Gemini Care Limited

The Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 January 2017; the inspection was unannounced. Our last inspection took place on 21 July 2016. An overall rating of Requires Improvement was made at the 2016 inspection. On that occasion we had concerns relating to staffing and issued a warning notice to lever improvements. On this occasion we found that matters had improved and people's needs were being met with the staff provided. There had been progress overall and this is reflected within this report.

The Lodge is registered to provide care and support to up to 44 people, some of whom were living with dementia. On this visit 31 people resided at this residential home. This service is required to have a residential manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently left and a replacement was actively being sought. At this inspection the deputy manager had become the acting manager and was present, participated fully in this inspection as did the provider.

The numbers of staff were sufficient to meet the needs of people living at the service. This was because the numbers of people resident had decreased and staff had been better deployed at key times, such as lunchtime. The acting manager was continuously assessing the needs and dependency of people at the service and had allocated staffing as a result. People and staff consistently said there was sufficient staff to meet the needs. Staff were trained and supported by the acting manager.

We have identified a breach in regulation. This is because people were placed at unnecessary risk of developing sore skin as risks were not adequately mitigated through clear instruction and actions of staff. In addition medicines were not consistently managed safely and we identified areas to improve safety. A medicine trolley was left locked with the key in it and unobserved by staff. Crushed and covert medicines were not as safely managed as should have been. Medicines prescribed as a cream were not safely managed. Records did not protect people and staff as would be expected.

Staff had undertaken training in The Mental Capacity Act 2005 (MCA). They were consistently offering choices and respected peoples decisions. However, they along with managers were not clear on more complex decisions and how to go about making 'Best Interest' decisions.

Staff were attentive, visible, kind and demonstrating meaningful relationships with people. Relatives were positive about the care their relatives received. Privacy, dignity and respect were afforded to people. People enjoyed good nutritious food, with the lunchtime experience being positive for most people. We have fedback further minor developments to ensure everyone has a positive mealtime.

People had access to healthcare to maintain their health. Visiting health professionals spoke positively about what they saw at the service. People had access to a variety of activities and interests that they were

able to participate in.

The acting manager had made improvements in a short space of time and relatives and staff spoke positively about the changes they had seen. The culture was set to improve with developments being planned. Since our visit we have been sent information and evidence that shows that mangers and the provider continue to develop and monitor the service to ensure the safety of people living here.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The service did not consistently manage medicines well to ensure people were as safe as they could be.

Risks were not consistently assessed with safeguards in place. Specifically in relation to preventing sore skin and pressure ulcers developing. Infection control methods were not consistently followed by staff.

The provider maintained safety by making sure that there were enough staff on duty to meet people's needs. Staff had received training in how to recognise abuse and report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was routinely sought, but staff did not understand processes that should be in place to make 'Best interest decisions'. Where people lacked capacity and their freedom of movement restricted, the correct processes were in place. The Deprivation of Liberty Safeguards (DoLS) was understood by the manager.

Staff understood how to provide appropriate support to meet people's health and nutritional needs. Mealtimes had improved but needed further development to ensure it was a pleasing experience for everyone.

Staff received the training they required to provide them with the information they needed to carry out their roles and responsibilities. However, staff applying knowledge in practice was not checked.

People were supported to maintain good health and had access to healthcare services. However records monitoring health were not consistently completed.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring in the way that they provided care and support. Managers showed a caring attitude towards staff that in turn reflected upon people at the service.

People were treated with respect and their privacy and dignity was maintained.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before coming to the service and formed the basis of care plans. Care plans were becoming more individualised.
People were supported to follow a lifestyle of their choosing, with varied activities on offer.

There was a complaints system in place and staff were confident to respond to concerns and learn from matters raised.

Is the service well-led?

Good

The service was well-led.

Staff told us the management were supportive and that developments and improvements had been seen. New management promoted a positive and open culture.

The acting manager was developing further systems to monitor the quality of the service to take action to improve the standards when necessary.

People and their relatives were consulted on the quality of the service they received.

The 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 checked 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 was primarily to follow up on the warning notice relating to staffing but the timing of the inspection was prompted by information of concern that had been sent to us.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of unsafe medicines management. This inspection examined those risks.

This inspection took place on 12 January 2017 and was unannounced. The membership of the inspection team consisted of an inspector from adult social care, a specialist adviser and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of experience was older people/ dementia care. Our advisor was a specialist in clinical governance and dementia.

During our inspection we observed how the staff interacted with people who used the service and spoke with five people who used the service, three people's relatives, the acting manager and provider, nine care staff and one domestic staff member. We spoke one health care professional during the inspection.

We also looked at nine people's care records and examined information relating to the management of the service such as health and safety records, medicines, staff recruitment files and training records, quality monitoring audits and information about complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 21 July 2016 and the previous inspection dated 15 June 2015 we reported that there were insufficient numbers of staff to keep people safe and meet their needs all of the time. Therefore we issued a warning notice to lever the improvements we needed to achieve to keep people safe. In addition we met with the provider and the registered manager at that time. During the meeting we were given evidence and assurances that staffing was safe. At this inspection we found that staffing numbers were appropriate to meet the needs of people.

Staff were attentive, visible, kind and demonstrating meaningful relationships with people. A relative told us, "It is fantastic, they get brilliant care, there are always staff around, the carers are gentle and take time to talk to them." Staff consistently told us that there were sufficient staff. One said, "Yes there is enough staff and people are safe." Another staff member said. "Six staff is enough but if people's needs change then we can tell (named the acting manager)."

We observed that people consistently had their needs met. We were told that a staff member was allocated to the quiet lounge whilst people were there. We observed that a staff member remained there at all times during our visit and staff communicated with each other for additional support with care or to take a break. Lunchtimes were more organised with staff given specific roles and delegated tasks to ensure people were supported with personal care and eating at this busy period of time. One staff member said that the team was working together particularly at lunchtimes that were now more organised. The manager was able to show us that each person had their dependency levels regularly assessed, so that if people's needs changed then so could staffing levels. Since the last inspection resident numbers had dropped by five people and the staffing levels had been maintained at previous levels. We saw three weeks' worth of current rosters and these showed that staffing was consistently maintained at six staff during the day and three staff at night. In addition kitchen and domestic staff were employed. The service was appropriately staffed to meet the numbers and people's assessed needs.

Medicines were not consistently managed safely and we identified areas to improve safety. We observed staff administering medicines, examined records, stocks of medicines and storage. We observed one staff member lock the medicines cabinet, but leave the keys in it whilst they went to the other end of the lounge area to administer the medicine to the person. The staff member was kneeling down to make eye contact and would therefore not have seen if someone had gone to the cabinet. The medicines were not as secure as they could have been and were potentially accessible to people living with dementia or the keys could have been taken leaving the remainder of the medicines inaccessible. Later that day a different member of staff was observed to keep medicines secure at all times. They dispensed medicines one at a time, administered this to the named person and then signed the medicines administration record (MAR). We over heard them say, "Hello [named person], how are you? I have some tablets for you" They used a spoon to enable the person to take the medicine. "Have some water to wash it down. Finished?...I have some gel for your hand to make it feel better." The staff member wore a glove to rub the gel into the persons hand, disposed of the glove and then signed the MAR chart. We spoke to staff about their training and they said that they had received training and had been given updates on training. One staff member said, "I have had

training recently. Four times in all since I have been here."

One person was having a medicated plaster applied to their body daily. However the chart used was so full it was difficult to decipher. The staff member agreed to replace it that day. We found that one person was having medicines crushed. This medicines could have been prescribed in liquid form quite easily as it was paracetamol. This would have removed the need to crush the medicine.

A second person was having their medicines crushed and covertly administered. Staff did not understand the implications of crushed medicines. One said, "We would do it as the GP said to." Crushing medication is not an easy process, either using spoons or a pill crusher, often some is lost or spilt and the full dose is not given. A pharmacist should have been consulted to decide if the medicine is suitable to be crushed as this will affect the absorption rate. Staff did not also understand their responsibility in relation to covert medicines and capacity assessments needed under the Mental Capacity Act (MCA) a 'Best Interest Decision' was not in place. The care plan stated, 'needs to be crushed and put in jam as per GP instructions.'

Creams were not safely managed. Body maps were inconsistently completed to guide staff where to administer cream. The MAR charts were signed by senior staff but care staff administered creams. In one case there were gaps on the MAR and we were told the person had ran out but it was on order. In another case we could not locate the cream in the persons room and a staff member told us, "The family have brought in E45 cream and that's the same, so we are signing when we put that on." One person was prescribed a corticosteroid cream. Instructions on use had not been transferred to the MAR chart. There was no instruction guiding carers to wear gloves or to apply the cream thinly, these are essential instructions for this type of cream and this knowledge cannot assume to be known by the person applying the cream. This placed people at potential risk. People need to receive prescribed medicines consistently for them to be effective. Guidance needs to be clear for staff so that they can effectively apply and be accountable for their actions.

We saw one person was prescribed Thick and Easy to make their drinks safer to swallow. The instruction was 'as directed'. We asked staff how much they would use and received a variety of answers. Therefore people were placed at risk of chocking as instructions were not known and written clearly for all staff to follow.

In one person's bedroom we found a number of medicines that did not belong to them, labels were not fully legible and some were out of date. We brought this to the acting manager's attention. They showed us a very recent room audit they had completed that also found these medicines. The acting manager had requested that the cleaner removed all of these items. They were removed before the end of our inspection. However, given that some of these medicines belonged to people no longer at the service and some were expired as long ago as December 2013 we believed that medicines disposal had not been effective and therefore people were placed at potential risk.

We asked to see the medicines policy and procedure that they followed. One staff member gave us what we knew to be an old document. This was confirmed by the acting manager. They could not locate the current policy and procedure that staff would follow. The acting manager explained that they had been reorganising the office and had needed to archive several documents and agreed to email this after the inspection. This was sent to us and was extensive and gave clear up to date guidance to staff based upon best practice. However, we were concerned that this was not readily available and in use by staff at the time of our visit. One practice that staff were not clear about was the recording of medicines administered. There was a double count system in operation whereby staff completed the MAR sheet as well as entering the date, amount and signing stickers that had been attached to the medicine packets and bottles. These were then discarded when the medicine was completed, but also this practice was not part of any written guidance to

staff. It was time consuming and duplicated other more comprehensive records such as the MAR charts.

All the above findings culminate in us determining peoples medicines were not managed safely This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe at the service. One person said, "I feel perfectly safe, I'm very happy with the staff, staff are always available. My room is kept clean, it's done regularly." Relatives told us that they believed their relatives were kept safe. When asked one relative said, "It is good, the way they treat the residents is good. They keep me in touch on the phone, any issues or something I need to know they tell me."

Risk assessments and action to mitigate the known risks were not always effective. Specifically in relation to preventing sore skin and pressure ulcers developing. We found that a number of people were using pressure relieving equipment; however, it was not always clear from records what the settings should be or clearly documented in care plans the purpose of the equipment. One person was on a pressure relieving cushion that was switched on and the setting was "Firm". On top of the cushion was an ordinary cushion and then a protective chair pad. This totally negated any benefit from having an airwave cushion, as the cushion and protective pad would not move and so no pressure was relieved from the sacral area. We looked at this persons care plan. There was no mention of the person's skin condition or why they were sitting on a pressure relieving cushion. A different person was sitting on a pressure relieving cushion. We looked at their care plan that told us that they had recently been reviewed. They had been provided with a high grade mattress and cushion because their bottom was sore and they were being monitored by the District Nurse. However, there was no record of the required settings for the mattress or cushion to guide staff.

Records of people being turned to alleviate pressure were not consistently completed and one person based upon records and our observation could have remained on their back for seven hours before they were repositioned. For a different person repositioning records were not contemporaneously completed and staff returned to the person's room and completed records later that day. Records did not have instruction for staff of how frequently people should be repositioned. Staff were unable to consistently tell us about equipment and repositioning regimes. Therefore it was our conclusion that people were placed at unnecessary risk of developing sore skin as risks were not adequately mitigated through clear instruction and actions of staff. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Moving and handling observations were good as were the records of assessments and instruction to staff. We observed staff using equipment to transfer people. They did this confidently and gave verbal assurances and instruction to people who were being hoisted. We observed staff transferring a person from a wheelchair to a dining chair and heard, "Put your hands on here for me, now push up, you can do it, you do this every day, there you go, well done." This showed encouragement given, reassurance and promoting independence. One staff member told us, "The training is good. You have to get in the hoist and be hoisted – then you know what it feels like." Moving and handling assessments in care plans were regularly reviewed and gave staff the detail to follow such as the size of sling and the equipment to use. We saw that care plans contained other risk assessments to guide staff and mitigate the risks relating to falls and weight loss. The service had two freely accessible stair cases from the ground floor to the first floor. One stair case had metal edges. We observed people living with dementia walking around the service. One person had a bruise to their face from a recent fall. We requested that the acting manager and provider risk assess the stair cases and ensure they had considered any potential risks that they could mitigate to prevent people falling down the stairs.

Staff told us they had received training in protecting adults from abuse and how to raise concerns. They understood the different types of abuse and knew how to recognise them. Staff were able to tell us what action they would take if any form of abuse was suspected, they were clear who they would go to internally and also said they would go to the local authority safeguarding team if they needed to report a concern externally. Information was available from the local authority detailing how to report a concern. Staff were also aware of the whistleblowing policy and said they felt that they would be supported and protected if they used the process. Staff told us that they had confidence that any concerns they raised would be taken seriously and action taken by the acting manager.

The acting manager demonstrated an understanding of keeping people safe. Where concerns had been raised, we saw that they had taken appropriate action liaising with the local authority, police and where appropriate staff had action taken by the provider and in some cases provided with additional training to ensure the safety and welfare of the people involved.

Infection control was not consistently monitored and as affective as it should be to keep people safe. Communal areas were kept clean and fresh. A relative told us, "Her room is always clean and tidy and never smells, her clothing is always clean." When we looked more closely we found pots of cream without lids and cream that had been in use for an extended time. Pots of cream where carers have to use their fingers to access the cream to apply it should only be open for one month to avoid cross infection as bacteria are able to grow in the tub.

We observed people in bed. Some of the bedding was worn. One person had pillows placed between their legs that had pillow slips but no pillow protector. One person had stained bedding on their bed.

We observed that staffs infection control methods were not consistent. One staff member wore a blue apron at lunch time. They had a second member of staff help them reposition a person in their bed before one supported the person to eat the other went to the dining room to support others to eat. Neither of them washed their hands or wore correct protective clothing. We observed two staff go into the large toilet with a person in a wheelchair, they took a hoist into the room to enable toileting. Neither carer wore apron or gloves. This room contained no supply of aprons or gloves. It was explained to us and we saw that supplies of protective equipment were kept in a central place and staff needed to ensure they took this with them to people bedrooms, en-suites and toilets. We saw in two en-suites that there was not always liquid soap and paper towels for staff to cleanse their hands after giving personal care. There were no rubbish bins or plastic bags for waste disposal. We observed staff wearing raised rings and wrist watches and wool cardigans whilst giving personal care to people. The wearing of raised rings on the hands and wristwatches means a high risk of damage to elderly frail skin when undertaking personal care or moving and handling. The wool cardigan was worn whilst completing other tasks such as serving food therefore potential cross infection issues arose. Hands cannot be washed effectively with a wristwatch in place or whilst wearing a cardigan. We asked the acting manager and provider to review the current policies in place and staff practice in relation to infection control to ensure people were not placed at unnecessary risk.

Requires Improvement

Is the service effective?

Our findings

We routinely saw that people were given choices and staff sought consent before they supported people. Staff consistently told people what was happening and what they were doing whilst giving them care. This was in relation to moving and handling, supporting them to eat and drink and consent to receiving personal care. People were able to determine what time they got up and when to bed. One person said, "It is fine here, I don't usually stay in bed but did today." This showed us that peoples choices were respected when they did not want care and support at a given time.

However, we found that more complex decisions were not routinely understood by staff. They told us and records showed that they had received training in The Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Despite having training staff were unaware about 'best interest decisions' and how these would be facilitated and made. People in more senior positions within the service did not know whom they would involve or consult to make more complex decisions. When discussing the matters of covert medicines and crushed medicines that were to be covertly crushed with senior staff, they did not know it was not a GP's sole authorisation to covertly give medication or state that medication can be crushed. Discussions about involving families were understood, but matters such as Last Power of Attorney (LPA) for care and welfare was not understood or actively sought. Pharmacist, social workers and others were not routinely consulted and we found no evidence of written 'Best Interest decisions' in people's care plans. The acting manager did not understand LPA nor was this part of the routine admissions assessment. Given this service was specifically for people living with dementia this should be an area known and used to ensure decisions are made involving the correct people and in a timely way.

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). The acting manager was able to inform us that 12 people residing at the service had authorised DoLS in place. They were in the process of checking records in relation to everyone else in the service and as they had not had a comprehensive handover of this information.

People were supported to have sufficient to eat and drink. We observed that refreshments were served throughout the day. One person told us, "Food is perfectly acceptable, I get enough to eat, and can ask for more and have done so on a couple of occasions and got more. My family bring in fruit for me." A relative said, "When [named relative] came for respite here I said never give her onions and they remembered that and the food always looks healthy and they give them stuff they would recognise."

We observed lunch and the food looked appetising and well presented. The soft diet came as separate portions on people's plate so looked attractive to eat. However, two staff then mixed the meat, vegetables

and potatoes into one brown mixture and then gave people this. It did not look appetising and would have all tasted the same. This was part of feedback on the day and assurances were given to address this matter. There were sufficient staff to support people to eat as a number of people needed encouragement and support. Staff supported people but were mindful of independence for example we overheard, "Can I help you there, do you want to try a fork rather than the knife?" and a little later, "how about, try with a spoon" and when the person stopped eating, "Can I help you with that." People were offered visual choices of plated meals to enable them to choose. One carer helped a person to remove their large cardigan so they were comfortable and could eat. We gave feedback at the end of the day that meal times were improved since our last inspection, but could be further enhanced. Some people who were independent did not understand why they had to wait and watch others eat in the lounge until staff supported through to the dining room. This should be reviewed along with providing plates that stay warm as some people took a long time to eat independently, supply adaptive cutlery, more side tables and consider the use of wet wipes before and after the meal. We saw that people had nutritional needs risk assessments in place and some people were on fluid charts to monitor their intake. We fed back that the amount of fluid given should be more closely monitored as the records indicated that some people may not have sufficient to drink.

At the end of the main meal we overheard a person say, "Nice, lovely, good, lunch was very nice."
Some people had a second desert. We spoke to the chef and they had appropriate training and knew about specific types of diets that people had and knew how to prepare the food needed. This included providing finger foods to make food more accessible and easier to eat for people living with dementia. This meant people had sufficient to eat and drink that met their needs.

People were supported to maintain good health. People were enabled to access healthcare such as GP. District nurses, Occupational Therapists (OT) and dieticians. We observed a person being supported to do exercise. A staff member explained, "[Name of resident] has exercises, and walks with their frame morning and afternoon and now they're walking much better and has been doing this for a month now. The OT gave us the leaflets and she showed us staff how to do the exercises and how to use the walker."

We met and spoke to a visiting District Nurse who had been appropriately called the previous day for a new wound injury. The relative had been informed and had visited that morning. We observed the staff handover and all information was passed on with actions taken to update with the changing health care needs of this person. Care records seen reflected these changes. The District Nurse told us, "Staff interact well with residents and they always ask for information about the residents. The staff are very caring and because the patient I have come to see doesn't like to go into their room, the staff have put a screen in here (small front lounge) for me to see them." This demonstrated that staff were responsive to the changing needs of people and ensured appropriate referrals were made. Relatives told us they were informed and kept up to date. One said "The temporary manager would ring me to say [named person] is unwell and they are getting the doctor – they always keep me informed." Another said, "Staff always talk to me and are always friendly and they say how [name of person] has been."

We asked people about the skill and training of the staff. A relative told us, "Staff are polite and friendly and helpful." A person at the service told us, "The ladies are very good." We spoke to staff about their training they had received. There had been staff recruitment and newer staff had received appropriate training before they started work. New staff spoke of completing three or four shadow shifts before they became part of the roster. They were able to tell us about many aspects of older peoples care and were confident with their answers. They were clear about their moving and handling training and safeguarding responsibilities. They were able to tell us about issues of consent and care for people with diabetes. We spoke to a staff member who had worked at the home for three years. They told us, "The training here is good. There has been quite a bit lately. The external training has been good quality and we have been shown and know

about feeding people. The dementia care training was very good."

We spoke to the acting manager about accessing the records that showed what training staff had received. There was no group record available to show how many staff had received what training and when. They showed us a pile of certificates that had been issued and were in the process of organising and indexing these. We were able to establish that 16 staff had received MCA and DoLS training in October 2016. However from discussions with staff and managers it was evident that this training had not been effectively transferred into the work place and no systems of checking was in place. Two weeks after the visit we were emailed evidence to show that a training matrix had been collated to show what training the whole staff group had received.

Staff spoke about the new acting manager with admiration and respect. They told us that they felt supported and had already had team meetings that had set out the expectations that they needed to meet. They told us that the acting manager was present at handovers and participated fully. They believed that any issues brought to the acting managers attention would be resolved and gave examples of matters that had been resolved since the weeks in which they had been in post. This level of confidence showed us that matters were set to improve.

Good

Is the service caring?

Our findings

Staff had developed kind and caring relationships with people. We saw and heard some warm interactions between staff and people. We observed interactions in all parts of the communal areas. In the quiet lounge there was a staff member designated to stay and support when people were present. We saw the member of staff went from person to person ensuring that they were comfortable, encouraging them to drink, chatting with those that were able, looking at a book that one person had, putting neck pillow in position for one person who was inclined to sit with their head falling forward. This attentive behaviour of the staff member showed us that they knew and understood people's needs and therefore knew what small actions they could take to make people comfortable. We spoke to the staff member and they told us, "I love working with old people, it is really active here and today I am in the Quiet Room."

We observed a person being hoisted from their wheelchair into an armchair. This was completed with the staff member giving assurances and instructions to the person to keep them safe and confidence in the staffs' ability. "Can you lean forward for me, right we are going up [named the person], straighten your legs for me, well done, now going down, lift your feet up, there we go."

Relatives consistently told us that staff were kind and took time to be with people. One relative said, "Carers are gentle and take time to talk to them and the music is on they get them to clap their hands and if able they get them up to dance." One relative explained how staff took time to walk with a person who they explained was 'having an off day'. We observed that staff were responsive to people who were distressed. Staff took turns in being with a person who was agitated. They were kind and chatted about things of the moment and used events to distract the person and quieten their mind.

One member of staff was knelt on floor looking up into a person's face who was almost bent over. They were trying to encourage them to sit up straighter. It was calmly done and in a caring manner.

People were given support and actively involved in making decisions about their care. We saw a member of staff was kneeling in front of a seated person showing them exercise diagrams and words, "Shall we try these?" and when the person said, "I remember these." The staff member said, "Good, you remember, we do these every morning, which one would you like to do? The one for your back or for your legs?" This showed us that choice and consent were obtained. The diagram was held in front of the person's eyes to help them. Good motivation and encouragement was given by the staff member. Another example was at lunch time. One person did not want to eat and rejected their meal. Alternatives were offered. The staff member came back with two pudding options to try and tempt the person to eat. They were gently persuaded to try the jelly and cream option. They independently finished the bowl full.

All staff we spoke with had a good knowledge of the people they cared for. They were able to tell us about the individuals and aspects of their life history. Staff told us that relatives were consulted and informed about peoples care. We were told that a daughter had visited early that morning and had requested a change for their parent and this had been done already.

Staff had a good understanding of the needs of people with dementia and encouraged people to make choices in a way that was appropriate to each individual. People told us they were able to make choices about what time they got up and went to bed. The majority of people were up and dressed when we arrived, but one person was having their breakfast and got dressed later.

Interactions between staff and people who used the service were caring and appropriate to the situation. Staff demonstrated an understanding of how to meet people's needs. They spoke about people respectfully and behaved with empathy towards people. Any personal care was provided in private to maintain the person's dignity. We observed staff knocking on people's doors and waiting to be invited in before entering. Doors were closed during personal care tasks to protect people's dignity and we observed staff discreetly and sensitively asking people if they wished to use the toilet. When we spoke to staff about ensuring privacy and dignity was maintained at all times they gave consistent answers. One said, "When using the toilet be sure to close the door and the bathroom door closed. Also I would cover them when drying them or putting clothes on."

We were informed that people can have visitors any time they wished. A relative told us, "I can visit any time, there are no restrictions." One relative drove quite a distance to visit. Staff were mindful and served their meal in the small dining room and they were able to sit together and eat and chat in private.

Good

Is the service responsive?

Our findings

People told us that their needs were met and how much they liked living at The Lodge. A relative said, "It is an old fashioned home, they get more one to one care here." They told us that staff were affectionate towards people and, "They (staff) smile and ask if she is alright and I see staff are kind to them. It is clean, I see the food and it is well prepared and I have been into the kitchen and the Chef is lovely. Everything I ask for they have done". A person living at the service said, "I don't need help but staff are always available and I feel I can always ask for help" They explained that they liked to join in certain events and activities provided but, "My choice to have my meals in my room. I am totally independent and this is the way I like it". This showed us that staff could be responsive to differing needs of people.

We found that communication was effective. We observed the handover and heard that detailed, relevant information was handed over about each person living at the service. This included one person's blood sugar levels and the need to monitor and that one person was, 'Very active but declined to sit and settle but had not been distressed'. We observed that this person had a member of staff assigned to support them closely throughout the afternoon as they were considered to be potentially at risk of falling due to their heightened anxiety levels. Different staff told us about the recent staff meeting and the communication about care plans. One staff member said, "We were told how we must improve care plans - what we write, need to give more details about what we have done, what was offered and if declined".

People had care plans in place that were based upon an assessment before they moved to the service and had evidence of regular review. Staff had access to the care plans and we saw them completing these regularly throughout the day. The acting manager informed us that they had begun a review of the care plans in place and had completed these for approximately 50% of the people resident. This showed us that matters were set to improve as developments were taking place. We saw that plans had begun to become more individualised and contained such information such as; 'Registered blind, hearing is not good. As I am blind, I like staff to touch me first before talking to me'. Relatives told us that they were involved and consulted as appropriate, but we saw no evidence of this in care plans that we examined.

There was a variety of activities provided for people to participate in if they wished. A relative told us, "Most afternoons something is going on like showing old tins like Typhoo Tea, they sing songs, Exercises such as play throwing things. The hairdresser comes in and she is good with them". A member of staff explained, "We do activities, like bowling, darts, we read, draw, paint and play cards with [named a person] who likes to count. One person likes to smoke after breakfast, lunch and in the afternoon". This person was supported to go outside and have a cigarette. There was a specific activities coordinator employed to work 15 hours a week. They were there during our visit and they organised a game of quoits with several small groups of people throughout the afternoon.
We observed that the staff member was getting those that could to count up the points and giving lots of encouragement and people appeared to enjoy the time they spent. A relative told us, "They have got Facebook page that tells of the activities that go on". We saw that this was displayed in the entrance hall way along with other information to keep people informed. Information on how to make a complaint was on display in the entrance hall.

The provider had a procedure in place to manage any concerns or complaints that were raised by people or their relatives. The organisation's complaints procedure was displayed openly throughout the service and we saw that complaints were recorded in line with these procedures. The manager said that they encouraged people to raise concerns at an early stage so that they could learn from them and improve the service. A person at the service said, "It's perfectly acceptable here, I've got no grumbles at all". Staff we spoke with were aware of how to respond to concerns raised with them. One staff member said, "They can write to the manager or go to CQC, or could speak to me and I would pass information to the manager. If nothing was done I would go to CQC or the managers manager". Another staff member said that the acting manager came to handovers and kept them informed of any complaints made about the service so they knew what was going on. The acting manager said that they had not been made aware of any written complaints since taking over. However, they had records relating to safeguarding matters that had elements of complaint in them that they were addressing and using to develop the service. The acting manager had shared these matters with staff to keep them informed and improve the service.

Good

Is the service well-led?

Our findings

The culture within the service was set to change. The previous registered manager had resigned and was about to be replaced. A new candidate had been identified and was due to start. In the interim an acting manager had been appointed. Feedback from staff and relatives was positive about the changes. A relative spoke of the acting manager, "She is brilliant, she is methodical and sees things through to the end". One member of staff said, "The place has changed since Christmas. It is a lot tidier and cleaner. They are stricter on paperwork and it is definitely going uphill from what it was". A member of the domestic team said, "There have been improvements – the rooms are less cluttered. Morale seems okay. The temporary manager is doing brilliant and I report to her now". A different member of staff said, "The temporary manager is the best, many improvements with her. Where standing hoists are used we needed less chairs and bits laying around, so know the rooms look better, less stuff that is not used". We could see that the environment was being improved.

Staff told us that they felt supported and that the acting manager was fair. One said, "You can speak to her about anything, she is very open, I might have an idea and she listens to me – communication is better with her". A different staff member said, "She is very nice, very good, nice woman, talks nicely to us and she listens and is supportive".

We asked staff about the aims and values of the service. Most understood and were clear about what the service aimed to achieve. One said, "Make sure residents are looked after to the highest standard in a clean environment and are cared for. We care for individual needs".

A senior carer said that she is, "Fair and she listens, she is very tidy and has begun to sort out the rooms and paperwork, we have had a meeting, so we all work together ". Staff understood that a key focus going forward was the improvement of care plans and all that they contained. The acting manager was keen to develop the service and believed the way forward was to involve staff. Listen to their ideas, but also delegate and give responsibility and ownership of changes that needed to be implemented. A new development was the handover book that had been developed for good communication between seniors. This had been positively received and was being consistently used.

We were aware that this was early days for the new management. After the visit we were forwarded a number of documents such as the training matrix that had been developed. The comprehensive medicines policy and procedure and records that related to the monitoring and improvement of people's health. Specifically monitoring of incidents and accidents relating to infections and falls prevention. This demonstrated that actions were being taken to monitor and prevent potential harm in these areas.

During the inspection we saw that medicines were being audited on a regular basis. This was thorough, but we gave feedback information based in this report how the audit could be improved upon. The acting manager had completed an environmental audit of the whole establishment. They had ordered a skip and staff within the home such as the domestics and handyman were given tasks to action elements of her audit. This was still in progress.

The acting manager was able to base staffing levels upon what was needed because they were regularly assessing people's needs and communicating with staff about changing needs. The acting manager was auditing care plans and had completed 50% of these. This demonstrated that the manager knew people at the service well and was able to confidently provide staff to meet those known needs.

We were also forwarded a copy of the latest resident and relative survey. This sought feedback on many elements of peoples care such as catering, activities, personal rooms and response to concerns. The report contained feedback on comments made as well as statistical information. The results were mainly positive. This survey was due to be completed again to measure any changes in people's experiences and to drive improvements.

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 1. Risks identified were not reasonably mitigated. Specifically relating to prevention of pressure ulcers. 2. Medicines were not consistently safely managed.