Ideal Carehomes (Number One) Limited

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

Summary of findings

Overall summary

We inspected Lydgate Lodge on 3 and 9 April 2018. Both days of the inspection were unannounced.

Lydgate Lodge is registered to provide personal care and ensuite accommodation for up to 64 older people, some of whom live with dementia. There were 54 people living at the home at the time of the inspection. The home has two floors accessed by passenger lifts. Each floor has one unit for people with residential care needs and one unit for people living with dementia. Units contain communal bathrooms, a lounge and dining area. Outside there is an enclosed garden with seating areas.

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

The home had a registered 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.

At the last inspection in January 2017, the service was rated 'requires improvement' and there were three breaches identified in the regulations for staffing, safe care and treatment, and good governance. At this inspection we found improvements were ongoing but there were still areas in need of improvement, some of which were featured in the previous inspection. These were understood by the management team and there was evidence these were being addressed.

Lydgate Lodge had a welcoming and professional approach; the environment was pleasant and homely, people said they felt happy and safe and staff reported good morale in the teams.

Systems for managing risks were in place, but were not sufficiently robust or individualised for some aspects of people's care. Not all staff were confident in the fire evacuation procedures.

People said that they felt safe at all times and were really clear about who they could turn to if they were worried or had any concerns. The staff were also aware of the role they played in keeping people safe by reporting any concerns. Staff understood procedures to follow to ensure people were safeguarded against abuse.

Staffing deployment at times did not ensure people's needs were met in a person-centred way; the rotating deployment of staff did not ensure consistent understanding of people's needs. Relatives felt that there were times when the team were short staffed although staff did not share this view.

The home was visibly clean in most areas, although the kitchenettes within each unit were not cleaned

thoroughly and some equipment was not cleaned or stored appropriately.

The administration and management of medicines at Lydgate Lodge was safe. An issue with topical medicines recording had been identified prior to this inspection and a solution identified.

There was effective teamwork and staff communicated well with one another about people's needs. Staff understood people's rights and the legislation which supported this, such as the Mental Capacity Act.

Staff felt supported through training and supervision, although training records were cumbersome.

People enjoyed their meals on the whole, although where some people had received specialist advice this was not always followed properly.

Staff used new technology to update information about people's care as it happened, although there were some inconsistencies in recording identified at this inspection.

People were aware of the complaints procedure and we saw complaints were responded to. Some relatives raised concerns about the laundry system and the provider was working to address these.

There was a range of suitable activities available for people at Lydgate Lodge, although not all people were able to participate in these.

The management team were very visible in the home and gave clear directions for staff who understood their roles and responsibilities. Audits were in place although these were not all sufficiently robust enough to show what action had been taken as a result of issues identified. There were plans in place to improve the quality of the audits, both in the home and corporately.

There were two continued breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment and good governance

This is the second time the service has been rated 'requires improvement'.
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.

Risks were not all thoroughly assessed and there was a continuing breach in the regulations which had not been fully addressed.

People said they felt safe, although relatives expressed concern about a lack of consistent staff.

The management and administration of medicines was safe.

Is the service effective?

Good

The service was effective.

Staff had opportunities for regular training and support and they had knowledge of people's rights and mental capacity.

People enjoyed the meals and there was a variety of choices available.

People had access to other professionals and healthcare as required.

Is the service caring?

Good

The service was caring.

Staff were respectful, kind and caring.

People's dignity and privacy was regarded.

People's independence was promoted and visitors were welcomed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care documentation was not always clear or accurately maintained.

People who were able to participate, enjoyed the range of activities.

Complaints were responded to, although ongoing regarding the laundry service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The regulatory breaches identified at the last inspection had been given some attention, but insufficient progress had been made to ensure the quality of the audits or risk assessments were improved by the time this inspection took place.

The registered manager was approachable and very visible in the service.

Feedback was welcomed from staff, relatives and people who used the service.

Lydgate 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 3 and 9 April 2018; both days were unannounced. The inspection team consisted of two adult social care inspectors and a specialist adviser in governance as well as two experts by experience on the first day of inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the team comprised of two adult social care inspectors.

We reviewed information the provider sent us in the Provider Information Return, although this was received before the last inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

To prepare for the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. We spoke with one visiting healthcare professional during the inspection.

During this inspection we spoke with 22 people who lived at the home and eight of their relatives to obtain their views of the support provided. We spoke with 11 members of staff who included care workers, the registered manager, the regional manager for the registered provider, the care manager, an administrative assistant, and the cook.

We spent time observing care in the communal lounge and dining areas in all four units to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records which included five people's care files. We also inspected three staff members' recruitment and supervision documents, staff training records, nine people's medicines

administration records, accident and incident records, and various other documentation related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found risk assessments were not a robust and accurate reflection of people's needs. At this inspection, we found there were some risk assessments in place but some of these contained generic information rather than clear detail about the individual risks.

There were standardised risk assessments such as a Waterlow scale, which is a tool to assess the risk of a person developing a pressure ulcer and a Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. One person who staff told us was eating a pureed diet did not have a clear choking risk assessment in their file, although staff were ensuring they were appropriately supported whilst eating. Another person who was identified as at high risk of choking, was served food such as bacon and sausage when they should have been offered a soft diet. We alerted the registered manager to this and they took prompt action to speak with staff who were working with the person. The person's risk assessment gave general advice, rather than specific guidance for staff to support the person safely.

One person's moving and handling care plan did not contain all the guidance required to safely move the person. When we questioned staff about this, they were unclear how they should move the person and had determined their own method which had not been recorded to demonstrate this manoeuvre had been risk assessed.

We found no risk assessments for people who slept in chairs or those who remained in bed, and it was not clear if the latter was from choice or from a lack of suitable equipment.

Risk assessments had been undertaken in relation to falls. However basic falls reduction measures were not in place and there was not enough awareness around how to prevent falls from happening. For example, we observed some people were wearing unsuitable footwear or were walking around in socks. Staff were able to describe the process to follow if a person fell. They told us senior staff analysed falls. We saw records to show clear action was taken following falls, to ensure people's safety, although there was not always robust analysis of falls to identify causes and establish lessons learned.

Each person had a personal emergency evacuation plan (PEEP) which detailed how the person would need to be supported in the event of an emergency. However in one file we looked at an out of date PEEP had not been removed from the care plan which provided out of date advice on how to support the person to be moved in an emergency.

The above examples illustrate a continued breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12, safe care and treatment, because there were weaknesses in assessing the risks to people's health and safety.

The registered provider had developed and trained their staff to understand and use appropriate policies and procedures to safeguard people from abuse. The staff we spoke with knew the procedures if they

suspected abuse and they could describe the signs of abuse they might see in a care home. Staff told us if they had any concerns about a colleague's practice they would feel confident to report this to the manager and if necessary to CQC.

At the last inspection we found there were not enough staff suitably deployed to meet people's needs. At this inspection, we found there were long periods of time where staff were not visible in communal areas or where people had to wait if staff were on their break and they needed two staff to support their needs. Staff we spoke with said they considered there were enough staff and they could always call for support from the management team if need be. However some staff told us they did not always know people well when they were moved to work on different units. Comments included, "I get so mixed up with who should have thickener in their drinks, they keep moving me from floor to floor", "When I came on duty today I was working on another floor. They brought me up here later and I don't know the people so well" and "We get moved around the home a lot. It stops you from getting to know people's needs."

Staff rotas were consistently maintained in numbers although we noted staff were deployed on rotation throughout the home, rather than being assigned to the same unit. In addition, there were agency staff whose knowledge of people was nothing more than was given through the handover. We found this meant staff's awareness of people's ongoing needs was not always consistent. We discussed this with the registered manager who said the handover information was delivered to ensure staff had up to date information. They told us they were monitoring staffing levels, with an ongoing recruitment process also in place to be able to fill any vacancies. We saw recruitment procedures were followed to ensure the suitability of staff before they worked with people in the home.

Relatives said there were times when the home appeared to be short of staff and consistent staff members. One relative said, "There are too many agency staff, they do not get to know people well enough."

We recommend the provider continues to keep the staffing in the home under review to ensure sufficient staff who know people well are deployed to meet their needs.

People said they felt safe. One person said, "I like it here, I feel safe and secure" and another person said, "The staff are so good, this makes you feel safe." Relatives said, "They certainly ensure that my [family member] is safe" and "The staff know my [family member] so well, they do all they can to maintain [their] safety."

As part of this inspection we observed a member of staff administering medicines on two of the home's units. We saw the care worker checked people's medicine administration record (MAR) before administering medicines and signed them after the person had taken their medicines. The staff member administered medicines from a medicines trolley which they locked when leaving it unattended. The care worker administered medicines to people in a caring and person-centred way, and made multiple attempts to administer medicines to people living with dementia who initially refused or were asleep. We saw a system was in place to ensure people's medicines were not missed if they could not be administered at the first attempt. The need to encourage some people and make more than one attempt with others meant the medicines round took over three hours on the second day of this inspection, although the care worker told us they were making additional checks as it was the first day of the new monthly medicines cycle.

A safe system was in place for the ordering, receipt and return of medicines at the home. The home had a monthly medicines cycle, which meant a month's supply of medicines was delivered to the home at the same time each month. Most people's medicines were supplied in pre-packed dosette boxes, but some were in boxes or bottles. We noted few unused medicines in boxes and bottles were 'carried forward' from

one month to the next, and instead were returned to the pharmacy to be destroyed. This included large unopened boxes of paracetamol and full bottles of lactulose which were well within their expiry date. We raised this with the care manager who agreed the service could coordinate returns with the pharmacy better to reduce wastage.

Medicines were stored in dedicated rooms on each floor which contained a fridge; both rooms and fridges were monitored to ensure medicines were stored at the correct temperature. We checked the stock of medicines, including those of controlled drugs, and found they reconciled with recorded amounts. Controlled drugs are those covered by misuse of medicines legislation, and include medicines such as strong painkillers.

People's MARs evidenced they received most medicines as prescribed; care plans were in place for medicines prescribed for people to take as and when they needed them. However we did note some gaps in people's MARs for their topical creams. When we checked people's rooms we found part-used creams and one person we spoke with told us staff helped them apply their topical creams. The care manager said the service was aware there was an issue with the completion of MARs for people's topical creams and was in the process of adding creams to the new hand-held devices introduced shortly before this inspection for care workers to record care interventions. This meant medicines management and administration was safe at Lydgate Lodge, and action was being taken to improve topical medicines recording.

We saw the home was clean on the whole and staff had access to plentiful supplies of protective aprons and gloves. Regular cleaning took place throughout the days of the inspection. In the kitchenettes within each unit, however, we found areas were not clean, such as the fridges and drawers. Most relatives and people we spoke with said they were happy with the standards of cleanliness in the home, although some relatives were not so happy. They told us their family member's room was not clean and tidy, although they put this down to lack of staff. Relatives did not feel that all areas of the home were clean and well presented. Some commented on malodours and a general lack of cleanliness at times. We recommend the provider reviews the cleanliness of the environment to ensure cleaning regimes are thorough.

Good

Is the service effective?

Our findings

At the last inspection we found the recording of people's food and fluid was not sufficiently detailed. At this inspection we found there had been improvements.

We observed the breakfast and lunchtime experience in the downstairs dementia unit. People told us, and we could see for ourselves, they could choose what to eat from a choice of cold and hot breakfast and freshly prepared food at lunchtime. Tables were laid nicely with table cloths, condiments and wine glasses and staff supported people when required. We observed people were offered alternative choices to the menu when they preferred this. Lunchtime was very calm and quiet with very little chatter. Staff assisted people to the table over half an hour before lunch was served on the day of our inspection although they were not unduly distressed by this.

People said that they could have cooked food for breakfast if they wanted it. People were seen ordering scrambled eggs with bacon and sausage. Menus were clearly displayed in a pictorial format and people were seen referring to this during the morning and at the main lunch time to make their choices to very good effect. If they did not prefer the main menu on offer an alternative was offered The care staff took the lead on serving the meals and the staff were seen to be very calm and patient when delivering meals.

The cook was aware of people's likes and dislikes and told us specialist diets were also catered for, such as vegetarian, diabetic and gluten free diets. People were heard to offer compliments to the staff for the meal they had just eaten. The cook told us, "I always make sure that I gather people's views about the meals. We are beginning to make small changes; all of the soups are made from scratch with fresh ingredients. If people do not eat their main meal they are always encouraged to have some soup. I am fully informed of people's dietary needs and special medical conditions. I can order anything I like, the management make it clear, the residents must have a choice"

People's comments about the food and drink were mostly positive. One person said, "The food is good and it suits me anyway" and another person said, "Meals are good and always edible, there's always a choice." Other comments included, "The food is grand, there's plenty of it", "You can have whatever you like for breakfast. I've had sausages. Lovely" and "All the meals are smashing."

Relatives we spoke with were mostly complimentary about the food, although one relative said there was little rotation of foods on the menu. One relative told us, "I eat here almost every day the food is fantastic" and another said, "The cooks come round asking if everything is alright with the food."

On one of the residential units we found there was limited conversation at mealtime and people did not have access to condiments. People were properly supported when being served in their rooms and meals were nicely presented. On another residential unit we found mealtimes were sociable occasions and people chatted together whilst waiting for and during their meals. One person especially wanted something that was not on the menu and staff arranged with the kitchen to accommodate this.

We saw effective communication within staff teams and we observed part of a morning handover. Staff were given clear and detailed information about each person and how to support their needs as well as key information about any particular events, such as visiting professionals.

Staff we spoke with said they felt supported to do their work and there were regular opportunities for training and supervision. The staff we spoke with told us they had undertaken a structured induction when they started to work at the home which included three days of shadowing. Staff reported their induction had been thorough and they felt supported by senior staff. One staff member said, "They don't leave you high and dry. They are very good." This included essential training, such as moving people safely, infection control, fire marshal training, dementia awareness and health and safety and control of substances hazardous to health (COSHH).

Although there was evidence of staff completing regular training, we found training records were not always accurate or easy to navigate for the management team, with reports of numerous glitches, information not being pulled through into reports and the wrong courses allocated to the wrong staff. The management team acknowledged there was work being done to improve this. The registered manager told us bespoke dementia training was being rolled out, but this was not within the training needs analysis or the training database. Falls prevention training had been undertaken by some staff and was to be cascaded to others, although this information was not held on the training matrix.

We found consent was sought and was appropriately used to deliver care. Where people who used the service were able to express their views, staff respected their decisions about their care and support. When people were less able to verbally communicate effectively we saw staff made every effort to interpret non-verbal cues to ensure people's best interests were being met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 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.

We found decision specific mental capacity assessments in the files we looked at. This contained a section to complete if a person had granted a lasting power of attorney (LPA) although this section had often been left blank or did not confirm which type of LPA the person had. An LPA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help make decisions or to make decisions on a person's behalf.

Some medicines were administered to people covertly. This was because some people living with dementia had refused medicines they needed to keep them well. We checked the records of one person receiving covert medicines and found the decision-making process with respect to the person's mental capacity had been followed correctly, and had involved the person's GP, a relative and a pharmacist.

The registered provider ensured people's health needs were met by ensuring prompt referrals to external health professionals. We saw in one person's care file, they had been visited by the continence nurse, district

nurse, dietician, GP, optician, and dentist in the last 12 months.

The home's décor and furnishings were of a high quality and the home had been built in line with recognised design for environments for people living with dementia. There was a newly refurbished café area which staff said was beginning to be used effectively and there were further plans in place for continued improvements.

Good

Is the service caring?

Our findings

People told us staff were kind and respectful, and we saw caring interactions throughout the inspection. The staff and people looked comfortable together and there was a lot of laughter and friendly banter between people. People said that staff were good at listening to them. Relatives and visitors were also welcomed in a caring and friendly manner. People's comments included, "All the staff here are good" ;"They are really good at looking after us" and "The staff are kindness itself." Relatives said, "The care offered here is excellent" and "The care offered by the whole team is wonderful, first class in fact."

We saw people chose where they spent their time, with some people choosing to stay in their rooms while others sat in communal areas, and staff respected these decisions. Some people preferred to get up later in the morning and we observed these decisions were respected during our inspection. We noticed however, some of the gentlemen had not been offered a shave on one of the units.

Staff used appropriate pace so people could mobilise in their own time without feeling rushed or compromising their independence. For example, we saw a member of staff patiently supported a person to turn whilst using a zimmer frame and they gave good reassurance and encouragement, saying, "That's it, take your time, nice and steady, you can do it, no rush at all." Staff responded warmly to people's spontaneous affection

Staff spoke about the importance of ensuring privacy and dignity was respected; telling us how they ensured this when providing care. We observed staff respecting people's privacy and dignity by knocking on people's door before entering their bedroom. People told us staff always knocked before entering. When people chose to be in their own rooms they said it was their choice whether to have the door open or closed.

People's own bedrooms offered privacy and were personalised with their own possessions, photographs and personal mementos. This helped to make each room personal and homely for the person concerned. Within communal areas the atmosphere was calm, with music playing and Easter displays. As staff walked past people they acknowledged them with friendly faces and smiles as well as personal greetings.

Care plans reflected the involvement of the person or their family members in their development.
People were supported with their religious and spiritual needs. Staff told us how they supported one person to follow their faith and ensured their diet met with their religious requirements.

Requires Improvement

Is the service responsive?

Our findings

We reviewed five care plans as part of our inspection. These contained a record of people's life histories to tailor care to meet the person's needs based on past life experiences, preferences and previous choices. Care files contained an evaluation section and we could see care plans were regularly reviewed and evaluated to ensure care provided was meeting people's needs. However, the care plans were not always updated but information added to the evaluation. This meant there was incorrect information contained within and staff had to read the whole section to determine how to support the person. When we asked staff to locate information in one person's care plan about support for eating, they struggled to find the information, which showed improvements were required in how care plans were updated. We recommend care plans are updated thoroughly when people's needs change, in order for staff to be able to access current information.

People and relatives said they were involved in their care plans and reviews. One relative said, "I am regularly asked to be involved in reviewing [my family member's] care plan." End of life wishes were recorded in people's care plans.

Some detail was recorded well in people's care records, although there were some inaccuracies in and conflicting detail. For example, one person's record showed them being able to use stairs, but another aspect stated they were immobile.

We asked staff how they were implementing the requirements of the Accessible Information Standard. This requires them to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. Although they were unaware of the requirements of the standard they told us and we saw a person's communication needs were recorded in their care plan. These provided detailed instructions on how best to communicate with the person.

We looked at the communications file in each unit and saw there was key information, such as people's short term specific care needs. Staff we spoke with said they referred to this to check what information they needed in addition to handover information.

Care we saw was mostly person centred, although some people remained in bed and it was not always clear whether they had been offered the choice to get up. Staff said there were not always appropriate seats available to support people's different posture needs. The registered manager said people would be referred to relevant other professionals such as occupational therapists for such equipment and they would take advice on using any equipment safely.

The lifestyle manager told us they were committed to the activities being enjoyable and beneficial. They displayed an understanding of the physical and psychological benefits of activities on people's wellbeing. The service was in the process of recruiting to three posts for the lifestyle programme and staff told us, "These staff will be dedicated to supporting all the activities on offer."

People were seen reading the recent edition of the 'weekly sparkle' a weekly newsletter/newspaper that covers items of interest, present and past. People were heard discussing items from the articles. Staff were also presented with 'carer's notes' which was a different version of the newsletter to assist them in engaging with people by suggesting conversational prompts. However, we saw staff did not have time to engage fully with people in this. When staff were able, they chatted with people about current matters, such as winning the raffle and what was in today's newspaper.

Relatives said their family members took part in and enjoyed a range of activities. They told us about recent musical entertainment, arts and craft and Easter celebrations including a Christian service involving the local school children. People said that they enjoyed community schools performing concerts and plays. On the day of the visit the planned arts and craft activity was not observed on one unit, although on another unit we saw a magic painting activity, using water and special painting books. Staff were seen supporting people to do a variety of puzzles such as word searches. Staff recognised people's religious and cultural needs and their associated customs. One person told us "There is a regular church service, this means so much to me"

Most of the people and relatives we spoke with said they had every confidence in the registered manager and knew how to complain. The complaints procedure was readily available and we saw complaints were recorded and responded to. However, some relatives said they had complained about the poor management of the laundry system. One said they felt it was 'disrespectful' to treat people's belongs in this manner. Comments we received included, "The manager has still not got to grip with some of the smaller things; the laundry is a nightmare, it's just not good enough", "They have lost so many of my [family member's] personal clothing. We have never been compensated" and "Many clothes are ruined in the wash these are expensive and some were personal gifts." We spoke with the registered manager who was aware of the concerns about the laundry and was actively trying to resolve the issues raised.

One relative we spoke with said the registered manager and 'all the staff' were approachable to be able to raise any concerns, and they were confident these would be acted upon.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we noted some quality checks were not robust enough to ensure quality was maintained. At this inspection we found evidence of improvements being made, but some were still in progress. For example, there were systems and processes in place which identified areas to improve but it was not always clear from the audits, how thoroughly checks were completed and what action had been taken following these.

We found the registered manager completed a quarterly monitoring checklist which included health and safety, financial audits and medication audits. Audits were given compliance rates and considered either excellent, reasonable or a fail, although only a fail needed an action plan. It was not always clear when care plan audits had been completed or how thoroughly, as we identified some weaknesses in the quality of the care plan recording.

In response to high incidences of people falling, the management team had introduced new technology, such as monitor sensor beams, but without consideration of the need for monitor sensor training, such as where to position the sensor or how to avoid a further trip hazard. Audit forms gathered data, but there was no clear indication of any changes made or lessons learned as a result of the information reviewed.

Some records of checks made of the environment were not in place from February 2018. Some equipment checks were in place although electric profiling beds and mattresses were reviewed as and when there was a problem rather than routinely. Fire evacuation forms for December 2017 indicated staff were unsure of how to manage in the event of a fire, but there was no clear evidence of learning and improving from fire drills, particularly as staff confidence in the system was identified as low.

The management team told us there were some imminent changes to the quality assurance systems used throughout Ideal Care Homes and Lydgate Lodge would be using these during the coming months. These included new checklists which the regional director would review monthly and which would be more outcome focused and evidenced. The management team were confident the new quality assurance systems would address the areas of weakness identified at the inspection. However, at the time of the inspection, these changes had not been implemented and this meant there was a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 good governance.

People we spoke with knew who the registered manager was and said they saw them frequently within the home. There was mixed feedback shared with us from relatives in relation to the management of the home. Some spoke of 'great improvement over the past few months' whilst others felt that 'things are still not right'. There were formal meetings with residents or relatives. Posters displayed the outcome of these meetings which showed people's thoughts and ideas were acted upon.

Relatives' comments included, "The manager has really changed things for the better", "The manager just gives you confidence that everything is alright" and "I go to all the relatives' meetings, it's a great forum for sharing ideas. We are always being asked what we think about the quality of the service".

Staff we spoke with told us they felt confident in their roles and their lines of responsibility were clear. We saw the registered manager gave clear direction for staff to know what was expected of them, whilst maintaining an approachable presence should staff wish to discuss any matters. Staff told us they were encouraged to approach the registered manager at any time should they need to. There was evidence of staff meetings and regular communication. Staff told us they felt supported in their work and felt the home was run well.

The registered manager told us about plans in place to drive improvement in the home further. These included extensive decoration, a new sensory room, a revised coffee shop, games area, cinema and music room, as well as dementia boxes which were work in progress.

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 Risk assessments were still not fully robust to ensure people's safety was effectively planned for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had improved since the last inspection and there was work ongoing, but not enough improvements had been made to ensure these were robust.