

Eagle Care Homes Limited

Paddock Lodge

Inspection report

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Date of inspection visit:
27 February 2017
02 March 2017

Date of publication:
07 June 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 27 February and 10 March 2017 and was unannounced. The service was previously inspected on 20 February 2015 and was not in breach of the regulations in place at that time.

Paddock Lodge is registered to provide accommodation and nursing care for up to 24 older people. There were 21 people living at the home on the first day of our inspection. There was a registered manager in post who had been registered since 2014. However their role had recently changed and although they were on site during the inspection, a new manager was in place and in the process of registering with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Standardised risk assessments had been undertaken for those people at risk of malnutrition and pressure sores. The home completed risk assessments to minimise falls, moving and handling, infection control and choking. However, we found not all risks had been minimised to the lowest level and we observed some moving and handling of people which was not in line with best practice.

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

The manager utilised a dependency tool to determine staffing levels but the calculation of people's dependency was lower than the tool stipulated. We observed there were times staff were not available in the communal areas during our inspection which drew us to the conclusion there were not enough staff at the service at all times during the day.

Medicines were stored and administered safely and we observed medicines being administered appropriately during our inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. Not all staff had received training on the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS), and staff did not have a good understanding of how to assess mental capacity, and the best interest process. This was not having a major impact on the people living there who mostly had mild cognitive impairment and could consent to their daily care requirements. The manager did understand the DoLS and had appropriately referred for authorisations.

People and relatives told us staff were kind and caring and we saw this ourselves during our inspection. Staff knew people well, and what they preferred to do each day and were patient and kind in their interactions.

People's privacy and dignity was respected and their independence promoted.

People were provided with care which met their choices and preferences such as what time they got up, went to bed, what they ate and they were encouraged to share their views on how they wanted the service to be run.

The home did not have a dedicated activities coordinator and staff undertook activities with people in and amongst their caring duties. The manager was encouraging engagement with community facilities to improve access.

Care records did not always reflect an accurate portrait of the person's care and support needs and had not been updated as people's needs had changed. Some of the records we reviewed contained information to enable staff to provide personalised care.

Some audits completed at the home lacked rigour and did not always look at the quality aspect of service delivery which meant shortfalls in service delivery had not been identified. For example, the shortfalls in the determination of staffing, out of date care plans, infection control practices, and management of risk.

People living at Paddock Lodge and care staff told us how approachable and supportive the managers were. The service was meeting their statutory obligations in terms of displaying their ratings and notifications to the Commission.

We identified three breaches of regulation ; regulation 12 (safe care and treatment), regulation 17 (good governance), regulation 18 (staffing)

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?

The service was not always safe

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

Risk assessments were in place, but we saw not all risks had been minimised or eliminated.

There were not always adequate staff at the home in line with the registered provider's assessed dependency levels.

Although most medicines were stored and administered safely, there was no system in place for staff to confirm they had applied creams and ointments.

Requires Improvement 

Is the service effective?

The service was not always effective

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

Mental Capacity assessments were not decision specific and did not contain information on how people were supported to make decisions. People were asked for consent before staff assisted with care. The registered provider was compliant with the Mental Capacity Act 2005 DoLS.

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

Requires Improvement 

Is the service caring?

The service was caring

We found staff to be caring and compassionate in their interactions with people. However, low staffing levels impacted on staff ability to supervise people and there were periods when people were left unattended and without attention to their wellbeing.

Requires Improvement 

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

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

Is the service responsive?

The service was not always responsive

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

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

The home did not have a dedicated activities coordinator and staff undertook activities with people in and amongst their caring duties. The manager was encouraging engagement with community facilities to improve access.

Requires Improvement 

Is the service well-led?

The service was not always well led.

Some of the audits carried out at the home lacked rigour and did not always look at the quality aspect of service delivery which meant shortfalls in service delivery had not been identified.

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

Environmental checks were in place which meant people were protected from harm caused by poor maintenance.

Requires Improvement 

Paddock Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 February and 10 March 2017 and was unannounced. The membership of the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, infection control teams and reviewed all the safeguarding information regarding the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed the lunch time meal experience in the communal dining area and observed care interventions throughout the inspection process. We reviewed five care files and daily records for people living there. We also reviewed the maintenance and audit records for the home and records relating to staff and their training and development.

We spoke with six people who lived at Paddock Lodge and six relatives who were visiting during our inspection. We spoke with the area manager, the registered manager, the manager, two care staff and the

cook

Is the service safe?

Our findings

All the people we spoke with said they felt safe. People's comments included, "I am safe and well looked after." Another person said, "I do feel safe although sometimes some of them (residents) shout at people." A relative we spoke with said their relation was, "Very well looked after, as safe as can be."

We asked staff about their understanding of safeguarding and how they protected vulnerable people from abuse. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They could describe the signs of abuse they might see in a care home such as a change in a person's mood or attitude, withdrawn, physical signs, feeling unwell, and they also said the person might also tell the member of staff about the abuse. One member of staff told us they would tell the manager, and if their concerns were not acted upon they would tell the area manager and report the matter to the Care Quality Commission.

We found during our inspection there was not always enough staff at the home and there were times when there were no staff in the communal areas. For example, at one point during the inspection just before lunch there were no members of staff in the communal lounge area for 20 minutes. This meant people who required supervision were not provided with this and were placed at risk of harm.

We asked the manager how they worked out the staffing levels to ensure there were sufficient numbers of staff to meet people's needs. We were shown the dependency tool used to calculate the staffing levels which took into account people's dependencies. This was done each week and we reviewed the previous four weeks calculations. We found anomalies in the calculations, which meant people with low needs were assessed as requiring one care hour each day instead of the two hours required by the tool. Some people were assessed as medium who should have been assessed as high according to the tool. This meant the tool had been inaccurately used to determine the appropriate staffing levels at the home.

The manager told us the shift pattern was as follows; 8 am to 3pm, 3pm to 10 pm and 10 pm to 8am with one person starting earlier at 7 am to support people to get up. On the day shift there were two care staff and one team leader. In addition during the day, the manager was present at the home Monday to Friday and the registered manager was there three days during the week. A cook was on each day between 8 am and 4 pm and a domestic between 9am and 2 pm. The manager told us all staff had the same training so if necessary the domestic staff could assist with care. However, when we checked the staff training matrix, the domestic staff were not up to date with essential care training such as moving and handling training. In addition, staff were expected to provide activities on the days when external entertainment had not been planned.

We asked people whether there were enough staff at the home. We received the follow comments; "There are enough staff to look after me" and "I think they could do with more staff". One person also said, "There are not enough staff on occasions the others are always wanting stuff." Relatives we spoke with during our inspection told us there were enough staff and one said, "As far as I'm concerned there are enough staff." Another told us, "Yes there are enough (staff) at all the times I have been here." Although one said, "Most of

the time, sometimes a bit rushed."

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were put at risk of harm due to the lack of supervision attributed to the deployment of staffing.

We found standardised risk assessments such as a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. The home also utilised risk assessments to mitigate the risks around falls, choking, and infection control. They had a comprehensive falls risk assessment and reduction plan although they had not completed this for one person who had regular falls and had been seen by a falls team. Another person's falls risk assessment we reviewed detailed 'Staff to ensure [name] is wearing correct footwear at all times and that footwear is of good fitting and condition.' We observed this person was wearing socks and no footwear on the laminated flooring, and as they were dependent on staff to support them to dress and put on their footwear, staff had not adequately reduced this person's risk of falls. One person had been assessed by a speech and language therapist and required a thin liquidised or very well mashed diet although their care plan had not been updated to reflect this. This posed a risk of choking to the person if staff followed the information contained within the care plan.

Each person had a personal emergency evacuation plan (PEEP) which should detail how the person would need to be supported in the event of an emergency. However, the PEEP's we reviewed did not contain this information although each one contained a section for assisting people downstairs irrespective of whether they had a room based on the first floor or were based on the ground floor. Such as, "In the event of fire or evacuation [Name] can be assisted down the stairs. If unable to do so then the evacuation sledge is to be used (as trained). We raised this with the manager to ensure they were amended to reflect people's actual needs.

We observed staff attempt to hoist one person from a chair to a wheelchair. The electric hoist at the home was not working as when staff attempted to use it the battery was flat and would not raise the person. The staff told us the night staff had not charged the hoist and they used a manual hoist as an alternative. However, they did not correctly fit the sling and they did not know how to operate the manual hoist. The person ended up being incorrectly positioned in the wheelchair as a result. There was a lack of planning of the activity and when cross referenced in the care plan, there was a lack of description on the method the staff were to follow such as positioning of the wheelchair. Additionally staff had not utilised the correct sling. The care plan was clear as to which hoist and which sling were to be used which was good practice. However, there was a lack of clarity amongst staff as to which sling was to be used for this person as staff we spoke with referred to a different sling being the correct sling. In addition, this person was assisted to reposition in bed and the instructions in the care plan stated staff were to move the bed in order to access both sides. However, this was a divan bed on wheels which was not therefore designed to be moved with a person in situ, and did not have holding points for staff to move the bed. Staff told us they managed this manoeuvre, however using equipment such as a bed in a way the manufacturer did not intend, and which had not undergone rigorous testing for this manoeuvre, is not considered safe.

We checked the staff training records and although they had received moving and handling training, there was no record at the home to confirm staff had been shown how to use every piece of equipment in situ and were competent to do so.

We looked to see how the home managed and controlled the risk of infection. There was a dedicated

cleaner for five hours each day and staff were responsible for any cleaning required outside these hours. People told us the home was clean and we received the following comments, "It's clean and tidy here" and "Very clean and well looked after." We did see some poor infection control practice such as used slings and handling belts were placed in a bag along the corridor with clean moving and handling equipment. Staff confirmed this was happening in practice when we raised our concern, and one said, "All the slings are kept there. " A transfer board was on the floor holding open one of the doors along the corridor and although no one at the home was using this equipment, the storing and utilising of it in this manner was not appropriate.

The issues we found in relation to the management of risk demonstrated a breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

We looked to see how the service was managing people's medicines. We found medicines were administered to people by trained care staff. Staff had completed the registered provider's training but in addition had attended local authority training. Staff competencies to administer medicines were checked by the manager, registered manager or area manager. We did however find staff had signed to say creams and ointments had been applied when they had not been the person applying the cream and could therefore not verify when or where it had been applied. This was not good practice as the person who administered the cream should sign to say this had been applied and record the location where the cream was applied to ensure a contemporaneous and accurate record. We also found one medicine had not been dated upon opening although other medicines had. It is good practice to date medicines on opening to ensure they are used within their efficacy time frame.

Medicines were administered sensitively by the team leader who offered people a drink to help them with their medicines. The home had recently changed its pharmacist and most medicines were supplied in blister packs. We inspected medicines storage and administration procedures in the home.. Two medicines trolleys were kept in the downstairs office which was locked when not in use and two trolleys were kept in an upstairs dining area, locked to the wall, although the room was not locked. We were told this was for the two people upstairs and for additional storage. Temperatures of the medicines fridge were checked daily to ensure medicines were stored at the correct temperature.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation (controlled drugs). The home had appropriate storage systems in place and staff followed the recommendations in the legislation in relation to signing the controlled drug register.

We saw 'as necessary' (PRN) medicines were supported by written instructions which described situations where PRN medicines could be given. Relatives told us their relations pain was well managed and one said, "They would recognise discomfort and give pain relief." One person living at the home said, "If you want they would give you paracetamol or aspirin."

We reviewed three staff files and found the necessary recruitment checks had been made to ensure staff suitability to work in the home. This included an application form, interview records, Disclosure and Barring Services (DBS) checks, reviews of people's employment history and two references had been received. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. The area manager told us they were actively recruiting to increase staffing levels. They did not utilise agency staff but had their own bank of staff who filled in for shifts as and when required and had received the necessary training.

Is the service effective?

Our findings

People told us they were happy with the meals. One person said, "The food is marvellous, you have a good choice all through the day." Another told us, "Oh boy, it's tasty and it's nice the food is good with plenty to eat and good choices." We also received the following comments, "I quite enjoy the food although at times it's iffy, good portions and good choices," and "The food is quite decent, plenty to eat and good choices. Good breakfast." One person also said, "I am on a special diet and they all know about it."

We observed the lunchtime meals in the dining room. Tables were laid out with table cloths, cutlery and condiments. Staff appropriately supported people with their meals. We spoke with the chef in relation to people with special dietary needs and they were able to tell us who was on a specialised diet and who required an altered diet due to their religious requirements. They told us they offered a cooked breakfast daily and they asked each person every morning what they would like for their lunch from a choice of two options. They also had visual aids to assist people to make a choice, but these were not required with the people living at the home at that time.

We looked to see how new staff were supported to develop into their role. The home was using the Skills for Care Common Induction Standards 2005 as a basis for their inductions even though at our last inspection the area manager told us that they were preparing to utilise the Care Certificate which replaced the Common Induction Standards in April 2015. The Care Certificate is a set of minimum standards that should be covered as part of induction training of new care workers dependent on their past experience and qualifications in care. This meant the home was not using the recommended standard for new care workers to attain.

The home utilised a mixture of training methods ranging from DVD's followed by a written test, classroom based learning and utilising the local authority training opportunities. The manager told us first aid training and moving and handling involved practical face to face training. Relatives told us staff had the knowledge and skills to care for their relative. One said, "They are well trained, they get on the job training at first and then get more." We reviewed the staff training matrix provided by the manager. This showed us training had been provided in mandatory training in topics such as moving and handling and infection control. We were shown a list of mandatory training planned for the month of March. This included a day of training on the following six subjects; dementia, food, adult abuse infection control, challenging behaviour, and first aid. The manager told us staff watched a DVD for between half an hour and an hour following which they completed a test which was sent away to a company to be marked.

The manager was not certain about the number of supervision session's staff were required to receive, but the area manager told us this was three supervision sessions and an annual appraisal. We reviewed the supervision records for four staff members, which showed staff were having supervisions but the dates of their supervision did not correlate to the supervision matrix we were given at inspection. We also saw staff were offered corrective supervision sessions where poor practice had been identified which showed the manager was tackling poor performance.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. Seven applications under the DoLS had been authorised.

Two stage capacity assessments were in place, but contained all the decisions to be made on one assessment, which meant they were not decision specific and there was a lack of detail about how the person had been supported to make the decisions. At our previous inspection we were shown a new form which recorded this information but this was not in use at this inspection. In one care plan we found mental capacity assessments in place which deemed a person had capacity but further into the file, we saw evidence which contradicted this and superseded this information and concluded the person lacked capacity to consent. We saw best interest decisions in care plans in relation to restrictions such as lap belt use in wheelchairs for those people on a DoLS.

Six staff had received training around the Mental Capacity Act and DoLS which meant most of the staff had not received training. We did not observe any practice which indicated people were not treated in a manner which was not in accordance with their best interests. However, staff did not have the knowledge around the assessment of capacity or the requirements of the legislation. Most of the people living at Paddock Lodge were able to make simple decision such as what to wear and what they wanted to eat. However, the lack of awareness amongst staff of the lawfulness of their approach represented a risk to people's rights and freedom of control over their daily lives. At the time of the inspection the impact of this was low due to people's abilities to contribute to decisions on a day to day basis.

We found consent had been sought for those people who were able to consent to their care and treatment and this was recorded in their care plans. We observed staff asking people for consent during the day and people confirmed this was their usual practice. They told us, "Yes I suppose they do ask for consent" and, "They make sure that you know what they are doing for you."

We saw people using the service had access to other health care professionals for example, GP's, district nurses, chiropody, dentist and optician. The Care Home Support Team (a team which aims to work with care homes in the Kirklees area improving education and confidence for care home staff, patients and their families to be able to better manage and have knowledge of their condition), were involved with supporting the home. This showed us people at the home were assisted to maintain their health and wellbeing by accessing external support when required.

Is the service caring?

Our findings

All the people we spoke with told us the staff were caring. One person said, "They are kind and look after me well." One told us, "The staff are nice and kind, it's comfortable." Although one person said, "To a point they are kind and caring; some are really nice, some are just doing a job." Relatives of people at the home confirmed staff were caring and compassionate and told us, "They certainly are kind and caring; I wouldn't have picked it if they weren't." Another said, "Absolutely kind and compassionate." And a further relative said, "Very pleasant, kind, caring and compassionate."

Throughout our inspection we saw people were treated with respect and in a kind way. One person living at Paddock Lodge told us, "They listen and look after you properly." Another said, "They listen to me and make me feel important." We saw staff encouraged people as they supported them although we did see one carer place a drink in front of a person without any communication. Although our observations evidenced care staff were caring towards people at the home, staffing levels impacted on staff ability to supervise people and there were times when there were no meaningful activities during our inspection. The governance arrangements and lack of oversight impacted on the ability of this aspect of care provided at Paddock Lodge.

We observed people were well groomed. Men were clean shaven. Some ladies had their nails painted and carried their handbags around with them which showed staff had support people to continue to take pride in their appearances. Most bedrooms were neat and tidy and contained personal effects, but some bedrooms had messy drawers.

People's privacy and dignity was maintained and people confirmed this. One person said, "They treat me with respect and look after my dignity." Another said, "They are very good, they treat me respectfully, very nice." We saw staff spoke with people patiently and respectfully and when a visiting community nurse arrived to assess one person, staff encouraged this person to go to their bedroom for privacy. Relatives reported there were no real restrictions on visiting although there was an understanding that meal times should be avoided "You can visit whenever you want but you are advised to avoid busy times like meals". And one person told us, "The family comes in for long visits when they want."

We observed staff encouraged people to do as much as they could for themselves. Staff told us they enabled independence by, for example, when a person is getting dressed staff encouraged them to do what they can for themselves. They told us they would say, "You have a go. We'll give you a little bit of help where you can't manage." Relatives confirmed this and told us, "They encourage [relative] to be independent." Another told us, "[Relative] is very independent as far as she can be, they manage the risks well."

We asked about equality and diversity and how people were supported in relation to their religious and cultural needs. The manager told us they had one person who practised a particular religion and they had obtained the services of a person from this faith to ensure they had this aspect of their spirituality met. They also told us they held a church service every Wednesday at the home and would support people of all faiths as required.

People were supported with advocacy when required, if family were not involved in their care. An advocate is a person who is able to speak on other people's behalf, when they may not be able to do so, or may need assistance in doing so, for themselves. Although there was no one at the time of our inspection who was being supported in this way.

Our review of care plans evidenced there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. This included an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. There was no one requiring end of life care at the time of our inspection. One of the relatives we spoke with during our inspection told us they had discussed end of life care planning with staff, and said, "I have talked through end of life and [relatives] life map." Another said, "Everything is in place."

Is the service responsive?

Our findings

People we spoke with told us they had been offered choice in how their day was planned. One person said, "I do decide things like staying up late at night." Another person told us, "I can make my own decisions about bedtimes." A further person said, "They know me and what I want to do" And one person told us, "The girls know what I like and don't like."

We asked people whether they were offered a choice of care staff in relation to gender preference. We were told, "I am not bothered about being seen by a male or a female carer" and, "There are males here but I am only seen by females". This demonstrated the home was respecting people's choices and preferences in how care was provided and who they wanted to provide this.

We reviewed preadmission care records at the home to ensure the service was assessing people appropriately to live at Paddock Lodge. The manager told us they always undertook a preadmission assessment to ensure they could meet the needs of the person but also to ensure their admission would not have an impact on other people living at the home.

As part of our inspection process we reviewed five care and support plans. Information in the care plans was person centred and contained a section called "This is me." This detailed people's preferred ways of support, such as "I like to get up at variable times but normally from 7 am onwards. " The information also contained people's religious preferences and information such as food they did not like. The manager told us team leaders undertook the assessment of people's needs and they utilised the preadmission assessment information for the first six weeks of a person's stay. They also completed necessary risk assessment. They told us if the person became a permanent resident after the six week period they put a full care plan in place.

Although some information in the care plans we reviewed were accurate and person centred, this was not always the case and we found contradictory information. For example, information which was no longer relevant had been left in one care plans which if followed would lead to poor care provision, such as how a person moved themselves and that they had been prescribed food supplements. We saw staff were recording the person had taken food supplements in their daily record but this had not been added to their care plan.

In another care plan we saw incorrect information about a person's nutritional care needs remained in their care plan when this information had been superseded by Speech and Language Therapist advice. This person's moving and handling care plan detailed they required a handling belt to move and on occasions, a standaid. However, we observed neither was used during our inspection and although the technique used was not unsafe, this demonstrated the moving and handling risk assessment and care plan in place was not reflective of the person's current needs.

We did see some good information in care plans. For example, where people who displayed behaviours that challenged others we saw a plan which advised staff on ways to distract the person to reduce the risk of

harm to themselves and others.

The manager told us people's care needs were reviewed every month or sooner if their needs changed. However, although staff were signing to say care plans had been reviewed and no changes were required, we found some people's needs had changed and the care plans were not always reflective of these changes. This posed a risk of inappropriate care delivery and did not evidence care plans were actually being reviewed as documented. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition to the care plan staff completed a daily record which was a record of a person's day completed three times at each shift. This included sections for staff to complete in relation to pressure care, personal care, information about dietary and hydration intake, professional visits, activities and socialising. The recording tended to be task focussed such as 'toileting needs met', 'small light diet', and 'pressure relief given.' There was very little evidence of choice recorded in these records such as what time people had chosen to get up or go to bed and particularly how they had been supported during the night or what equipment night staff had used to get people in and out of bed.

It was clear from our observations that staff knew people well and were knowledgeable about the things that were important to them in their lives. We saw they supported people to make choices in their everyday lives taking into account their views and preferences which demonstrated they were providing person centred care. We asked people at the home whether they had been involved in writing their care plan and only one person we spoke with told us they had been involved in the compilation of their care plan. Relatives told us, "I am kept up to date but I don't know about a care plan," and "I have been involved in planning her care, she has a say in her own care." Another told us, "I was involved in the care plan at the start but nothing really has changed."

At our previous inspection we found there was a lack of meaningful activities for people living at the home. At this inspection we checked to see if the situation had improved and whether people had meaningful occupation throughout the day to enhance their mental wellbeing. There was no dedicated activities coordinator at the home and staff undertook this role as part of their caring duties. The manager told us staff tended to do activities with people at 10.30 am and 2.30pm and it was recorded in their care plans what they liked to do. They told us they also undertook 1:1 activities with people such as having a chat with people. Our observations during the inspection were that there were long periods where there was very little happening apart from accessing the television and very little was recorded in people's care plans in relation to what they had done that day. Some entries stated, "watching TV" for their morning and afternoon activity. We asked people at the home their views in relation to activities. One person told us, "There is plenty for me to do here; I choose if I want to join in." Another said, "I just want to watch my telly." And a further person said, "There isn't much to do during the day, I go out when I want." The home had made links with a local community centre, the Jubilee Centre and arrangements had been put in place for a couple of people to attend. We were also told that staff volunteered to take people. Other activities included a company that came in to the home to do armchair exercises once a month and sensory stimulation sessions.

We asked people whether they knew how to make a complaint. People told us that although they did not know the formal complaints procedure this was not an issue as they did not want to make a complaint. "I get on well with the staff and have no complaints, if needed I would find out how to". Those who reported that they had raised concerns told us they used an informal route "I have never made a complaint; I just discuss things with the girls." People reported a positive response and one said, "I have raised a minor issue about a carer being off hand, it's been resolved". And one person said, "I feel happy and comfortable in raising issues with the staff. They didn't make me feel uncomfortable about complaining". The manager told

us there had been no complaints but their door was always open for people to raise any concerns. We noted a file full of thank you cards, but there were no dates on most of these and those with dates dated back many years, so it was difficult to determine whether the compliments received in these cards were current.

Is the service well-led?

Our findings

People told us how much they liked living at Paddock Lodge. One person said, "It's marvellous living here." Another told us, "It's nice living here." We asked people living at the home whether they thought the home was well-led. we received the following comments from people using the service , "The managers are nice and approachable," "It's well run," and "It's managed not too badly, short of staff at times" and "Everybody is friendly and approachable, they keep you updated."

There was a registered manager in post who had been registered since 2014. However their role had recently changed and although they were on site during the inspection, a new manager was in place and in the process of registering with the Commission. The manager told us they were signing up to undertake their Level 5 NVQ in management to develop into the role. They shared their vision with us, "I want it to get excellent. I'm improving on activities and getting people out into the community. I feel it is a nice friendly home." They told us their aim was to improve as a leader. The registered manager told us their vision was "Just to keep improving with anything we can to make it better. Keep it running as it is and maintain a high standard."

We reviewed the audits carried out at Paddock Lodge to determine how the registered provider was assessing the quality of their service and how improvements were identified and implemented. The manager and registered manager completed regular audits at the home including mattress audits, infection control audits, weight loss audits, risk assessments, care plans, domestic audits and wheelchair audits. The wheelchair audit asked whether wheelchairs were clean, free from stains, tagged when clean and in a good state of repair. However, this audit was not effective at identifying issues with wheelchairs as the wheelchairs were not numbered, one in use on the day of the inspection was not clean and the tags to confirm they had been cleaned had not been dated. The wheelchair policy stated, "The management will carry out a monthly check on all wheelchairs as per the checklist available." However, as there was no list of all the wheelchairs in situ it was not possible to verify that each one had been checked. Similarly, the hoist sling policy stated, "Once a week each sling is to be washed according to manufacturer's instructions. A sling cleaning record sheet is to be put in place to monitor this cleaning." We could not find this information to confirm this was happening. The care plan audit had not picked up on the incomplete and out of date information contained in the care plans we had reviewed.

The manager provided us with the accident and incident information for the year. We reviewed this information which contained basic information such as the time of the incident, where it had happened and whether the incident was witnessed and a brief description of what had happened but no real analysis. However, the most recent incident contained a new incident analysis reporting document which provided more information for the manager to be able to analyse any trends or themes and to put in relevant measures to reduce risk, which when embedded should improve analysis of accidents and incidents at the home.

We inspected records of lift, hoist and sling servicing and testing. Although we found the hoists and lift had been serviced and had been tested and met the Lifting Operations and Lifting Equipment Regulations 1998

(LOLER) the slings had not been included in this check. All but one sling had been recently purchased so would have met the requirements. However, the home did not have a procedure in place and did not know that slings also needed to be checked for compliance which was a deficit in their governance arrangements. The failure in robust auditing of quality demonstrated a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home is required to display the Care Quality Commission ratings and we observed these were displayed in the entrance of the home and on the registered provider's website in accordance with the Commission's regulation. They were also required to notify us about certain events at the home and we saw they had notified the Care Quality Commission of all events that required reporting including those relating to deaths, DoLS, and safeguarding.

The home was connected to the telehealth hub at Airedale NHS Foundation Trust (accessed over the internet and staffed by specialist nurses who can assess and triage residents as well as support care home staff to provide any additional care). They had taken part in the trial project designed to reduce hospital admissions and people using A&E departments. We asked the manager how often they had used this. They said, "We sign in every month to check its working and say hi." They told us they had not used it much lately but, "Someone came out last month to talk to us about it and to advise us we can use it whenever we want." In addition to this valuable service, the home was supported by the Care Home Support Team, which provides multidisciplinary support to care homes in the area.

The manager told us they undertook a daily walk around at the service as part of their monitoring arrangements but they did not record their findings, so were unable to evidence the effectiveness of this. The area manager had a presence at the home weekly and monitored the quality of the service provided. They provided us with their quality monitoring report titled "Governance Audit and Action Plan for the Care Home" which reviewed the previous quarter's visits and was used for all the registered provider's homes. However, this was dependent on the managers to state whether the action was complete or not and the information was not checked to confirm compliance. This demonstrated that although audits were completed regularly, not all the audits completed were robust enough to identify gaps in the monitoring of quality at the home.

We reviewed the minutes of the latest team leader meeting held on 3 February 2017. These showed discussions were held around medication, activities, handovers, clothing and uniforms, reviews and the meal time experience. The staff team meeting held on the same day reminded staff to inform team leaders if there had been any change in a person's needs to they could change the care plan immediately. This demonstrated they had recognised care plans were not always reflective of people's current needs.

The registered provider published a monthly newsletter detailing what activities had taken place that month, upcoming events and birthdays, advising people a tuck shop would be available each Friday, a reminder to families to ensure their loved ones had access to spending money, and to see the manager if anyone has any suggestions or ideas for the home.

The home held residents' meetings every month and we were shown the minutes of the latest meetings which had taken place in November, December 2016 and February 2017. The meetings followed the same format and a discussion about activities on offer, the environment, the menus, and staffing were held at each meeting. The manager told us they invited relatives to the meetings but they had not attended. Relatives told us they would speak to the manager or staff if they had any concerns and felt they could influence how care was provided. One said, "I speak to [manager] in the corridors, very friendly and approachable." Another said, "I could influence things but I don't need to." This showed that although

relatives were not attending meetings, they were comfortable to speak with the manager as and when required.

Surveys had been sent to people using the service and their relatives in 2016. 23 questionnaires had been sent out and 11 returned. We saw the results had been analysed and a narrative section reflected the comments received around the key areas of quality of care, environment, activities, communication, and general matters. Where comments had been made around improvements which could be made, the area manager had responded with proposed actions. The only negative comments had been around items of clothing going missing, the decoration of some bedrooms, and more outings required. This demonstrated the home was actively seeking the views of people using the service and putting in actions to improve the quality of the service provided.

We reviewed audits which confirmed electrical hard wiring and gas services had taken place and all portable electrical equipment testing was up to date. We saw that regular checks were undertaken in relation to maintenance at the home, and water temperature checks and window restrictors had all been checked in February 2017. Radiators all had covers on them to protect people from the risk of scalds.

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 17 HSCA RA Regulations 2014 Good governance Care plans were not reflective of people's current needs. Audits had not picked up issues in relation to some aspects of the delivery of a quality service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had not ensured there were adequate numbers of staff who were deployed to ensure people's needs were met in accordance to their assessed needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not assessing and managing all foreseeable risks to ensure people were protected from avoidable harm.

The enforcement action we took:

The service was not assessing and managing all foreseeable risks to ensure people were protected from avoidable harm.