needed DoLS authorisations had them or an application for one had been made. However, we found two instances when people's DoLS had been returned with conditions by the local authority and these conditions were not recorded in people's care plans. Despite this, we could find no evidence either person's liberty was being adversely affected. We raised this with the home manager; they said all DoLS would be reviewed to make sure any conditions for individuals were reflected in their care plans.

We found there was a discrepancy between the way MCA assessments and best interest decisions were documented on the different floors at the home. On the ground floor, the care files of people living with dementia had MCA assessments for various aspects of their care, for example, help with personal care and support with eating, plus records of the best interest decisions made for people who could not consent. On the first floor we found three people with DoLS had no MCA assessments or best interest decisions for other aspects of their care. This meant the ability of people on the first floor with known capacity issues to consent to their care and treatment had not been established. Again, we did not find evidence to suggest people were being supported inappropriately. We raised this issue with the home manager. They told us staff from the ground floor had already been allocated to support staff upstairs on the nursing floor, to assist them with completing MCA assessments and sharing their good practice.

We noted people's care records did not always contain evidence their relatives had been granted Lasting Power of Attorney (LPA) by a court to make decisions for them, when applicable. We saw two relatives had signed consent forms for people when their LPA had not been established. The home manager told us the home always tried to involve people's relatives. This is good practice as relatives can be consulted during

best interest decision-making for family members if they lack capacity, however relatives cannot be the sole decision-makers unless it has been established they have the correct LPA. One relative told us, "I have lasting power of attorney but I've not been asked to show a copy of it." We raised this issue with the home manager. They said they would obtain copies of the required documentation from people's relatives who said they had LPA.

We found staff members' knowledge of MCA and DoLS was appropriate for their roles. They could describe how they supported people to make decisions by providing choices and all knew the process for making decisions on a person's behalf if they lacked capacity. During our inspection we observed people were supported to be as independent as possible by staff who provided them with options and choices.

Care workers described a person at Earls Lodge who could on occasion display behaviours that may challenge others. Staff we spoke with could explain how they supported the person with their personal care and medicines, and the distraction techniques they used. When we checked the person's care records they did have a behavioural management care plan, however, it was generic and contained none of the person-centred detail the staff had described to us. This meant staff unfamiliar with the person would not be able to support the person effectively using the information in their care plans.

Feedback about the food and drinks served at Earls Lodge from people and relatives was all positive. One person told us, "The food is either very good or excellent", a second person said, "Plenty of choice. You can have a full English breakfast and porridge every day", and a third commented, "We have snacks in between meals." We observed two meals during the inspection and one of our inspection team had meals with people using the service. We saw tables were set nicely with tablecloths, napkins, cutlery and condiments. People who preferred to dine in their rooms or who were nursed in bed, received their meals there. We saw people saw were given a choice of foods; one person told us, "They ask me what I want for lunch, if I don't want what is on they will make me a sandwich of my choice." Those needing support with eating and drinking received it, although care workers encouraged people to be as independent as they could be.

We looked around the kitchen and spoke with two of the cooks. Both could explain how they modified foods for people with special requirements, such as texture or low sugar for diabetes. The most recent food hygiene inspection at the home in October 2016 had given a rating of five out of a possible five, which meant the standards of hygiene were good. We noted there was a whiteboard in the kitchen listing details of people's dietary needs, but it did not include their preferences or dislikes. This was also not recorded elsewhere in the kitchen; the cook told us they relied on care workers to give them this information. We fed this back to the home manager and operations director for the provider; they told us this information was recorded in people's care plans and would ensure the kitchen whiteboard was updated accordingly.

We noted inconsistencies in the way the way some people's nutritional risks were assessed and managed. For example, a letter from a speech and language therapist recommended a person have a pureed diet and one and a half scoops of a thickening agent in their drinks to help them swallow safely. We saw this information was recorded correctly on the whiteboard in the office, however, their electronic care plan stated they needed two scoops of thickening agent in their drinks and to have their food cut up into small pieces. In addition, the whiteboard showed the person was to have their fluid input and output recorded and their weight monitored monthly, whereas their care plan included neither of these things, and did not describe the support the person needed to eat and drink. Another person's care plan did not include any special dietary requirements, whereas the whiteboard in the office showed they needed a soft diet and drinks containing one and half scoops of thickening agent. This meant people's care plans did not contain the information staff needed to support them to eat and drink safely.

At the last inspection in April 2016 we could not inspect the home's training records as they had been taken by the previous registered provider when the home changed providers at the end of 2015. At this inspection we found there was a training matrix in placed which evidenced staff were up to date with a range of core subjects, including moving and handling, first aid and infection prevention.

Staff we spoke with gave positive feedback about the opportunities provided for them to do additional training so they could develop personally and professionally, and better meet the needs of people. For example, non-nursing care workers had been encouraged by the home manager to attend courses on catheter care, wound care and percutaneous endoscopic gastrostomy management. One told us, "I've absolutely loved learning. My confidence level is up here now. I feel like [the home manager's] pushed me and I've loved it." A second care worker said, "I've asked for courses and [the home manager] has sorted them out for me." This meant staff received the training they needed to support people effectively and the home manager used training as a way to develop and motivate staff at the home.

No care workers new to a health and social care role had been employed by the home in the year prior to this inspection, although the registered provider could evidence their induction process met the requirements of the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. Staff we spoke with who had been employed by the home since the last inspection gave us positive feedback about their induction.

Staff we spoke with told us they had access to supervision with a more senior member of staff. One care worker said of supervision, "They're a regular thing. I'm due an appraisal." Records showed staff were receiving supervision on a regular basis; this included a discussion around their areas for development and training needs. We noted the record of staff supervision on the electronic care system included a pre-populated statement in the 'staff comments' section which had not been amended by staff members in all bar one of the supervisions we saw recorded on the system. The home manager acknowledged this issue, and showed us supervision paper documentation they planned to implement at Earls Lodge. We saw this was much more detailed. The human resources director for the registered provider also planned to audit supervision outcomes for trends to identify common issues or training needs. Records showed appraisals with staff had been booked for spring 2017. The home manager said they had wanted the opportunity to get to know staff before doing appraisals so they could be more meaningful. This meant staff access to regular supervision had improved and annual appraisal for all staff had been planned.

People told us they had access to other healthcare professionals when they needed them. One person said, "The staff took me to the doctor last week. They are good like that." A relative told us, "They have sorted out [my relative's] physical health problems and the [condition] on [their] legs [they] had when [they] came here."

People's records evidenced they saw a range of healthcare professionals. During the inspection we noted representatives from several different services coming in to see people. We saw most of these wrote up their consultations with people on the home's electronic care records system. People's records evidenced they had seen dieticians, speech and language therapists, community nurses, GPs, social workers and tissue viability nurses, amongst others. We spoke with various healthcare professionals during and after this inspection and they all gave us positive feedback about the home's communication around people's healthcare needs and willingness to follow advice and instruction. One healthcare professional told us, "They will ring when they've got a problem", another stated, "They have managed quite complex needs", and a third said, "They're very good. Communication is brilliant." This showed us the home worked well with other services to meet people's wider healthcare needs.

We noted the ground floor of the home where some people living with dementia were supported had been modified according to evidence-based practice around dementia environments. The walls had photographs and memorabilia, and each corridor was themed. For example, one corridor was a beach themed 'pier' and another has a musical theme, with pictures of singers and musical instruments mounted on the wall. We also noted all the toilet doors were painted the same colour to help people find them more easily, and picture signage was in place to assist people to navigate.

The training matrix showed dementia awareness was considered a core training subject so we asked staff what good dementia care looked like. Comments included, "Good dementia care is all about the individual", "We talk about the past and old photos", and, "There's got to be activities and stimulation." The manager described how they had researched appropriate wall and door colours, and the use of doll therapy. Doll therapy describes the use of lifelike baby dolls to provide stimulation and comfort to people living with dementia. This meant the home manager had investigated and implemented ways to make the environment of the home and the care people received more dementia friendly.

Good

# Is the service caring?

## Our findings

People and their relatives described staff at Earls Lodge as kind and friendly. Comments included, "The staff are absolutely marvellous. Very good. Really helpful", "The staff cannot do enough for me", "The staff interact well with us. They are great", "There was good banter – when it was appropriate", and, "We had a [age] birthday party for my relative last week, [they] really enjoyed it."

During the two days of inspection all the interactions we observed between staff and people were caring and supportive. People and care workers frequently shared jokes and laughter, and people who were anxious or worried were provided with the reassurance they needed. We found there was a relaxed and pleasant atmosphere at the home and people could decide what they wanted to do and when. One person said, "I get up when I want", a second said, "I have choice in what I do", and a third commented, "Staff help me to my room when I want to go there from the day room." A care worker told us, "They (the people) might refuse to get up early. Quite a lot do. Some don't have a routine." We arrived early both mornings of the inspection and people up and about told us they had always been early risers. This meant people could exercise choice over what they did and when.

We spoke to staff about the people they supported and found they could describe people's likes, dislikes, preferences and personal histories in detail. They also described how they encouraged people to remain as independent as possible during personal care or at mealtimes. One care worker said, "We encourage people to do the little things." During the inspection we observed staff supporting a person to stand from a chair. A staff member told the person, "Keep going. Remember what the physio (physiotherapist) showed you yesterday. Push up, that's good." One person told us, "I am doing my exercises, they (the staff) help me and I can now walk four steps. It's great! I couldn't have done it without them."

One person told us how the staff had supported them to regain their confidence so that they were now ready to move into their own flat. They told us, "The staff and manager are out of this world. They supported and listened to me. They made me believe in myself." A healthcare professional involved with this person commented, "I felt that staff have had a good understanding of [their] needs and have supported [them] in providing required information." Other people and their relatives we spoke with all said they felt listened to by staff and involved in designing their care. Comments included, "Staff listen to me. They involve me in everything to do with how they care for me", and, "We have been fully involved in [my relative's] care. I am told about any proposed changes and we agree a way forward." This meant people were supported to be independent and were involved with decisions around their care.

People told us care staff supported them to maintain their dignity and also respected their privacy. People's rooms were personalised with their own belongings and photographs. We observed people were dressed appropriately for the time of year in clean clothing. We spoke with a hairdresser who visited the home weekly and saw people in a little salon at the home. They told us staff brought people down to the salon that had requested a haircut, and commented, "The staff are all lovely." We also observed care workers making arrangements for one person to have their hair coloured according to their preference. During the inspection we saw care workers always knocked on people's bedroom doors before entering. This meant

staff at the home respected people's privacy and dignity.

Care records showed people who lacked capacity had received the support of advocates when bigger or more complex decisions needed to be made. The home manager gave examples of referrals the home had made for people to advocacy services and we saw information about advocacy services was available at the home for people to self-refer. This meant people could access independent advice and support to make decisions if they needed it.

We noted 'do not administer cardiopulmonary resuscitation' or DNACPR forms were clearly displayed at the front of the paper record files of people who had them. Those we checked had people's correct name and address details on. The home manager told us the first floor nursing unit of the home specialised in palliative and end of life care; they commented, "My staff love palliative care and MacMillan provide a lot of support." We noted some staff had received additional training on end of life care; those we spoke with said they had got a lot out of the training and were very enthusiastic. One care worker commented, "I learned it's all about their choices and thinking about what they feel. We did case studies and shared stories."

We asked care staff what they thought was important in terms of good end of life care. Comments included, "It's about feeling safe and having emotional support", "If the relatives want to spend the night they can. They can have food and drink", "We need to make sure they're comfortable", and, "It's about being compassionate and making sure they get what they want." Feedback from relatives of people who had received care at the end of their lives at Earls Lodge was positive. Comments from thank you cards included, "You cared for [my relative] exactly how [they] wanted to be and [they] were so content and happy while [they] were with you", "The kindness and respect shown to [my relative] by everyone who cared for [them] was absolutely the best", and, "You were all so kind on the day [my relative] passed away very peacefully." Feedback from healthcare professionals who supported the home with end of life care was also positive; one told us, "They want the best for the patients. [The home manager] has tried to implement everything we've suggested." This meant the support people had received at the end of their lives at Earls Lodge was good.

During the inspection the home manager told us about a memorial tree they had sourced for the garden home as part of the home's 20 year anniversary in 2016. Information they provided described the tree as 'Evergreen and always growing, like the memories of those it represents.' The home manager explained friends and relatives had been invited to come and hang personalised ornaments in memory of their loved ones and sit in remembrance. Relatives we spoke with about the memorial tree said they planned to come and see it; one told us, "I'm going to hang something on the tree. I think it's a wonderful idea." Relatives also praised the support they had received from the staff at the home when their family members had lived there; they intended to keep attending the coffee mornings the home held for relatives of current and past residents of the home. One relative told us, "The support they gave me was second to none", and a second said, "They were so good to [my relative]; to me, too." This meant the home offered support and comfort to people's relatives before and after their family members had died, and had provided a means to remember them in the future.

Requires Improvement

# Is the service responsive?

## Our findings

People and their relatives told us staff at Earls Lodge responded to their needs. One relative told us, "When [my relative] was ill [they] liked things in certain places and to be fed in a certain way. They (the staff) knew just how [they] liked it", and second said, "They (the staff) loved [my relative] and knew all [their] little quirks. They knew just what [they] liked." A healthcare professional we spoke with commented, "They are responsive. If we make recommendations they follow them."

The home used a combination of electronic care records and paper records. People's risk assessments, care plans and daily records were kept electronically on a specialised computer system. Other paper records, such as consent forms people needed to sign, their 'do not administer cardiopulmonary resuscitation' or DNACPR forms and letters from healthcare professionals were kept in individual files.

At the last inspection in April 2016 we found care plans were not always updated when people's needs changed. At this inspection we found there was a marked difference between the quality and content of care plans on the ground floor and the first floor. Care plans on the ground floor were mostly of a better quality and more person-centred, although we did identify examples where people's dietary needs and Deprivation of Liberty Safeguards authorisation conditions had not been included on their care plans. On the first floor, all the care plans we inspected were almost entirely generic, in that they contained the pre-populated content suggested by the electronic system. This meant they lacked the meaningful detail care workers needed to support people safely and effectively.

For example, a care plan for a person's stoma gave the make and size of the bag and noted the person needed 'full support.' There was no detail as to the location of the stoma, its purpose, the frequency of bag change or what full support meant. A stoma is an opening made surgically into the abdomen which diverts the flow of faeces or urine into a bag outside the body. A care plan for a person's urinary catheter was the same: it listed the type and size but gave no details about the frequency of changing or what support the person needed. As discussed earlier in this report, other people's care plans for managing risk to their skin integrity, mobility and nutrition lacked person-centred detail. We also noted people who, according to the whiteboard, were receiving end of life care, did not have individualised care plans for the care they were receiving. A healthcare professional we spoke with also commented on the level of detail in some care plans, describing the content of one person's care plan as 'simplified'.

During the inspection we identified one person who had been at the home for seven days. When we checked the computer system we found their mobility care plan was not person-centred, even though we were told their level of mobility varied and observed them being supported by two staff to mobilise safely. They also had no skin integrity care plan in place but see saw they were sleeping on a pressure relieving mattress. The operations manager was surprised at this; they said they would expect basic care plans to be in place within 48 hours of a person's admission. They assured us the person's care plans would be updated that day. This meant people's care plans did not always include the information care workers needed to meet their needs.

We checked the electronic system to see how care staff recorded the care and support they provided to

people. Records we saw were often short and lacked detail, and at times it was difficult to source the information we wanted. A health care professional who visited the home agreed, they told us "I sometimes find that daily logs are unclear in terms of time of events; for example recording will state early hours of the morning on one day but refer to supper time." When we wanted to see how many baths or showers people had in the month prior to the inspection, we also found care workers had recorded this information at least five different ways which made checking difficult. We discussed this with the home manager. They agreed the system gave too many options for recording intervention and said they would amend the system to reduce the choices available and provide further staff training to improve consistency and quality of recording.

When we identified the lack of detailed care plans on the first floor, we asked four care workers how they knew what support people needed. They all said they relied on the summary information recorded on a whiteboard in the office and on verbal handovers provided at the start of each shift. They said they read the care plans of people newly admitted to the home, but did not generally do this for people using the service in the longer term. This meant the care workers did not routinely read people's care plans to find out if their needs had changed. Issues with poor quality care plans and daily records had been exacerbated by a lack of regular audit of the relevant documentation.

We fed back our concerns about the lack of improvement with care plan content since the last inspection, particularly on the first floor, to the home manager during the inspection. The home manager agreed some care plans were not sufficiently individualised, stating, "We need more meat on the bones." The home manager said they were already aware of the issues and showed us a care plan audit tool they were about to trial at the home. The operations manager said a member of staff from the ground floor had already started providing advice and support to care staff on the first floor on care plan improvement. We will check the home's progress with their planned improvements at the next inspection.

Issues with care plans and care records were a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Records showed potential new admissions to the home had an assessment with two members of staff. The home manager said, "I think it's good practice to have two people", and described how they had encouraged senior care workers involved in assessments, "So they can see the process all the way through." The home manager told us they felt it was important staff at the home were confident they could meet the needs of people either admitted or returning from hospital; they described how they had worked with healthcare professionals at a local hospital to improve the process of readmission of people to the home after they had gone into hospital. This involved staff from the home visiting the person in hospital to make sure their needs could still be met safely. One healthcare professional we spoke with told us, "Our experience on transition and the quality of communication has been excellent." This showed the home had an effective system of admission assessment in place.

People and relatives we spoke with told us there was lot going on at Earls Lodge. One person said, "There's plenty to do. I enjoyed the singer." During our two days' of inspection we saw this was the case. The home had an activities coordinator who worked 28 hours a week over five days, including every other Saturday. We found they were very enthusiastic about their role. They told us, "It's person-centred. I ask people. I have done a nine page document for each person." We saw this was a detailed assessment of each person's preferences in terms of activities. One person told us, "They identify what activities we want and put them on." During the inspection we observed people, relatives and staff enjoying a comedy 'drag' act; we saw people were smiling and laughing. The deputy manager commented, "It's nice to see the residents singing along, isn't it?"

Planned activities were advertised on noticeboards at the home. Upcoming events included a singer who was a finalist on a popular TV talent show, twice-weekly exercise sessions, regular visits by Wilf the 'pat dog', coffee mornings, arts and crafts, reminiscence and movie afternoons. The home also received free flowers from a local supermarket regularly, and photographs showed people flower arranging. People who chose to stay in their rooms received regular one-to-one visits from the activities coordinator and other staff. The human resources director for the registered provider told us, "I've been focused on people in their bedrooms because we don't want social isolation. I want to make a difference."

The home had recently created a 'friends of' page on a social media site, so people's relatives and friends could see what was planned and look at photographs of activities that had happened. The activities coordinator also attended monthly meetings with other activities coordinators from other local homes in order to share good practice; they told us, "We learn from each other." Feedback from people and relatives and our observations showed people were provided with a range of activities at the home which they enjoyed.

No formal complaints had been made to the service since the last inspection in April 2016; we saw a complaints policy was in place and details of how to complain were displayed around the home. One person who had raised minor concerns verbally told us, "If I've had an issue it was sorted out straightaway." A second person commented, "Nothing bad. If there was I would complain to the manager", and a relative told us, "The manager is approachable and I can talk to him anytime." This meant people and their relatives felt able to raise concerns if they needed to, which showed there was a positive and open culture at the home.

Requires Improvement

# Is the service well-led?

## Our findings

People and their relatives gave us positive feedback about the manager of Earls Lodge. Comments included, "I have every confidence in [the home manager]. He's great", "He's very approachable. He's always willing to come and have a chat", and, "[The home manager] is brilliant. [They] always keep me informed about my [relative's] situation." We observed the home manager was very much involved in the day-to-day planning and delivery of people's care and could describe individuals' needs and personal histories in detail.

At the last inspection in April 2016 we identified a breach of regulation relating to good governance as there were limited systems in place to monitor the quality and safety of the service. At this inspection we found that a range of regular audits were in place for aspects such as the incidence of pressure ulcers, people's weight loss, maintenance of the building, bed rails, infection control and medicines. This was an improvement; however, some audits were not effective. For example, medicines audits had not identified the issues with medicines administration records or topical medicine recording we found. There had also been no auditing of care plans, which had resulted in their continued poor quality in some cases. We noted audits did not contain action plans to evidence how any issues identified had been addressed. Results of audit were also not analysed for trends. This type of oversight can be particularly useful for identifying when improvements to practice, changes to staffing levels or staff training, is required.

The operations manager for the registered provider visited the home weekly and conducted an audit monthly. We noted an audit conducted in October 2016 had identified some of the issues we found at our last inspection in April 2016 and again at this inspection in February 2017. This included a lack of detail in care plans on the first floor nursing unit and mental capacity assessments which still needed to be completed. This meant the registered provider had been aware issues identified at the last inspection in April 2016 were still outstanding for four months prior to this inspection.

The home manager and operations manager for the registered provider were receptive to our feedback about the quality of audits in place and resolved to make improvements. They said they would review the areas covered by audits, add a care plan audit and include action plans, so they could evidence when improvements had been made. They said they would also analyse data collected for trends. The deputy manager commented, "I don't want it to be right, it should be better than right." We will check this again at the next inspection.

Issues with audit and monitoring were a continuous breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

One of the responsibilities of a registered provider is to report specific incidents to the Care Quality Commission (CQC). Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. We checked the records for these types of incidents and found they had all been reported appropriately.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both their care home

and on their websites. We saw the ratings from our last inspection were displayed in the entrance foyer to the home and also on their website.

The home manager had used national guidelines and evidence to change practice at the home. During the medicines round we observed medicines were entirely administered from boxes and bottles, rather than pre-filled blister packs which are commonly seen in use. The home manager showed us research they had used to evidence the change back to original medicines packaging; they told us it should lead to fewer mistakes, less medicines wastage and better patient-centred care. As noted earlier in this report, the home manager had investigated and used best practice around environments for people living with dementia. The home manager had also made available a range of information and national guidelines on subjects such as infection control and adult social care provision to people and their relatives; this was located in the reception area of the home. This meant the home manager sourced and shared good practice, and had used it to make changes at the home.

People and their relatives had been given opportunities to provide feedback to the home about the service they received. They had received an annual questionnaire in 2016; the home manager told us they had responded to feedback about people's lack of access to activities at the home by recruiting the activities coordinator. The home also held monthly residents' and relatives' meeting, although these were not always well attended. We saw the list of dates for forthcoming meetings was displayed prominently on the wall. One resident told us, "I have been to the monthly residents' meetings and I feel I and other residents have been listened to."

We asked staff what they thought of the management at Earls Lodge. Comments included, "They seem to have the right ethos", "[The home manager] comes up every day to speak to residents", "We say if we have any issues. We can share ideas and make suggestions", and, "[The home manager] is definitely approachable and fair." Staff at the home had been given the opportunity to fill in a questionnaire about the home and attended regular staff meetings. The 2016 staff survey had ask for feedback on workload and communication at the home, and had also asked staff how they would improve any issues they had identified. For example, one question asked, 'What would you change if you were in total charge?' This showed the management at the home was interested in the ideas and opinions of the staff who worked there.

We saw the home manager had made opportunities to recognise and reward staff for their contributions and achievements at the home. This had included nominating various employees for the Great British Care Awards in November 2016, one of whom got through to the national finals. The home manager said of the staff member, "We are very proud that [they are] getting the recognition [they] deserve." The home had also recognised their so-called 'unsung heroes', the catering and domestic staff, on their social media page on Christmas Day. Photographs showed staff working and had the header, 'We need stars like this to help make it that little bit more special.' This showed the home's management valued and recognised the contribution made by all staff.

We noted the registered provider's philosophy of care, 'Everyone has a life worth celebrating', was stitched onto the breast of care workers' uniforms. We asked the staff about the philosophy, what it meant to them and why they chose to work at the home. Comments included, "I love the banter with residents. They feel like family to me but I know you're supposed to keep it professional", "I like making sure people have what they want", "I really love the people", and, "Older people are so maligned in our society. Somebody needs to care enough to want to do it right. We should honour them, not just tolerate them." Feedback and our observations demonstrated the provider's philosophy of care did underpin the care and support provided by staff at Earls Lodge.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>We identified issues with the way risks were assessed and managed. This had been an issue at the last inspection. We observed some people were not supported appropriately by staff to manage their risk of falls and pressure ulcers.<br><br>12 (1) and (2) (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>We found issues with medicines recording and documentation, some of which were identified at the last inspection.<br><br>17 (1) and (2) (c)<br><br>Some people's care plans lacked the detail staff would need to support people safely and effectively. This was an issue at the last inspection.<br><br>17 (1) and (2) (c)<br><br>The system of audit and monitoring implemented since the last inspection had failed to identify and address the issues with medicines and care plans we found at this inspection.<br><br>17 (1) and (2) (a) (b) (f) |