EAM Lodge Community Interest Company

EAM Lodge (Trafford)

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 18 and 19 October 2017 and was unannounced.

EAM Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

EAM Lodge accommodates up to five people in one adapted building. The service provides care, including nursing care to young adults who have a learning disability and/or complex heath care needs. The home provides support to people staying at the home for short breaks (respite), as well people who live at the home on a longer term basis. At the time of our inspection there were four people living at the home on a long term basis, and one room was available to people staying for a short break.

This was the first inspection of EAM Lodge (Number 46) since the service's registration with the Care Quality Commission (CQC) in September 2016. At this inspection we identified two breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to training and providing safe care and treatment. You can see what action we have told the provider to take at the back of the full version of this report.

We have made two recommendations. These relate to reviewing good practice guidance and advice in relation to: Assessing people's needs in relation to the use of assistive technologies and assessing the safety of the premises and equipment.

EAM Lodge had a 'homely' feel that was commented on by both relatives of people using the service and staff. Staff knew the people living at or supported by the service well and had developed positive, caring relationships with them.

Staff were aware of people's care needs and preferences. They communicated effectively with people and involved them in decisions about their care as far as was possible. People's relatives told us they were involved in planning their family member's care when this was appropriate. They told us the service were good at keeping them informed about any changes to the care their family member received.

People were supported to engage in a range of activities at home and in the local community. Staff had considered how they could support people to maintain and develop relationships with peers, family and others.

Staff assessed risks to people's health and wellbeing and were aware of plans in place to reduce risks. However, some risk assessments, such as those in relation to the use of bedrails, were generic and had not considered risks that could be unique to each individual.

We found there were sufficient numbers of staff on duty to meet people's needs. Prior to our inspection, concerns had been raised with CQC and the local authority in relation to the practice of having one member of nursing staff on a sleep-in shift to cover both EAM Lodge and the neighbouring service, EAM House. Whilst this arrangement had been put in place out of necessity due to difficulties recruiting nursing staff, we were satisfied the provider had considered how to ensure this arrangement was safe.

Competent persons completed regular servicing and inspection of the premises and equipment. We found the provider was in the process of completing outstanding actions identified in their fire risk assessment completed in October 2016.

Staff were not monitoring people's weights on a regular basis where this would be required to ensure they received the correct nutritional support. This was in part due to the service not having scales to weigh people with limited mobility. We also found the home had no back-up suction machine in case of breakdown. Whilst the service was able to obtain a same-day replacement, the risk of this potential delay had not been considered.

Staff told us they received sufficient training to feel they were able to undertake their job roles and meet people's assessed needs. We saw training in a wide range of topics had been completed and staff's competence to carry out care tasks had been assessed. However, there were gaps in training such as epilepsy, learning disability awareness, the mental capacity act and behaviours that challenge. We also found evidence that staff had not followed good practice in relation to supporting people with behaviours that could challenge the service.

The home did not have a call bell system and was not using assistive technologies such as seizure monitors or pressure/movement sensors to detect and help prevent falls. To manage risks in these areas, staff completed regular, recorded 10 minute checks. However, use of assistive technologies in some cases may have been less intrusive.

Care plans were detailed and person centred. They contained information about people's preferences as to how they received their care. Staff were aware of these details.

The service had a registered manager in post. 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. Staff felt well supported by the registered manager and colleagues at the service. We found staff received regular supervision and feedback on their performance. Staff were also able to discuss any concerns they might have at staff meetings.

The registered manager completed a variety of checks and audits to help monitor the safety and quality of the service. However, the medicines audit was limited in scope. The provider had not ensured that staff training in key areas was kept up to date and in some instances, complete records of care provided had not been maintained.

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 consistently safe.

The temperature medicines were stored at was not being monitored to ensure they were not damaged by being either too cold or too warm.

Risk assessments in relation to the use of bedrails did not consider risk factors specific to the individual.

Checks and servicing of the premises and equipment were carried out to help ensure they were safe.

Is the service effective?

Requires Improvement

The home was not consistently effective.

Whilst staff had completed training in a range of relevant topics, there were gaps in the provision of training in subjects such as learning disability awareness and responding behaviours that challenge. This had an impact on the support staff provided.

The service had not consistently monitored people's weights when this would be required. This was as they did not have the required equipment.

The service supported people to make choices, and involved people in decisions about their care whenever possible. However, we saw some consent forms had been signed on behalf of people using the service by others who did not have lawful authority to provide consent on their behalf.

Is the service caring?

Good

The service was caring.

Staff knew people living and staying at the home well. They had developed positive, caring relationships.

People's care plans identified ways in which staff should support their independence and respect their privacy and dignity. We found staff were aware of and followed this guidance.

Staff interacted and communicated well with people living at the service.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in a range of activities both within and outside the home. Staff had considered how to support people to maintain and develop relationships with their families and friends.

Care plans were person-centred and provided staff with the information they needed to meet people's needs and preferences.

The service had not received any complaints. People and relatives told us staff listened to them and that they would feel comfortable raising any concerns they had.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff felt supported by the registered manager and provider.

The registered manager and staff at the home valued the importance of providing person-centred care.

A range of audits and quality checks were completed by the registered manager. However, the provider had not ensured staff training was always up to date. Risks relating to the provision of sufficient equipment had not always been considered.

EAM Lodge (Trafford)

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 18 and 19 October 2017 and was unannounced. We carried out this inspection at the same time as inspecting the neighbouring service, 'EAM House'. This was due to concerns that had been raised in relation to EAM House, which is owned by the same directors as EAM Lodge, and with which it shares a staff team. A separate report has been produced for EAM House, which you can find on our website.

The inspection team consisted of one adult social care inspector and a specialist advisor. The specialist advisor was a paediatric nurse who had experience of running a registered service.

Prior to the inspection we reviewed information we held about the service. This included any notifications the service had sent us about safeguarding or other significant events that had occurred whilst providing a service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The provider last updated their PIR in July 2017.

We asked for feedback about the service from commissioners of the service, including Trafford local authority quality and contracts team and Stockport, Trafford and Salford Clinical Commissioning Groups (CCGs). We used this feedback to help plan our inspection, and where relevant have referred to the information we received in the main sections of this report. We also requested feedback from Trafford Healthwatch and Trafford's infection control team. Neither had any information they could share with us about the service at that time. Healthwatch is the consumer champion for health and social care.

Most people living or staying at EAM lodge had limited verbal communication. However, we were able to communicate with one person who lived at EAM lodge with the support of the registered manager. We used

the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the family member of one person using the service during our inspection site visit, and spoke with a further two relatives by phone shortly after the inspection. We spoke with five staff members. This included the registered manager, the nominated individual, two care staff and one registered nurse.

We looked at records relating to the care people were receiving. This included four care files, daily records of care and five medication administration records (MARs). We also reviewed records related to the running of a care home, such as records of servicing and maintenance, training and supervision records and four staff personnel files.

Requires Improvement

Is the service safe?

Our findings

Relatives we spoke with told us they always found there were sufficient numbers of staff on duty when they visited to meet the needs of their family members and to assist them to take part in planned activities. The registered manager told us they listened to what staff and people using the service were saying to help work out how many staff were needed. During the inspection we saw the registered manager arranged for extra staff to come in to provide additional support to a person who needed to go to hospital at short notice. This demonstrated that the registered manager was responsive to the changing needs of people using the service when arranging staff cover. We looked at rotas and saw that the names of people who would be staying at the home for a short break were recorded against each day, along with any planned activities and appointments. This helped the registered manager plan how many staff were required for each shift.

During the inspection we saw there were sufficient numbers of staff to meet people's needs in a timely way and to allow frequent interactions between staff and people using the service. The registered manager told us the service did not use agency staff due to consideration of the preferences of people using the service and to maintain consistency. They told us the existing staff team at EAM Lodge and the neighbouring service EAM House picked up any shifts that had not been covered in most instances. We confirmed this by reviewing the staff rotas.

Prior to our inspection we received concerns from one of the commissioners of the service about the level of cover provided by qualified nursing staff. They reported an incident where there had been no cover by qualified staff at EAM Lodge for a period of 25 minutes, which they had reported to the Care Quality Commission (CQC) and Local Authority. We reviewed staff rotas and saw that during the day there was always a registered nurse on duty at EAM Lodge. The registered manager told us on this occasion they had been the nurse on duty and had been attending a meeting at EAM House next door. Due to an issue with the phones not working, staff had been unable to contact them at that time, and one staff member had to walk over to EAM House to get them. They confirmed the issue with the phones not working had been resolved, and we saw a procedure for contacting the nurse on duty had been devised for any occasions they may be off site.

The home had an arrangement whereby one registered nurse provided nursing cover for both EAM Lodge and the neighbouring service, EAM House during the night on a sleep-in shift. The nominated individual acknowledged that this arrangement had been put in place out of necessity due to three registered nurses leaving employment with the home in a short period, and difficulties recruiting new nursing staff. However, we were reassured that the provider had given reasonable consideration as to whether and how they could meet people's needs with this staffing arrangement. The registered manager told us they were confident staff were able to meet people's needs and provide safe care following this staffing model. Care staff we spoke with told us they were always able to contact the sleep-in nurse if they needed advice or assistance. Additional measures to help ensure this arrangement was safe included an on-call system and training for care staff in a range of essential care tasks delegated by the registered nurses. This included training and competency assessments in the administration of medicines (including emergency 'rescue medicines') and oral suctioning.

Nurses and senior care staff were responsible for administering medicines. We reviewed medication administration records (MARs) and saw staff had access to the information they needed to enable them to administer people's medicines safely, and in accordance with the prescriber's instructions. For example, we saw each person had a cover sheet in the MAR folder with their photo and information about any allergies they had. Where people were prescribed medicines to be taken 'when required' (PRN) we saw there was written guidance as to when staff should administer these medicines. The service had a system in place to help ensure they had current information on people's medicines when they came to stay for short breaks. We saw people coming to stay for a short break or their representatives had been asked to provide a list of currently prescribed medicines, along with details about any changes in their care needs. This information was kept in the medicines file so it was easily accessible, and would help ensure staff were aware of any changes.

We found most medicines were kept securely. People's medicines were kept in locked cabinets in their bedrooms or in a larger cabinet if there were additional stocks that did not fit in the bedroom storage. However, we found one person's fluid thickener was stored insecurely in a kitchen cabinet. A patient safety alert was issued by NHS England in February 2015 in relation to risk of asphyxiation through accidental ingestion of thickening agents. We drew this to the attention of the registered manager who moved the thickener immediately. They acknowledged the thickener should have been kept in locked storage, but assured us they did not feel this had presented a risk to people using the service, most of whom would have not been able to access the cupboard. We found the service was not monitoring the temperature that medicines were stored at in people's rooms or the larger medicines cabinet. It is important that services monitor that medicines are kept at temperatures recommended by the manufacturers, to ensure their efficacy is not affected.

The service had a safeguarding policy that gave staff information about the roles and responsibilities of different people within the organisation in relation to safeguarding. It also contained information on the procedures staff should follow to report any safeguarding concerns they might have. We saw the registered manager had discussed the safeguarding policy and procedures at a recent team meeting, and safeguarding was a standard agenda item on staff supervisions. This would help staff maintain awareness of how to recognise signs of potential abuse and ensure staff were aware of how to escalate their concerns appropriately. Staff we spoke with were able to tell us the signs they would look for that might indicate someone was being abused or neglected. They told us they would feel confident raising any safeguarding concerns with a nurse, the registered manager or one of the directors.

We saw staff had completed individual risk assessments for people using the service that considered risks including skin breakdown, risk of aspiration, malnutrition, emergency evacuation (PEEPs) and use of wheelchairs. People's care plans also contained details of how staff could help manage and reduce any identified risks. However, we found the process for completing risk assessments was not consistent, and some people's care files contained risk assessments that others did not. For example, we found one person who stayed for short breaks did not have any risk assessments in place in relation to skin breakdown or malnutrition, despite their care plan indicating these were areas of potential risk. Some care plans in place also lacked detail about the control measures in place. For instance, we saw care plans relating to skin integrity made reference to frequent repositioning, but did not state how often 'frequent' was. We were also unable to confirm how often staff supported people to change their position when they required pressure relief as no clear records of this support had been maintained. From our conversations with the registered manager and staff, we were reassured however that this support was provided two to four hourly when required, and no person living at the home currently had a pressure ulcer.

The service had not notified the Care Quality Commission (CQC) of any serious injuries since it opened in

September 2016. We confirmed no notifiable serious injuries had occurred by reviewing records of accidents and incidents and speaking with the registered manager. Where staff or people using the service had had minor accidents, we saw these were recording on an accident form, and if needed, a body map to document any minor injuries sustained.

There were a number of people living or who stayed at the home who had bed rails in place to help manage the risk of them falling from their bed. The provider showed us they had carried out an individual bedrail risk assessment for one person using the service. However, for everyone else using bedrails, there was one generic bedrail risk assessment. This identified measures to help ensure these people were safe when using bedrails, such as regular cleaning, a daily visual check, ensuring bumpers were in place and regular 10 minute checks on people whilst they were in bed. We saw recorded evidence of 10-minute checks taking place, and there was a record of staff carrying out a monthly check of the condition of bedrails to help ensure they remained safe to use. We found bedrails were not used for all people without consideration for individual circumstances. However, the lack of risk assessments that were specific to each individual would increase the risk that staff would not identify factors that might mean bedrails were not safe to use. This would include considerations such as the individual's mobility and any cognitive impairment they had.

We saw regular servicing and maintenance of the premises and equipment took place to help ensure their safety. Inspections of the gas, electrical and lifting equipment (such as hoists and the passenger lift) had been undertaken as required. The home had a legionella risk assessment in place, and was following measures to help control the risk of legionella developing in the water system. We noticed that some of the window restrictors in place in the home were of a design that could be disengaged without the use of a special tool. This is contrary to guidance issued by the Health and Safety Executive in relation to managing the risk of falls from windows in social care settings. The registered manager told us they did not believe anyone using the service would be at risk of falling from a window based on their care and support needs.

We recommend the provider reviews guidance from a reputable source in relation to assessing and managing risks in relation to the safety of the premises and equipment: This should include window restrictors and bedrails.

The home had contracted a third party to carry out a fire risk assessment on their behalf in October 2016. We saw most actions identified on the risk assessment as needing attention had been completed. The final outstanding actions from the fire risk assessment were in the process of being completed at the time of our inspection. We saw staff had taken part in fire drills, four of which had been held in 2017. There were frequent recorded checks of the fire alarms and emergency lighting systems.

We saw procedures had been followed to help ensure staff employed by the service were of suitable character and held any required qualifications for the role they were being employed for. This included obtaining references, identification, a health declaration and a disclosure and barring service (DBS) check prior to making an offer of employment. A DBS check provides information on whether the applicant has any convictions and helps providers make safer recruitment decisions.

The registered manager carried out a bi-monthly infection control audit. The home was visibly clean and free from any malodours and we saw personal protective equipment (PPE) such as gloves and aprons were available for staff use. There were prompts and guidance displayed around the home to remind staff of good practice in relation to hand hygiene, and we saw the registered manager had audited practice in this area in August and September 2017. We visited the laundry area and found procedures were in place to help ensure clean and dirty laundry was kept separately to reduce risks of potential cross contamination.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with felt staff were competent and able to meet the needs of their family member. One relative told us, "Staff are knowledgeable and able to meet [person's] care needs." Staff told us they received adequate support and training during their induction to allow them to feel confident to carry out their job roles effectively. One staff member told us they had received training in a range of care tasks as part of their induction including tracheostomy care, use of oxygen and administering rescue medicines to people who could have epileptic seizures. They said, "If I didn't feel confident, I could ask for extra training, which I would get."

We saw the registered manager or another competent person had assessed staff member's understanding of the training they had received. They had also completed competency assessments to ensure staff were able to safely carry out care tasks they had received training in. Checks of staff practice were also carried out as part of the supervision process. For example, this included observation and feedback to a member of staff following the support they provided to a person who had had a seizure.

Records showed training in a wide range of topics was provided to staff. Staff had received some of this training prior to the opening of EAM lodge whilst working in other services, including the neighbouring EAM House. This included training in safeguarding, first aid/resuscitation, moving and handling and clinical care tasks such as suctioning, medicines administration and percutaneous endoscopic gastrostomy (PEG). A PEG is a tube that is inserted into the stomach, often to provide food, fluids or medicines to people who are not able to take them orally. However, we also found gaps in training provision that was important to ensure staff were able to provide safe and effective care to people living at the home. For example, in the previous three years, of the staff team of 16, six (38%) had not completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Eleven staff (69%) had not completed training in learning disability awareness, and five (31%) were still to complete epilepsy training. The providers training matrix showed that one staff member had received training in behaviours that challenge/de-escalation techniques. The provider assured us that eight staff had received this training, but the information had not been added to the training matrix. They also said that other staff had been briefed as to the content of this training in a team meeting. Whilst we observed staff providing effective support to a person whose behaviours could challenge the service during the inspection, we also found evidence that good practice was not always followed. We reviewed records of incidences of behaviour that could challenge and in two cases, staff had recorded that they had employed negative techniques, rather than using distraction, de-escalation or positive responses.

Staff had not received adequate training to ensure the consistent provision of effective care. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received supervision approximately every month to every three months, although the deputy manager had received less frequent supervision. The registered manager told us this was due to difficulties scheduling supervisions due to their shift patterns. We saw actions from the staff member's last supervision were revisited, and a range of topics discussed. This included a review of the staff member's training, a

discussion around selected policies, health and safety, role and duties and feedback on the staff member's performance. This would help the registered manager ensure staff received adequate support and were aware of the home's policies and procedures.

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.

The registered manager had identified potentially restrictive practices and had made DoLS applications as required to the supervisory body (local authority). We saw four of the applications had been authorised, and the registered manager was aware of any conditions attached to these authorisations. Staff had a reasonable understanding of the principles of the MCA and DoLS and were able to tell us, for example, that any decisions made on behalf of a person who lacked capacity should be in their best interests. Staff told us they would always ask a person for permission before providing any care and support, and we observed this happening throughout the inspection.

Care plans contained a standard note that they had been developed in consultation with the person and those involved in their care to be in their best interests. One care file we reviewed contained a good level of detail about how staff could support this person to be involved in, and wherever possible, make decisions themselves. For example, information was provided about how to present choices and support this person to communicate their decisions. However, we also found less positive examples of practice in relation to the MCA. One person's care file stated to respect the wishes of the person's family member if they did not want them to participate in certain cultural events, without stating how that person's own wishes should be taken into consideration. In two people's care files we saw forms had been signed by people's relatives to consent to contact with their GP, sharing information and taking photos for example. It is good practice to consult with and consider the opinion of other people involved in an individual's care. However, other people are not able to provide consent on behalf of the individual unless they have proper legal authority, such as a lasting power of attorney for care and welfare. This practice would increase the risk that decisions about people's care would not be taken in accordance with the MCA. The provider told us they would review the wording of people's care plans and remove consent forms that had been signed on a person's behalf when that person did not have proper legal authority.

The home environment was light, clean and spacious. The home had wet rooms and equipment such as shower tables and tracking hoists to help meet the needs of people with reduced mobility. There was no call bell system in the home and the registered manager told us there was no use of assistive technology such as pressure sensors (to detect falls or someone getting out of bed) or seizure monitors for example. They told us such risks were managed though frequent 10-minute checks carried out when people were in their bedrooms. We saw evidence that these checks had taken place. The provider told us they felt regular checks were the best way to monitor people's wellbeing and ensure their safety. They told us few people using the service would be able to operate a call-bell and that the use of 10 minute checks was a standard approach as detailed in their statement of purpose.

We recommend the provider reviews, on an individual basis, whether the use of assistive technologies may

provide a potentially less intrusive way to monitor people's safety and wellbeing.

We found a number of people living at the home required the use of suctioning to remove secretions, maintain oral hygiene and keep a clear airway. We found each person had one suction machine, but the home did not have its own back-up machine in case these failed. The registered manager told us they had access to a service that provided a same day replacement, but acknowledged this could take several hours. The provider had not assessed whether this posed a potential risk to people using the service, nor identified any ways in which to manage this risk.

When reviewing people's care files we saw their weights had not been recorded at regular intervals. The registered manager told us it was difficult for the service to record the weights of people who were not mobile as they did not have hoist scales or other means of measuring the weight of people who were not mobile. This was of concern as the weights being provided to dieticians to determine what nutritional support people required were potentially out of date.

The provider had not ensured equipment required to meet the needs of people living at the home was always available, or assessed how to manage risks associated with such equipment not being available. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed a chef who also worked for the neighbouring service EAM house. There were no set menus, and the registered manager told us the chef would prepare food to meet people's needs and preferences based on who was staying at the service at that time. Staff told us most of the people who used the service were not able to clearly state their choices for meals, so they would offer options once prepared. They told us they would always offer alternatives if the person showed signs they did not want to eat the food that had been offered. Staff we spoke with were aware of the support people needed to eat and drink, and any dietary requirements, as detailed in their care plans.

Relatives we spoke with felt the service were effective at noticing any changes in their family member's health and making referrals to other professionals as required to meet their health care needs. One relative told us, "They [staff] responded straight away when [person] had some skin soreness." Another relative talked about the service making a referral to a speech and language therapist (SALT) to get advice in relation to the support they needed with eating and drinking. The registered manager told us people living permanently at the home were supported to attend an annual health check with their GP, and records showed there was frequent contact with other health professionals such as dieticians, GPs, physiotherapists and SALTs.

Good

Is the service caring?

Our findings

We were able to speak with one person who lived at the home with the support of the registered manager. It was clear from our observations of the registered manager's support that they had a thorough understanding of this person's communication support needs and they were effective at helping this person communicate with us. The person told us they were happy living at the home, liked the other people who stayed at the home and felt they could let staff know if they had any worries or concerns.

Relative's we spoke with told us there were consistent teams of staff who knew their family member's well. One relative we spoke with told us, "The staff are warm and friendly with everyone living there." Another relative told us that staff had supported their family member when they had to be admitted to hospital and told us nurses at the hospital had commented on how well staff from EAM Lodge knew their family member. They commented, "Staff are fun and enjoy doing what they are doing." A third relative said their family member always returned from their stays at the home in a good mood and happy. We observed one person returning to the home after a day out and staff greeted them positively and enthusiastically. Their family member told us this kind of approach worked well for them and they told us staff had taken on board advice they had given on how to support their family member effectively.

The service had a 'homely' feel, which was commented on by both people's relatives and staff at the service. People's rooms were personalised and contained personal effects and photos. We also saw people's art-work displayed around the home. One relative told us the staff were like 'friends' to their family member, and when asked what they felt the service did particularly well, staff talked about having close relationships with the people living there who they described as being 'like family'.

Staff we spoke with were knowledgeable about people's likes, dislikes and preferences. Staff communicated effectively with people and in ways that supported their independence and respected their dignity. For example, we saw staff would speak to people at their eye level and present clear choices and support people to make decisions themselves as far as was possible. Staff were responsive to people's needs and we saw they were aware of people's non-verbal communication and respected their choices. For example, at one point during the inspection we observed people were supported to take part in a group 'pamper' and massage session. We saw one of the staff member's picked up that one person wasn't enjoying the session and offered them alternative ways to join in with the activity. The registered manager told us that in the past staff had supported people's communication using aids such as pictures or Makaton (the use of signs to support verbal communications). However, at that time they told us most people using the service would not benefit from the use of such approaches.

People's care plans contained information about people's abilities and how staff could support them to retain as much independence as possible. We found staff were aware of and followed this guidance. For instance, one person's care plan stated that they liked to help set the table at meal times and we saw staff supported and encouraged to complete this task during the inspection. Staff also supported people to engage in activities such as playing on a games console by using hand on hand support.

Care plans also contained personalised information on how staff could help maintain people's privacy and dignity, whilst for example, providing intimate personal care. Staff told us they would always explain what support they were going to give to people clearly and would try and involve them in their care as much as possible. They told us they would be mindful to ensure doors were shut when providing care to help maintain people's privacy. However, as discussed in the effective section of this report, the provider had not considered the impact that routine 10 minute welfare checks might have on people's privacy. There may have been less intrusive ways the provider could manage risk to people's safety and wellbeing that were less intrusive.

The registered manager told us there was not anyone using the service at that time who they had identified as having any specific support needs in relation to their sexuality, culture, gender or other characteristics. We saw any needs in relation to people's religious or cultural support had been considered as part of the care planning process.

Good

Is the service responsive?

Our findings

Staff supported people to engage in a range of activities both inside the home and in the community. We spoke with one person living at the home who told us they had recently been supported to go to see their favourite band in concert. Relatives told us their family members were supported to take part in activities on a regular basis. One relative told us, "[Person] has been out to the cafes and pubs around the area recently. They love going out, and they [the staff] seem to be doing more of that. It was a worry [person] would be left sat here when they moved in, but that doesn't happen."

The registered manager had introduced an activity planner for people living at the home, which included people's usual activities. This included sewing, attending day centres, wheelchair dancing, music sessions and art groups. We saw the registered manager had discussed activities during a recent staff team meeting and had stressed that the activity time-table was a guide but was flexible to meet people's preferences. During the inspection we observed a pamper session, staff supporting people to play a video game and a music session. We could see people enjoyed these sessions from their involvement and smiling and laughing.

The service supported people to maintain social relations and to be involved in their communities. For example, one person regularly attended church, and people attended local luncheon clubs. On the second day of our inspection, we were present when a number of people returned from attending college, day services or trips out. Staff greeted people warmly and supported them to sit together and partake in discussions about their day and other activities. This would help people living at the home build and maintain relationships with one another. We saw staff supporting one person living at the home to use a tablet computer to email family who were not able to regularly visit. Staff also supported them to email a member of staff who worked in the neighbouring service who they knew well and had a good relationship with. This showed that staff had thought about how to meet people's social needs and prevent social isolation.

Staff had assessed people's health and social care support needs in relation to a range of areas, including specific health care needs, communication, personal care, hydration/nutrition and activities. Care plans identified how staff should meet people's assessed needs and were personalised for each individual. We saw care plans had been reviewed at least every six months, and often more frequently than this. People who were coming to stay for a short break at the service, or their relatives/carers, were asked to provide a written update on any changes to their care and support needs for each stay. This would help ensure staff had up to date information on the care and support they needed, and any changes to their preferences.

Care plans contained information on people's preferences in relation to how they liked to receive care and support, and how staff could support them to have a good day. For example, one person's care plan in relation to sleep contained a good level of detail on that person's preferred bedtime routine. This included information on the prompts staff should provide and their preferred clothing/bedding. This would help enable staff to provide person-centred care. Staff were asked to read and sign care plans, although we noted not all staff on duty during our inspection had signed all the care plans we reviewed. However, staff we

spoke with had a good understanding of how to meet people's needs and preferences as was detailed in their care plans.

Relative's we spoke with told us they had been involved in the planning of their family member's care where this was appropriate. We spoke with one relative about the process followed surrounding their family member's move to the home. They told us the service had provided them with lots of information and they said they were able to ask staff lots of questions. The care plans for their family member had then been developed with their input so they could be tailored to reflect their family member's usual preferred routines.

The service had a complaints policy in place that set out the organisations expectations as to how they would handle any complaints. The registered manager told us no formal complaints had been raised since the service opened. Relatives we spoke with told us they would feel comfortable raising any concerns they might have with the registered manager or another member of staff. One relative said, "I have no complaints. Staff are really accessible and will listen to any concerns you have." Another relative told us they had raised a concern when their family member first started living at the home, which had been promptly addressed to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Care Quality Commission (CQC) since September 2016. The registered manager was also a registered learning disability nurse. The registered manager told us they were new to the role as a registered manager, but felt they received sufficient support from the directors of the company to fulfil the requirements of their role.

The registered manager knew the people living at the home well. Through our observations of their interactions with people using the service, we could tell they had developed positive and caring relationships. Our discussions with the registered manager also led us to conclude they strove to provide person-centred care, high quality care. For example, they spoke about balancing the need some people had for structure and relating to their physical support needs, with providing a service that was homely and was not institutional. These values were also reflected in the discussions we had with other members of the staff team, and confirmed by relatives we spoke with. For example, one relative told us, "What we like about The Lodge is it is quite a small home with a family, homely atmosphere, whilst continuing to meet care needs."

Staff told us they felt supported and were comfortable approaching the registered manager or one of the nurses for advice and support should they need it. We saw monthly team meetings were held, which included discussions around topics such as activities, provision of care and policies and procedures. Staff told us they were also able to raise topics for discussion and they felt they were listened to. Staff told us they felt valued for the work they did and generally enjoyed their jobs. One staff member told us, "It [their job] is challenging but rewarding… I think it [the service] is fantastically run."

Relatives we spoke with told us staff at the home communicated well with them. One relative commented that if they left a message, they knew it would be passed on to the right person. Another relative told us staff had kept them updated by text message when they were abroad and their family member had to be admitted to hospital, which they had appreciated. Relatives told us staff at the home were open and honest, and informed them of any 'mistakes' that happened whilst caring for their family member.

The manager undertook a range of audits to help monitor and improve the quality and safety of the service. This included an infection control audit every other month and monthly checks of daily records of care, care plans and risk assessments. The registered manager told us questionnaires had been sent out to relatives of people using the service to ask for their feedback, although these had not been returned at the time of the inspection. We saw people were routinely asked for feedback on their experiences during their last stay when they stayed at the service for short breaks.

The registered manager completed a weekly audit of medicines, which involved checking the stocks of medicines. However, we found this system of auditing made it hard to easily check whether medicines had been administered as prescribed, and in one instance we found a clerical error indicated there were 10 more tablets in stock than we found there actually were. The medicines audit was also limited in scope and did not consider factors relating to the safe management of medicines such as staff training/competence, safe storage and destruction. We also found staff had inconsistently completed records of medicines checks

during handovers. These had been recorded only one time in October 2017 and on two days in September 2017. However, we did not find any significant shortfalls in the safe management of medicines other than the absence of temperature monitoring.

There were shortfalls in the provider's oversight and management of the quality and safety of the service in relation to the training of staff, and provision of sufficient equipment meet people's needs in a way that was safe and effective. The provider had not been ensured that staff had received training in all areas that were relevant to provide people with effective support, and there was no evidence that consideration had been given as to how to effectively monitor people's weights in the absence of suitable scales for example. This is discussed in more detail in the effective section of this report. Not all care being provided was clearly recorded as staff had not maintained records of repositioning for people that required this support.

The provider had a range of policies in place to help guide staff and ensure a consistent approach across the staff team. We saw policies and procedures were discussed with staff during their induction, supervisions and team meetings. This would help ensure staff remained aware of the correct approaches to follow, for example, in relation to safeguarding and social media.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured equipment required to meet the needs of people living at the home was always available, or assessed how to manage risks associated with such equipment not being available. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received adequate training to ensure the consistent provision of effective care. Regulation 18(2)