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Earlfield Lodge

Inspection report

25-31 Trewartha Park
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 and 23 September 2016 and was unannounced. At the last inspection in June 2015 we found the provider was not following the principles of the Mental Capacity Act 2005. After the inspection, we issued a requirement action in relation to the breach of the Health and Social Care Act 2008, which we identified. Following the inspection the registered provider sent us an action plan stating that they had met the relevant legal requirement. During this inspection, we found that the registered provider had made improvements in relation to assessing people's mental capacity and providing care and treatments in their best interests.

Earfield Lodge is a care home providing accommodation for up to 65 older people some of whom are living with dementia but do not having nursing needs. During our inspection there were 59 people living at the home. The home is a large detached house situated in a residential area of Weston Super Mare and is set out into four separate units called Buttercup, Poppy, Lilly and Bluebell Cottage. Poppy and Lilly units provide residential care to older people, Lily and Bluebell Cottage provide care to older people who are living with dementia.

A registered manager was in post at the time of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not receiving their medicines safely. We found other concerns in relation to the management of people's medicines. Improvements were needed in the management of people's medicines. This is a breach of Regulation 12(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of this report.

People told us they felt safe living at the service. The environment was kept clean and free from hazards. Equipment and hazardous substances were safely stored and used appropriately.

Staff received training in relation to keeping people safe and they were confident about the action they needed to take if they had any concerns about people's safety, including safeguarding concerns. Care plans included information about people's abilities to make decisions and where required applications had been made to the local authority for Deprivation of Liberty Safeguards (DoLS) authorisations in respect of people. Staff obtained people's consent prior to delivering care and support and they respected people's decisions.

People received the care and support they needed with their healthcare needs. They attended appointments as required with their GP and other health care professionals involved in their care. Prompt referrals were made for people to other professionals when concerns about their health and wellbeing were noted.

Risk assessments had been carried out when planning people's care and appropriate risk management plans were put in place instructing staff on how to provide people with safe care and support.

People's dietary needs were understood and met. People told us they liked the food they were offered and that they were given plenty to eat and drink. Mealtimes were a positive experience for people and they had a choice of food and drink and where they ate their meals.

Staff received training and support which they needed to meet people's needs. Training was provided to staff on an ongoing basis and their competency was checked to make sure they understood and benefited from the training undertaken.

Regular staff meetings and one to one supervision sessions enabled staff to explore their training needs and discuss any additional support they needed to carry out their roles effectively.

People's privacy, dignity and confidentiality were respected.

Staff had a good understanding of people's needs, including their preferred gender of carer, routines, wishes, likes and dislikes.

Staff approached people in a kind, caring and patient manner. Information about the service including planned changes to the environment and up and coming events was shared with people and their family members in a timely way.

People, family members, staff and external health and social care professionals were complementary about the way the service was managed.

People, their relatives and staff described the management team as approachable and supportive and they had confidence in them. They said there was an open door policy operated at the service, which enabled them to speak openly, and in confidence with the management team.

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.

People's medicines were not always managed safely.

Risks people faced were planned for and managed safely.

People felt safe and staff had received training and were able to demonstrate what to do if they had concerns relating to people's safety.

People were supported by staff who had adequate checks prior to commencing their employment.

Is the service effective?

Good

The service was effective.

People were supported by staff who received appropriate training and supervision.

People made decisions in relation to their care and support and where they needed support to make decisions they were protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring and who knew them well.

People and those that were important to them were involved in planning their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's needs were reviewed regularly and any changes were responded to quickly.

People had access to a range of activities.

People's concerns and complaints were always taken seriously and were part of driving continual improvement within the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems for checking on medication need to be more effective at identifying areas found during this inspection.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

People had confidence in the management team and the way they managed the service.

Earlfield 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 the 22 and 23 September 2016 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection was carried out by one adult social care inspector; one specialist advisor with a nursing background and one Expert-by-Experience (ExE). An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During this inspection, we spoke with 12 people living at Earlfield Lodge and seven relatives about the quality of the care and support provided. We spoke with two health professionals, the registered manager, the deputy manager and10 staff who held various roles including care staff, domestic staff, chef and maintenance person.

We looked at seven people's care records and documentation in relation to the management of the home. This included nine staff files supervisions, training and recruitment records, quality auditing processes and policies and procedures. looked around the premises, observed care practices and the administration of medicines.

We also reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events, which the provider is required to send to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The provider supplied us with a range of documents, which gave us key information about the service.

Prior to this inspection we obtained information from the council who had commissioned the service. The council told us that they had seen improvements in the service that people received at Earlfield Lodge.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

People were not receiving their medicines safely because we found a number of problems with medicines management. There was an allocated medicines manager whose responsibility was to oversee the medicines within the home. They had received medicines training recently.

During the inspection we were unable to obtain or see a copy of the medicine policy due to computer problems. We were sent this following the inspection. We were also unable to see the master signature list that details all the staff signatures and initials who have the responsibility of medicine administration. This list is used to identify who was responsible in the event of any drug errors or issues detected by audits. We asked the deputy manager for a copy but they were unable to find it. The deputy manager confirmed that they would ensure a new one would be drawn up and provided to us. We have not yet received this list from the service.

We checked all the Medicine Administration Records (MARS) and found over a half of the MARS charts that had not been signed. After checking the blister packs it seemed the medication had been given but the MARS charts not signed. This meant that if staff looked at the MAR charts they could assume that the person had not been given their medicines and possibly be given a second dose which could be dangerous for the person. We also noted that a number of the MARs charts were loose and not attached to a folder like the majority of charts. This presents a risk that the MARS charts could easily be mislaid or lost and therefore staff would not know when medication had been given.

A number of MARS charts did not have a photograph of the person on them. This is important as people's appearances can change rapidly and photographs need to be dated when taken and updated as necessary. Where photos had been taken we found some of these to be dated. This ensures that staff who are unfamiliar with the person, such as new staff or agency staff, are able to accurately identify the person prior to the administration of medication. Allergies had been noted on the MARS charts.

The room that medicine stocks are stored in should have the room temperature taken on a daily basis; this ensures that medicines are kept in optimum temperatures and keeps them effective and safe to use. When we first entered the room it felt hot and had no natural ventilation apart from keeping the door open. The provider had installed an air conditioning unit for the purpose of keeping the room cool but it had not been switched on. We found that the room temperature had not been recorded since the 13th of January 2016. We immediately informed the deputy manager, who told us that they would ensure that it would be taken daily and would make sure a supervision session would take place with the staff responsible for recording it. However, we found that the fridge temperatures had been recorded daily; we found that they had and all were found to be within optimum limits, therefore the medicines that were stored in the fridges, such as those used by people with diabetes, were stored at the correct temperature.

Four people within the home were managing their medicines themselves. They had completed and signed a

service agreement regarding the self-administration of medicines that was kept with the MARS charts. However, we found that risk assessments had not been completed for these people and there was no guidance for staff on how to reduce any risks regarding self-administration of me We informed the managers who responded immediately and completed comprehensive risk assessments for all four people.

We also saw that a resident with epilepsy had not been given an epileptic drug in the morning; we immediately informed staff who rectified the situation. We followed this up on our second day and found that the person had received their medicines correctly. We discussed this potentially harmful episode with the deputy manager and they assured us that they would discuss this with the medicines manager and they would ensure that the staff member would be spoken with and their competence to give out medicines would be re-assessed if it was required.

This was a breach of Regulation 12(1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were not protected from the proper and safe management of medicines.

We noted that one person had not received a prescribed drug for 4 days. The drug was recorded as being unavailable. We were told that on occasions some prescribed medications were subject to delays in delivery and that staff had to 'chase' the pharmacy in order for drugs to be delivered. This could result in people not receiving the medications that have been prescribed for them by their general practitioner. The medicines manager told us that they were moving pharmacies to try to prevent this from happening in the future.

Staff who dispensed medications had received three sessions of observed practice and group medication training. Staff told us that the training had been very good. The medicines manager told us that further observed practice and training would be made available to staff who did not feel fully competent and confident.

We checked all four medicine trolleys and found that the majority of bottled medicines contained in the trolleys had been labelled with the date when opened. This is important as some liquid medicines need to be disposed of after they have been opened for a certain period of time. We checked a random sample of boxed medications and did not find any medicines that had expired.

All four medicine trolleys were securely fastened to the wall and the medicine keys held by the senior carer. When dispensing medicines we noted that the staff wore red tabards indicating that they were engaged on a medicine round and not to be interrupted unless necessary. Staff told us that it minimised interruptions and helped them focus and maintain their concentration when giving out medicines.

People told us that they felt safe living at Earlfield Lodge. They told us they felt safe, commenting: "I have not been here long but I have a gut feeling I am safe, and all my possessions are safe too", "I am safe, I am not bothered and I do not get any interference, it is as I like it", "I am safe because I am cautious as I walk, I can ring for help if I need it" and "I am safe because there are plenty of staff around to help me if I need them." Relatives generally felt confident their loved ones were safe. They told us, "The security is good; there is a constant staff presence".

Staff had undertaken safeguarding training and they had access to the provider's safeguarding policy and procedure and those set out by the relevant local authority. Staff were able to describe the different types and indicators of abuse and they were confident about how to report such incidents. A record of concerns, which had occurred at the service, was kept. The records showed that relevant staff, including the deputy

manager had taken appropriate action by informing the relevant authorities such as the local authority safeguarding team and the Care Quality Commission (CQC).

Staff demonstrated they were aware of whistle blowing procedures and they said they would not hesitate to use them if they needed to. Whistle blowing occurs when an employee raises a concern about dangerous or poor practice that they become aware of. Staff said they had access to the numbers they needed to use to raise any of these types of concerns, including the contact details for the relevant local authority safeguarding teams and the Care Quality Commission. Staff had access to key contacts such as the registered provider, manager and deputy manager should they need to contact them outside of their usual working hours for advice and support. Staff told us that they were notified about who would be on call and that the on call person had always responded when they called upon them

We spoke with the registered manager and deputy manager about timeliness of reporting allegations and the types of incidents that were reported and whether more incidents needed reporting to show how they were investigating and resolving situations as they were not always reporting incidents and how they resolved them. The registered manager and deputy manager agreed that they would action this and ensure prompt action. There was also evidence of action taken to reduce further risks to people.

After the last inspection, we recommended that the provider reviews their infection control systems in line with The Departments of Health's Code of Practice on the prevention and control of infection.

We found that people lived in a safe environment, which was hazard free, and clean. Equipment, which people needed to help with their independence, comfort and mobility such as wheelchairs and hoists, were clean and stored safely in dedicated areas when not in use. When using cleaning equipment and substances hazardous to health (COSHH) domestic staff supervised it closely and locked it away in secure cupboards after use. Appropriate warning signs identifying the storage of potentially dangerous substances were displayed on the outside of the cupboard doors. This was in line with Guidance on the Control of Substances Hazardous to Health (COSHH). Cleaning schedules were in place and being followed as required.

The home has a policy that isolates people for 24 hours on return from hospital in case of an acquired infection thus preventing any potential spread of infection throughout the home. However the room they use for this did not have a sink outside the room that staff could use to wash their hands on leaving the room or a receptacle for the disposal of used protective clothing. This presents a cross infection risk. We spoke to the registered manager about this and they told us they would look at putting a sink outside as a matter of urgency.

Staff used personal protective equipment (PPE) such as disposable gloves and aprons when carrying out tasks, which had the potential to cause a spread of infection, for example handling soiled laundry and waste.

Each person and staff member had a personal emergency evacuation plan (PEEP) which provided staff with information about how to support and assist the person out of the building in the event of an emergency. A copy of each person's PEEP and the registered provider's evacuation procedure was stored in a file held near to the main entrance of the service and staff knew where to locate it.

Risks people faced were assessed and planned to keep them safe. New risk assessment documentation, which was introduced prior to this inspection, had been completed for each person. Care plans documented any identified risks. For example, where a person was identified of being at risk of falls, measures staff were required to take to minimise the risk were included in the person's care plan. This

included the use of equipment and the support they required from staff, including the number of staff.

Risk assessments were carried out in respect of people for other things such as nutrition, the environment and moving and handling. Risks to people were regularly reviewed and care plans were updated when a new risk was identified or if an existing risk reduced or increased.

There was a system in place to record and monitor accidents and incidents. Following an accident/incident a reporting form was completed which recorded the name of the person affected, date, a description of the incident and action taken. In addition, an incident/accident log was completed and analysed each month as a way of monitoring any patterns and trends. Any patterns or trends were acted upon to keep people safe. For example, when it was noted that a person had experienced an increase in falls an appropriate referral was made to the community falls team.

Staff recruitment records showed that appropriate checks had been undertaken before employment was confirmed. Staff members had completed an application form, attended an interview and provided photographic evidence of their identity. A Disclosure and Barring Service (DBS) check had been carried out and a minimum of two references were obtained in respect of the majority of staff members, including one from their most recent employer. A DBS check consists of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This helped the registered provider to make safer decisions about the recruitment of staff. We discussed a staff file, which did not have two references on it, and the deputy manager told us they had chased them in the past but would get the office manager to contact them again. The office manager told us they had begun to do this.

There were sufficient numbers of suitably qualified and experienced staff to keep the numbers of people currently living in Earlfield Lodge safe. The staffing rota was developed a minimum of two weeks in advance and took account of the occupancy level and the needs of people who used the service. The deputy manager explained that they were actively recruiting more staff because they did not use agency staff to cover staff holidays or sickness and they recognised the current staff team had worked very hard over the summer and more staff were needed.

At the time of our inspection there were 10 care staff on duty, the registered manager, deputy manager and a team of ancillary staff including cook, kitchen assistant and domestic staff. The staffing arrangements at night were four care staff, which included a senior carer. Discussions with people and the staffing rotas showed that these arrangements were usual. People who used the service, family members and staff told us that they thought the amount of staff on duty each day and night was sufficient to keep people safe unless numbers of people living at Earlfield Lodge increased and the number of staff would need to increase to safely support and care for people.

Good

Is the service effective?

Our findings

The service was effective.

At the last inspection, the provider was in breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to obtain the consent of people for their care and treatment at Earlfield Lodge. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

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.

We found that two people were having what is called covert medicine administration. This meant that the person taking the medicines is not aware they are being given. When we looked at these people's care files we noted that the home's processes had not been followed. We informed the managers who immediately responded and completed a mental capacity assessment for both people and were arranging for a best interest meeting to be held that would involve a relevant health professional and their relatives. These meetings will be fully documented, records kept in the people's care file and a review date set within the following six months.

However apart from the above, we saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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 made applications for DoLS where appropriate. For example, one person who lived with a dementia related illness kept trying to leave the service but was unable to due to risks to their wellbeing. There was an up to date DoLS authorisation in place for this person. People were protected from the use of avoidable restraint. We saw that where people had the capacity to consent to aspects of their care and support they had signed consent forms which were kept in their care plans.

People were supported by staff who had knowledge and understanding of the MCA. Both staff we spoke with had a good level of knowledge about their duties under the MCA and how to support people with decision-making. People decided how and where they spent their time as well as make decisions about their care and support. People told us that they are able to make their own decisions. One person told us, "I get up when I want and I go to bed when I want. Everything I do is up to me." Another person told us, "If don't want

to sit in the lounge I can go and stay in my own room. I love my room. I love to watch the birds through the window. There were plans in place informing staff of how people's behaviour should be responded to and what may trigger the behaviour. Although staff had not yet been given training in relation to responding to behaviour using least restrictive methods the staff we spoke with had an understanding of people's behaviour and how best to support them. The acting manager told us this training was being arranged via the area manager.

People were supported by staff who were given training in how to support people safely. People who used the service and relatives told us they felt staff were competent and well supported. One relative told us, "The ones (staff) that are here do seem to be well trained." The deputy manager told us that staff were trained to meet the health and social needs of people who used the service and that this training was ongoing to ensure staff skills and knowledge was current. The home was also considering implementing an on line training system and providing computers in a separate space in the home where staff can update their training.

Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. They told us that their training was good and that managers responded when staff identified ongoing training needs. We saw records, which showed that staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and infection control. Staff told us they felt they needed training in relation to supporting people who sometimes expressed themselves through behaviour due to living with a dementia. We spoke with the deputy manager about this and they told us this was already being addressed and the care manager was arranging training sessions for staff.

People were cared for by staff who were supported to gain the skills and knowledge they needed when they first started working in the service. New staff were given an induction before they started caring for people and this included completing the care certificate. The care certificate is a nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the care manager or senior staff member and were given feedback on their performance. However when we looked at the supervision timetable we found that only 11 supervisions had taken place since June 2016, the most recent supervision was dated 10 July 2016. Supervisors' signatures had not been recorded on the majority of supervision records that we looked at and no review date had been identified. We did note a number of 'observational' supervisions.

Regular supervision gives staff the opportunity for focused one to one time with a senior member of staff to discuss how they feel they are performing in their role. It also enables the senior staff member to feedback on the employee's performance and addresses any performance issues. It is also an opportunity for staff to offer ideas and suggestions to improve the service. We spoke with the deputy manager about this and they told that due to time pressures over the summer period they had not held as many supervision sessions as they needed to but they did say they tried to speak with all staff members' on an informal basis to make sure they were alright. This was confirmed by staff. With regards to yearly appraisals we could only find 22 completed appraisals, the most recent conducted at the end of July 2016. The appraisal documents that we looked at did contain the name of the appraiser and identified the dates that the appraisal covered. However, the next appraisal date had not been clearly identified.

People were supported to eat and drink enough. People felt they had enough to eat and that they enjoyed the meals. One person said, "We get good plain cooking which is what I like. Teatime is really good because we get a good choice of sandwiches or poached eggs on toast." Another person said, "We can have beans on toast or tomatoes and sometimes we have kippers for a change. Then there is always a nice cake to follow." We observed lunch and saw the meal looked appetising and nutritious. People were supported to eat when this was needed and the cook had a good knowledge of people's individual needs and preferences.

People's nutritional needs were assessed regularly and there was information in care plans detailing people's nutritional needs. We saw staff had noted when one person had lost weight and they had sought advice from the person's GP. This person had been placed on supplementary food to boost their calorie intake and we saw staff were giving these appropriately. Staff were also recording what the person ate so that their nutritional intake could be monitored. Another person had been assessed as needing a specialist diet and we saw guidance was recorded in the person's care plan and we observed the person was given the specialist diet on the day we visited. People were supported with their day-to-day healthcare.

We looked at a number of food and fluid charts and found them to be completed with details of the amount of fluids a person ideally will be drinking throughout the day. This helps care staff to encourage fluids and prevent potential dehydration that can lead to urinary tract infections and other problems.

We saw people were supported to attend regular appointments to get their health checked. Staff ensured people had access to their GP, optician and chiropodist. One person told us, "When I'm poorly, they bring the doctor and they let my daughter know as well. It's never a problem because the doctor will come to anybody who needs help." Staff sought advice from external professionals when people's health and support needs changed. We spoke with a visiting health professional and they told us they visited the service regularly to support staff with the health needs of the people living in the home. The visiting professional told us they felt staff were proactive in seeking health care advice and implemented any recommended actions. We saw there was a range of external health professionals involved in people's care, such as physiotherapists and the Speech and Language Team (SALT).

Good

Is the service caring?

Our findings

The service was caring.

People felt happy living at Earlfield Lodge . They told us staff are very kind and friendly, they chat to them whilst doing personal care, they are never rushed. People said call bells are responded to in a timely manner and staff didn't rush them. People said: "Staff are most willing, they are nice people and are polite" and "Staff are very friendly and caring, they are nice, they try to help me as much as they can and are not nasty". Another explained, "Staff are discreet and careful, they do things as I want them, they are kind to me." However, we did observe one incident that involved a carer not informing a person that they were going to put the head of the bed down. A senior member of staff immediately informed the carer that this was unacceptable and to always speak with the person before doing anything so that they are aware of what is going to happen.

Relatives were very also happy with the care their loved ones received. Their comments included; "Staff are kind and caring, my relative is no longer active, they do not want to tell the staff if they are in pain but they know, and react to it." and "Recently staff recognised that my relative was not well and immediately contacted the GP surgery. A Nurse came straight away and called for an ambulance to take them to hospital. Staff are kind and caring, respectful and good humoured."

Staff were able to tell us parts of people's life histories and the service was working on putting this information together into a comprehensive record. Staff we spoke with enjoyed their role in supporting people and spoke with affection when describing the people living at the home. One staff member told us, "I love my job. I love working with the elderly."

People had been involved in developing their care plans wherever possible. When this was not possible, we saw that relatives had been involved to plan care based around people's known preferences. Care plans were person centred and contained information about people's likes, dislikes and preferences for care. People's individual conditions had been considered in their care plan and the specific support the person required was documented.

People told us that their relatives could visit with no restrictions and one relative told us, "I come whenever I want." Another relative informed us, "I appreciate the hospitality they show me." Another relative told us, "It's a comfort for us that we can visit when we want to with no restrictions." Relatives were happy that the service kept them informed of any changes to their relative's care and one relative told us, "They keep me involved with care. We ring each week and they keep me updated." Another relative told us, "If anything crops up that's worrying they will ring and let us know what's happening." People's relationships with relatives were encouraged and respected by staff and people's privacy was respected at this time.

Relatives told us that they valued the way the service supported their relative and themselves. One relative explained the importance of this and told us, "I appreciate that I can visit to keep in touch. I can still partake in their life and know there cared for when I leave." Relatives described an approach of working closely with

the service to ensure their relative received care based on their preferences. Staff that we spoke with clearly knew the residents well and were able to identify and respond to residents' personal preferences.

Staff told us that they tried to support people to remain as independent as they could be wherever possible. One staff commented, "We encourage them to do whatever they can." People living at the home had their dignity maintained and staff had taken care to support people with their appearance.

People told us that staff treated them with dignity when supporting with personal care tasks. One person commented staff left them to shower independently but that they were nearby should the person need support. This person commented, "I do most things, except a shower but they leave me in the shower room which I like. They keep knocking to make sure I'm okay - that I don't slip." We saw that people could access their bedrooms when they chose to should they wish to have some privacy.

Good

Is the service responsive?

Our findings

The service was responsive.

People felt they received personalised care which was responsive to their needs and that their views were listened to and acted on. One person told us, "All the treatment is very good." A health professional described staff as being, "Very attentive," in responding to people's changing needs.

We looked at seven care plans were detailed, comprehensive, up to date and contained information that related to the persons' social history. This ensures that a person's care plan is an accurate reflection of their current level of need. Care plans contained information about personal preferences, routines, and interests as well as details about medical history, medication, weight, risk assessments, sleep, hearing and eyesight, communication and body maps. Body maps are important as they help to identify the location of any injury.

Records showed that people, and where applicable, their families, had been involved in discussions about resuscitation, and their wishes recorded. We also observed sensitive and thoughtful actions such as putting names on family photographs so that people could be reminded of family names. The deputy manager told us how they viewed people's care plans as an ever-evolving document, and were continually working with people and staff to ensure the contents were person centred. This ensured care plans were individual to that persons care needs.

A 'resident transfer and discharge page' provided a summary of information about people's needs. This was useful to health professionals if the person needed to go to hospital in a hurry. One person confirmed how their care plan reflected the level of care and support they received, as well as their individual preferences on how the support should be given. This showed that the information was being kept up to date and reflected people's needs and choices. We asked the manager and staff questions about people's individual needs, and the information they gave us reflected what we had read in people's care plans. This demonstrated that staff had read the documents and had a good insight into people's needs.

We looked at the turn records of people who are unable to get out of bed and observed that they were all accurately recorded. This ensures that people who are at risk of developing pressure areas are regularly turned to prevent pressure on one part of their body.

Staff had provided support throughout the week to enable people to participate in the available activities. We saw evidence that activities were carried out. People told us that there were social events that they could participate in. One person said, "Lovely home always something going on." Another person spoke about the, "Wonderful music and quizzes," arranged by staff. Some people told us that they preferred to stay in their bedroom, rather than join in with organised activities. One said, "Do puzzle books and puzzles…I like to be here with all my things." One spoke about regularly attending the weekly, "Men's club," which they had just been to, this was organised by a male member of staff. They said that they played pool, cards and just chatted about things.

We observed a person living with dementia, reading the daily paper, which their care notes said they enjoyed doing. The range of social activities offered took into account people's differing needs. People were very complimentary about having a chapel built within the home and how it enhanced their wellbeing. One person described them as being, "Very inspirational, very good. We spoke with the deputy manager about those people who were at risk of social isolation if they chose to stay in their bedroom and they told us that staff made sure they went in and out of those rooms on a regular basis to ensure they were not left alone for long periods but that they were aware that the activities should be more meaningful to them. One person told us, "We have had some very interesting talks." The home provided chiropody twice a week, hairdressers twice a week and daily newspapers for free. The home also has a minibus and which takes people for various social activities in the local community, for example to a local garden centre for a cup of tea.

We observed notices around Lily and Bluebell Cottage to guide people who might have memory loss; either on their bedroom doors or to guide the way to other areas such as the dining room. We observed staff directing people to those areas. The deputy manager took us into the garden adjoining Bluebell Cottage and explained that people could come out whenever they wanted too as the garden was secure and built especially for people living with dementia. The registered manager showed an award given by Dementia Care Matters. Earlfield Lodge were one of only three homes in the area to be given this for their work supporting people living with dementia.

People knew who to speak with if they needed to make a complaint. They said that they felt confident that their comments would be listened to. One person said they would, "Tell the manager." There was a complaints procedure in place, which was displayed in the service, and explained how people could raise a complaint. There were systems in place for recording, investigating and responding to complaints. The deputy manager said that 5 complaints had been raised formally in the past 12 months. We saw that these had been dealt with in line with the providers' policy. A relative provided an example of where they had raised a concern about a person's food going cold before they had a chance to finish, and how they worked with the manager to address it. The manager told us how they used feedback from concerns and complaints raised in a positive manner, ensuring they took action to reduce the risk of it happening again, as part of driving continuous improvement within the service.

A relative told us they had recognised several months ago improvements to the overall management of the service. They commented that they thought the improvements had been sustained and that they had noted further improvements to the service. For example, they said they had received continuous updates over the telephone regarding their relative, which was important as they lived out of the area and found it difficult to visit as often as they would like to. The relative described the management as efficient and proactive.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led

At the last inspection we recommended that the service improve their systems for monitoring and assessing the quality of the service. During this inspection, we found that there were more effective systems in place for monitoring the quality of the service and making improvements. However, we found checks around medication failed to identify the issues found during this inspection. For example, that the temperature of the medicines room had not been taken since January 2016 and risk assessments had not been completed for people who self-administered their medicines. The service conducts monthly MARS chart audits and we noted that this had been last done on the 23 August 2016. A six monthly medicines audit had been completed on 3 August 2016. The service also, according to its medicines policy, is meant to conduct daily second person checks of MARS charts for omissions. This had not been done consistently since 10 September 2016which meant the provider had not followed their own policy and had missed opportunities to find omissions. We received confirmation from the manager during and following the inspection that they had acted upon the concerns.

The manager, deputy manager and senior staff carried out checks at various intervals on other things such as people's care records, the environment, housekeeping, catering, and staffing and infection control. A record of the checks which were kept detailed the specific areas covered, the outcome of the check and where required comments were recorded detailing any required improvements which were needed. Action plans were developed, to address areas for improvement and they included who was responsible and timescales for action. Once the action was completed, it was checked and signed off by the manager.

People who used the service, family members, staff and visiting health and social care professionals were complementary about how the service was managed. They described the registered manager, care manager and deputy manager as supportive and approachable. Comments people and relatives made included, "They are always around checking if we are ok", "So much has improved lately because of them [managers] "Just amazing", "We are never kept in the dark about anything. I have a lot of confidence in them".

People and their relatives received an annual survey to complete about the home, staff and care. feedback was analysed in order to make the right improvements to the service. People and relatives also were invited to attend 'residents and relatives meetings. During the inspection, staff freely approached the manager and deputy manager for guidance and advice as well as to update them on changes to people within the home.

Staff described an open and supportive culture amongst the team. They said they had no concerns about approaching the management team with any questions or requests for advice or if they had a personal issue which impacted on their work. Minutes of staff meetings showed staff were provided with updates and encouraged to ask questions and make suggestions about the service. The minutes also showed that the management team consistently reminded staff of the visions and values of the service and encouraged a positive culture amongst all. They promoted high standards of care for people who used the service and acknowledged staff for their hard work. One member of staff told us that they had learned a lot from the

deputy manager.

There was a system in place for reporting and recording any accidents or incidents, which occurred at the service. The records were analysed on a regular basis as a way of identifying any trends or patterns and they were used to learn lessons and help prevent any future occurrences. Policies and procedures were in place to promote the delivery of safe and effective care at the service. The documents were kept in clearly titled files and stored in areas accessible to staff should thy need to refer to them.

During the previous inspection, the deputy manager told us that the care manager was in the process of reviewing all of the policies and procedures in place and we saw that this had been done. This meant that staff and relevant others had up to date information on delivering safe, effective care and support to people. Updates made to information, which impacted, on the service delivery were shared with staff through group and one to one meetings.

The manager and registered provider had informed us about any incidents or events which occurred at the service. This was in line with their responsibilities under The Health and Social Care Act 2008 and associated Regulations. For example, statutory notifications had been received in relation to accidents and safeguarding concerns which had occurred at the service.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment . People who used the service were not protected from the proper and safe management of medicines.