Eagle Care Homes Limited

Paddock Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

This inspection took place on 22 and 29 August 2017 and was unannounced. The service was previously inspected on 27 February and 10 March 2017 and was in breach of the regulations in safe care and treatment, good governance and staffing. The registered provider sent us an action plan and at this inspection we checked to see if improvements had been made.

Paddock Lodge is registered to provide accommodation and nursing care for up to 24 older people. There were 21 people living at the home on the first day of our inspection. There was a registered manager in post who had been registered since 2014 and was currently working part time at the service. They intended to deregister once the person who is in the role of manager registered with the Care Quality Commission. 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.

At our last inspection we found not all risks had been minimised to ensure people were safe. There had been improvements in this area but we still had some concerns in relation to moving and handling for those people requiring support to move.

Risk assessments had been undertaken for those people at risk of malnutrition and pressure ulcers. The home completed risk assessments to minimise falls, infection control hazards and choking. The manager had analysed falls and implemented measures to reduce the number of falls at the home which had been effective.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any safeguarding incidents.

At our last inspection we concluded there were not enough staff to ensure people were supported safely. At this inspection we found staffing numbers had increased to ensure there was always a member of staff to support people in the communal areas.

Medicines were administered safely and we observed medicines being administered appropriately during our inspection. However, the temperature of the storage area had exceeded recommended guidelines which meant they were not stored safely.

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 systems in the service support this practice. The manager understood their responsibility in relation to the Deprivation of Liberty Safeguards and had appropriately applied for authorisations. There had been some improvements around the assessment of mental capacity

but further improvements were required.

People received appropriate support in order to have their nutrition and hydration needs met. Mealtimes were a pleasant experience and people told us they enjoyed the food. People received support to access health care services to ensure they maintained their health and wellbeing.

People told us staff were kind and caring and we saw this ourselves during the inspection. Staff knew people well, and were patient and kind in their interactions. People's privacy and dignity was respected and their independence promoted.

Support was provided for people to maintain their cultural and religious preferences, including meal requirements and help to practice their faith.

People were provided with care which met their choices and preferences and they were encouraged to share their views on how they wanted the service to be run.

The home did not have a dedicated activities coordinator and staff undertook activities with people in and amongst their caring duties. There was a programme of activities available and we received a mixed response in relation to whether people were satisfied with the level of activities on offer. We have made a recommendation about the provision of meaningful occupation to improve mental wellbeing.

Care records had improved. Some records we reviewed contained information to enable staff to provide personalised care, whereas others needed further improvement.

People living at Paddock Lodge and care staff told us the managers were approachable and supportive; they felt listened to if they had any concerns. The service was meeting its statutory obligations in terms of displaying their CQC ratings and notifications to CQC had been made as required

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

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any safeguarding incidents.

Risk assessments had improved; however, the assessment of moving and handling of people was not always in line with best practice.

Staffing levels had improved and there were enough staff to ensure people's needs were met in a timely manner.

We found medicines were administered safely although the temperature of the storage area exceeded recommended guidelines.

Is the service effective?

Requires Improvement

The service was not always effective

People told us how much they enjoyed the food and we saw snacks on offer throughout the day.

The registered provider was compliant with the Mental Capacity Act 2005 DoLS. Some mental capacity assessments were decision specific although best interest decisions did not provide details of the discussions. People were asked for consent before staff assisted with care.

People had access to healthcare professionals where appropriate, and staff facilitated this.

Is the service caring?

Good

The service was caring

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy and dignity were protected at all times.

People were encouraged to maintain their independence around activities of daily living and with their mobility.

People were supported to maintain their cultural and religious preferences, including meal requirements and support to practice their faith.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care records had not been updated as people's needs had changed which meant they contained inaccurate information on how to support people.

Staff knew people's preferences which enabled people to have choice in how they were supported.

Complaints had been acted upon to the satisfaction of the complainants.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some of the audits carried out at the home had improved and the manager had become more confident in their role. Some shortfalls in service delivery had not been identified and further improvements were required.

The service held regular meetings with staff and people using the service to inform developments at the home and involve them in proposed changes.

Governance checks and auditing systems were in place in relation to the environment which meant people were protected from harm caused by poor maintenance.

Paddock 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 22 and 29 August 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had not been asked 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.

Prior to this inspection we reviewed information we had received from the provider, such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, infection control teams and reviewed all the safeguarding information regarding the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We observed the lunchtime experience in the communal dining areas and in one of the communal lounges. We spoke with five people who lived at Paddock Lodge and three relatives who were visiting during our inspection. We spoke with a further three relatives over the telephone following our inspection. We spoke with the area manager, the manager, two team leaders, and two care staff.

We reviewed five care files and daily records for people living there. We also reviewed the maintenance and audit records for the home and records relating to staff and their training and development.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2017 we identified a breach of the regulation relating to staffing as there was not always enough staff at the home and there were times when there were no staff in the communal areas. At this inspection we found staffing numbers had been increased by one care staff and the communal areas were monitored most of the time. The manager provided us with the previous four weeks rota and their dependency tool which confirmed staffing had increased. The manager told us they had used agency staff when their own bank staff were unavailable, but agency staff were always paired up with experienced staff to ensure continuity of care for people at the home. People told us there were enough staff to support them when they required. One person said, "I think there are enough all of the time. No problems." Another person told us there was a consistent group of regular staff to support them and little use of agency carers. One person said, "You don't see many new faces." This meant the breach in the regulation around staffing had been rectified.

During our inspection people told us they felt safe at Paddock Lodge apart from in relation to one person whose behaviour challenged others and who was waiting for a more suitable placement. This person was receiving one-to-one care for several hours each day. We were told and we saw documentary evidence, this was to be increased so people living at the home felt safe. Apart from this, people told us they were safe; comments included, "Oh yes, I feel safe no problem at all I am happy where I am"; and "I've got a lock and nothing ever goes missing."

We asked staff about their understanding of safeguarding and how they protected vulnerable people from abuse. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They could describe the signs of abuse they might see in a care home.

We found standardised risk assessments such as the Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer, and Malnutrition Universal Screening Tool (MUST), which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. The registered provider utilised risk assessments to identify and mitigate the risks for paraffin based treatments, falls, choking, and infection control hazards. One person living at Paddock Lodge had experienced frequent falls and the manager told us what steps they had put in place to reduce the number of falls. This included an analysis of the time and place of the falls. Through the use of increased monitoring and the use of equipment they had significantly reduced this person's fall which demonstrated they were analysing information to improve people's safety. Accident and incident monitoring had improved and the manager was utilising information to reduce further incidents to ensure people were kept safe.

At our last inspection we found personal emergency evacuation plans (PEEP's) did not reflect people's actual needs or contain detail on how the person would need to be supported in the event of an emergency. At this inspection we saw there had been an improvement and documentation had been amended. Staff received fire safety training and fire alarms were tested weekly. We noted the top of the fire escape staircase was being used for storage and contained flammable items. We brought this to the attention of the manager

as it is important for fire escape staircases to be free from clutter.

At the last inspection we identified a breach of the regulation relating to safe care and treatment because people were not always moved safely. At this inspection, we observed staff utilising a hoist with one person to transfer between a wheelchair and their bed. The technique utilised ensured the person was safe, although the space in this person's bedroom was limited and there was no detailed risk assessment or care plan to guide staff or to maximise the environmental space. This put them at risk of harming themselves. We discussed this with the area manager and the manager who told us they had three larger bedrooms which would be more suitable for those people requiring hoisting and they would try to ensure these were reserved for those people with more complex needs. The registered provider had purchased several profiling beds since our last inspection which assisted staff to move people safely when utilised correctly. We did see one person moved in their wheelchair without their pressure reducing cushion although the care plan stated, "Propad cushion must be transferred into the wheelchair." We brought this to the attention of the staff during our inspection who confirmed this was an omission on their behalf.

We did see some moving and handling practice that required further improvement. For example, one person was assisted to move by two care staff, who placed their hands underneath the person's armpits. This is not good practice as it can lead to staff taking the person's weight and causing damage to their skin, joints and muscles. One member of staff was observed assisting a person to move when they had not undertaken practical moving and handling training. They had therefore not been assessed as competent in this area, although we were shown this training had been booked in. We questioned one member of staff in detail about their knowledge of moving and handling techniques and they demonstrated they had a full understanding of the different techniques to use to ensure people were moved safely. This demonstrated there had been some improvement since our last inspection but further work was required.

We looked to see how the service was managing people's medicines. We found medicines were administered to people by trained care staff. Medicines were administered sensitively by the team leader who offered people a drink to help them take their medicines. Staff competencies to administer medicines were checked by the manager, registered manager or area manager. At our last inspection staff had not signed to confirm creams and ointments had been applied and body maps were not in place to guide staff where to apply creams. Medicines had not always been dated upon opening to ensure they are used within their efficacy time frame. We found an improvement in these areas and the administration of medicines and recording practices were in line with good practice.

Most medicines were supplied in blister packs and stored in trolleys secured to the wall with a chain and padlock. Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation (controlled drugs). The home had appropriate storage systems in place and staff followed the recommendations in the legislation in relation to signing the controlled drug register. Temperatures of the medicines fridge were checked daily to ensure medicines were stored at the correct temperature. Temperatures of the room where medicines were kept were taken each day but for the past month had been regularly over the recommended limit of 25°C. This had been reported to the registered provider to look at environmental changes to reduce the temperature to the recommended range but at the time of the inspection a resolution was not in place.

We reviewed three staff files and found the necessary recruitment checks had been made to ensure staff suitability to work in the home. This included an application form, interview records, Disclosure and Barring Services (DBS) checks, reviews of people's employment history and two references had been received. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

We looked to see how the home managed and controlled the risk of infection. We found liquid soap and paper towels, personal protective equipment in all the areas we looked at. Areas of the home were undergoing refurbishment such as a new bath, and new flooring. Some areas of the home had been redecorated whilst other areas required repainting. The registered provider had a refurbishment plan in place to refresh the appearance of the home. On the first day of inspection there was a malodour as you walked into the home, and the manager told us they were refreshing carpets with more suitable flooring to eliminate this problem.

Requires Improvement

Is the service effective?

Our findings

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 application 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.

The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. Six applications under the DoLS had been authorised and the manager was awaiting the outcome of a further two applications. Those people who were not on a DoLS told us they were free to come and go as they wished. One person said, "Yes, you can go out; you just have to tell them where you're going."

At our last inspection in February 2017 we found mental capacity assessments were not decision specific. At this inspection we found an improvement and there was a record of decision specific capacity assessments for the following decisions: use of a lap belt, use of a bed wedge, and receipt of a flu vaccination. There were none in relation to medication and there was some confusion amongst staff in relation to the difference between compliance and consent in relation to taking medicines. This had been rectified by the second day of our inspection. People's records stated their families had been consulted to make the best interest decision "and the decision had been made in the persons best interest." The MCA Code of Practice on best interests recommends information such as how the decision about the person's best interests was reached, what the reasons for reaching the decision were, who was consulted to help work out best interests and the date, and what particular factors were taken into account. Although there was no evidence to suggest the registered provider was not acting in people's best interests their recording of the decision was not sufficiently robust to demonstrate this.

Most of the people living at Paddock Lodge were able to make simple decision such as what to wear and what they wanted to eat. Consent had been sought from those people who were able to consent to their care and treatment and this was recorded in their care plans. We observed staff asking people for consent during the day and people confirmed this was their usual practice.

We observed the lunchtime meals in the dining room. Tables were laid out with table cloths, place settings, glasses, cutlery and condiments. There were no menus on the tables but there was a four-week menu in small type on the wall. Our observations of the people's lunch time experience in the dining room concluded mealtimes were a sociable event with people chatting amongst themselves and between tables. People could choose where they wanted to eat, either in the dining room, in the communal lounges or in their

bedrooms.

The cook and up to three carer workers were present in the dining room for most of the meal to support eleven diners and the food was served quickly. Care staff interacted with people giving individual attention when talking with them. The food was served by the cook who described the choices individually to people. The cook demonstrated a good knowledge of peoples preferences with comments such as, "I know mince is your favourite." One person was offered sandwiches when they did not want either of the choices. People were not rushed and all were encouraged to finish their meal. We saw they were offered fruit juice at the beginning of the meal and hot drinks at the end of the meal. People told us they liked the food. One person said, "It is very good, nice, good choice, plenty of it, too much really." Everyone we spoke with said there were snacks and drinks available between mealtimes and one person told us, "The trolley comes around, there is enough to drink, fruit juice is always available. I've put weight on since I have been here."

One person at the home required a blended meal. A member of care staff told us this person would choose bacon and eggs from the menu, so they would blend this meal to fulfil their choice but ensure a consistency in line with the person's nutritional requirements.

People living at the home told us staff had the knowledge and skills to care for them. One person said, "They (the staff) are well trained to work as a team." One relative we spoke with told us they were of the opinion staff did not have a good knowledge in dementia.

We looked to see how new staff were supported to develop into their role. Staff told us they had a three day induction into the service which included two days shadowing more experienced staff. Induction also included ensuring the safety of the environment such as how the window restrictors worked and staff had their competency to check the window restrictor's assessed. This demonstrated the registered provider was aware of their responsibility to ensure staff knew how to work equipment at the home. The registered provider utilised their own induction and had not yet commenced the Care Certificate. The Care Certificate is a set of minimum standards that should be covered as part of induction training of new care workers dependent on their past experience and qualifications in care. This meant the home was not yet using the recommended standard for new care workers to attain.

The registered provider utilised a mixture of training methods ranging from DVDs followed by a written test, classroom based learning and the local authority training opportunities. We reviewed the staff training matrix provided by the manager. This showed us training had been provided training in topics such as moving and handling, dementia, protection of vulnerable adults, fire safety, challenging behaviour, first aid, Deprivation of Liberty Safeguards, and infection control. The manager provided us with a list of training for staff to be completed by 15 September 2017, which would mean all staff training would be up to date at this time although this was not the case at the time of the inspection. Staff received supervision and an annual appraisal to support their development. Appraisals were just out of date by the time of this inspection but the manager told us they would all be completed over the following two months.

Records showed people using the service had access to other health care professionals for example, speech and language therapists, dieticians, GP's, community nurses, chiropodists, dentists, opticians, and the Care Home Liaison Team. One person told us "If you need one [doctor] they get one in as soon as possible", and another person said, "I have seen a chiropodist recently." This showed us people at the home were assisted to maintain their health and wellbeing by accessing external support when required.

The home maintained a homely atmosphere with some adaptations in place to support people with both physical and mental difficulties. Improvements in flooring and lighting had been made since our last

inspection. Further improvements in signage would improve the environment to become more 'dementia friendly' and an improvement plan was in place.

Good

Is the service caring?

Our findings

All the people we spoke with told us the staff were caring. One person said, "They are friendly, there is nobody who is not nice." Another person said, "Most of them are. One or two are very pleasant." A further person told us, "The staff are approachable and friendly." Another said, "The staff are easy to talk to." When asked if staff involved them in their care. One person said, "They explain things and make sure I know what's going to happen," and another said, "They explain what they are going to do and ask if it's OK."

People's privacy and dignity was maintained and people confirmed this. One person said, "They knock on the door, I sleep with my door open but they still knock." Another said, "They close the curtains and the doors they are very observant like that." One relative told us, "The staff are OK. They show a lot of compassion and respect."

We observed staff encouraged people to do as much as they could for themselves. People confirmed this. One person told us, "I can't really walk much anymore but they encourage me to try to." Another person said, "They have got me back walking around again." A third person told us, "They let you do things for yourself and do not rush around helping you all the time."

We asked about equality and diversity and how people were supported in relation to their religious and cultural needs. The manager told us one person had a religious requirement in relation to meat and although they were not aware of what they were eating due to a cognitive impairment, catering staff always ensured they were not provided with a meal which did not conform to their religious requirements. They also told us they held a church service every Wednesday at the home and would support people of all faiths as required. This meant the registered provider was supporting people with their spiritual requirements.

We asked people at the home whether they had been involved in writing their care plans or where aware they had a care plan. The majority could not recall they had been involved. One person said they had been involved in the compilation of their care plan and told us, "I went through things with the top manager". We saw evidence in people's care plans and from our discussions with families that people had been involved in compiling their care plans to enable staff to provide compassionate care.

People were supported to access advocacy services when required, if family were not involved in their care. An advocate is a person who is able to speak on other people's behalf, when they may not be able to do so, or may need assistance in doing so. People told us, "I did have an advocate, I hope to get another soon." Another person told us, "I had an advocate but I stopped [name of advocate] now." Another person told us, "My [relatives] are my advocates." This meant people had access to independent support with decision-making when they needed it.

Our review of care plans evidenced there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. There was no one receiving end of life care at the time of our inspection although two people had anticipatory medication in place. The area manager told us about the registered provider's end of life document titled, 'Celebration of my life.' Although they said not all families had participated in this. In

one of the care records we reviewed we noted the manager had detailed the person's preference for a priest to attend when they reached the end of their life who spoke their native language. The record detailed who would organise this which demonstrated the registered provider had considered the importance of this to the person they were supporting.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2017 we found information in care plans was not always accurate, and out of date information had not been removed. At this inspection we reviewed five care and support plans to check for improvements. We found improvements had been made, but there were still areas where further improvements could be made. By the second day of our inspection some of these improvements had been actioned.

People we spoke with told us they had been offered choice in how their day was planned. We asked whether this choice was extended to the gender preference of staff supporting them. All but one person told us they did not have any preference. This person said, "I have no problems with the gender of the carers but we could do with more men." People told us staff took time to get to know them and what they liked to do. One person told us, "They know how we want things done." Another person said, "They know what I like them to do."

It was clear from our observations that staff knew people well and were knowledgeable about the things that were important to them in their lives. All interactions between staff and people living at Paddock Lodge were positive. We saw they supported people to make choices in their everyday lives taking into account their views and preferences which demonstrated they were providing person centred care.

We reviewed preadmission care records at the home to ensure the service was assessing people wishing to live at Paddock Lodge. The area manager told us they always undertook a preadmission assessment to ensure they could meet the needs of the person but also to ensure their admission would not have an impact on other people living at the home. The area manager told us how difficult it was to determine accurately how they could meet a person's needs as often the information provided at the preadmission stage had not correlated with a person's actual needs once they came to live at Paddock Lodge. This had meant they were supporting a person whose needs they were currently unable to meet and whose presence was having an impact on others at the home.

In addition to the care plan staff completed a daily record which was a record of a person's day completed three times at each shift. This included sections for staff to complete in relation to pressure care, personal care, information about dietary and hydration intake, professional visits, activities and socialising. There had been some improvements in the recording of these daily records from our last inspection, but was still missing information. For example, a record of how a person had been assisted with moving and handling to enable the manager to analyse a person's deterioration requiring an update to their care plan. Information which should have been recorded on this form such as support with oral hygiene, bathing and shower was kept on a different form, which meant the two had to be read together to gain a full picture that the person's needs had been met. Baths and showers were offered to people on a weekly basis. People told us they were happy with this and told us they could ask for more if required but they hadn't wanted to request this and they told us they were happy with the current arrangements.

At our previous inspection we found there was a lack of meaningful activities for people living at the home.

At this inspection we checked to see if the situation had improved and whether people had meaningful occupation throughout the day to enhance their mental wellbeing. We noted there was no dedicated activities coordinator at the home and staff undertook this role as part of their caring duties. The manager told us staff tended to do activities with people at 10.30am and 2.30pm, and it was recorded in their care plans what they liked to do. The manager told us about activities that had taken place recently such as flower arranging using flowers picked from the garden, a tea party and dance held once a month and they said people were currently making sensory items with buttons, zips and wool. The home had held a clothes party the day before the inspection to enable people at the home to view and purchase new clothing. People we spoke with had mixed views about the activities on offer. One person told us, "We do chair exercises; there is plenty to do during the day." Another person told us, "There is not much. Sometimes we play ball games, sometimes we sing. There is no activity coordinator." Other people told us they were happy to sit and watch television and one relative told us their relation would not take part in activities even if they were on offer as they had never shown any interest in their past life. We observed very little activities taking place during our inspection although we did observe staff chatting to people. We recommend the registered provider continues to seek nationally recognised guidance on supporting people with mental well-being through the provision of meaningful occupation.

We asked people whether they knew how to make a complaint. Most people told us they had not needed to complain but knew who to go to if they did. One person told us they were unaware of how to make a complaint. Another person said, "I have complained to the manager and the area manager. I was listened to and I think they managed to sort it out." They added, "They did not make me feel bad about complaining at all." We reviewed the complaints logged at the home since our last inspection and one complaint had been formally reviewed. The outcome of the investigation was not kept with the complaint, but the area manager found the information in the person's care file. The record evidenced a meeting had been held with the complainant, and detailed the measures put in place to resolve the complaint to the satisfaction of the complainant. This meant the registered provider was acting on complaints to drive improvements at the home.

Requires Improvement

Is the service well-led?

Our findings

People told us how much they liked living at Paddock Lodge. One person said, "It's good, I like it. There are good rooms and good friends." People told us they had good contact with the manager and one said, "I know the manager, she is nice and easy to talk to." Care staff we talked with told us how much they liked working at Paddock Lodge. One said, "I love it here. There is a good morale, good teamwork and enough staff on duty." The manager told us staff morale was "really good" and said, "New staff have been brilliant and fitted in really well." Our observations confirmed staff morale had improved and all staff were relaxed throughout our inspection and were friendly and welcoming.

There was a registered manager in post who had been registered since 2014 and was currently working part time at the service. They intended to deregister once the person who was in the role of manager registered with the Care Quality Commission. The manager shared their vision with us, "I want it to get outstanding. Eventually we will. I've learnt a lot from the inspection. I've taken on feedback and made it better."

We saw a range of quality assurance systems were in place and a number of audits were carried out regularly. At the last inspection we found audits were not always thorough. Audits we looked at during this inspection, included medicines audits, accident and incidents, care plans and risk assessments, and staff files. Some audits had identified areas where improvements were required, for example a kitchen audit had highlighted tea time team leaders were not probing food and all team leaders received supervision to ensure this was rectified. However, the care plan audit had not identified the issues we found so this audit required improvement. This meant that although some audits had been robust others still required improvement to enable the registered provider to demonstrate they were robustly monitoring the quality of the service provided.

The manager was supported in their role by the area manager who was present at the home at least one day each week. They were supporting the manager to improve the quality of the service provided. They provided us with a copy of their 'Provider Performance and Quality Site Visit Document" completed in July 2017 which showed they were measuring the service against the CQC standards. This was comprehensive but lacked the details of the evidence audited to determine how they had come to their conclusions. However, with continued improvements this audit will support the area manager to measure the quality of the service provided at Paddock Lodge.

There had been an improvement in the analysis of accident and incidents since our last inspection and the manager was analysing records for trends or themes. This enabled them to introduce measures to reduce risk and improve the safety of people living at the home and the staff supporting them. However, there was a lack of overview in relation to moving and handling to ensure people were protected from poor moving and handling techniques. This included ensuring staff had been trained in practical techniques and had their competencies checked prior to assisting people to move. Oversight was also lacking in terms of making sure people's moving and handling risk assessments and care plans were updated as soon as their needs changed.

Environmental audits confirmed electrical hard wiring and gas services had taken place and all portable electrical equipment testing was up to date. We saw regular checks were undertaken in relation to maintenance at the home, and water temperature checks were regularly made. New window restrictors had been fitted to all the windows at the home including the ground floor. Radiators all had covers on them to protect people from the risk of scalds. This meant the risk posed to people by utilities and facilities had been managed.

We inspected records of lift, hoist and hoist sling servicing and testing. At the last inspection we found hoist slings had not been checked. At this inspection records showed all hoists and slings had been tested and met the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). The manager had compiled a list of all the equipment and the serial numbers to ensure equipment could be easily identified. This meant the systems to ensure equipment was safe had improved and was meeting the required standards and demonstrated an improvement in governance arrangements.

The home is required to display their latest CQC inspection ratings. We observed these were displayed in the entrance of the home and on the registered provider's website in accordance with the regulation. Registered providers and managers are also required to notify CQC about certain events at the home. Records showed all events had been reported to CQC as is required.

We reviewed the minutes of the latest staff meeting held on 6 June 2017. These showed discussions were held around their recent infection control review, the latest CQC inspection and the local authority contract monitoring inspection. The record also contained information for staff on how to complete the daily record sheets. There had also been a team leader meeting on 26 May 2017. Minutes showed discussions had been held on medications, including the recording of the application of prescribed creams, how to complete the registered provider's new medication administration sheets, controlled drugs, and ensuring people were protected from sun burn with sun cream. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service and the registered provider was meeting this requirement.

The registered provider published a monthly newsletter detailing what activities had taken place. It showed in July 2017 the home had held American Independence Day celebrations. The newsletter also listed people's birthdays, details about the home's tuck shop, and a reminder to families to use the hand gel when visiting their relation.

Surveys had been sent to people using the service and their relatives in 2016. The survey for 2017 had not been sent out at the time of this inspection but was due to be sent out shortly after the inspection. We saw minutes from a residents' meeting held in August 2017. The dates of further meetings were displayed on the notice board in the entrance. Each meeting followed the same format and included a discussion about the activities on offer. The manager told us they invited people's relatives to the meetings but they had not attended. However, a relative we spoke with told us they were unaware of these meetings. A resident and relatives meeting provides the registered provider with a forum to seek feedback about the quality of the care provided and lead to improvements. It can help to demonstrate how the registered provider has used feedback to lead to improvements.