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

Summary of findings

Overall summary

The inspection of Lydgate Lodge took place on 25 and 26 January 2017. This was the first inspection of the home with the registered provider, Ideal Carehomes (Number One) Limited.

Lydgate Lodge provides care and support to a maximum of 64 people. The home is purpose built over two floors with a total of four separate units, two of which provide care and support to people who are living with dementia. One the day of our inspection there were 62 people living at the home with another person being admitted on the first day of our inspection.

The service 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.

People told us they felt safe and staff understood their responsibilities in keeping people safe from the risk of harm or abuse. Accidents and incidents were reviewed and analysed to enable possible trends to be identified and appropriate action taken.

People's care plans contained a variety of risk assessments, but they were not always a precise reflection of people's care and support needs. We also found staff had not always assessed people's risk correctly. This raised the risk of people receiving unsafe or unsuitable care.

External contractors were used to service and maintain equipment at the home, however, the internal checks completed by the maintenance staff could not be located on the day of our inspection. Information was readily available for staff in the event of an emergency, this included contractor telephone numbers and personal emergency evacuation plans for people living at the home.

We found staff recruitment was safe, but we were concerned there were not enough staff on duty on a daily basis to meet people's needs. Relatives and staff told us there were not enough staff on duty and we observed staff were busy and lacked time to spend with people other than part of a task related activity.

People's medicines were managed safely, however, we could not accurately tally all the medicines we audited. Staff's competency to administer people's medicines was assessed and staff were also provided with training in medicines awareness.

Staff attended a handover prior to their shift although we found the information on the handover record was not always reflective of people's current needs.

New staff completed a two weeks corporate induction programme although evidence of this was missing in two of the four staff files we reviewed. There was a programme in place to ensure staff received regular

refresher training and management supervision.

Staff respected people's right to make decisions. Where a person lacked the capacity to decide they wanted to live at the home, a capacity assessment had been completed but there was a lack of capacity assessments regarding other aspects of their care. A number of applications had been made to the local authority to ensure that where people were deprived of their liberty, this was lawful.

People were happy with the meals provided at Lydgate Lodge. We found people were offered a choice of meals but the method staff used to help people choose was not consistently appropriate to people's needs.

People were not offered the choice of a hot drink during or immediately after their lunchtime meal and staff did not always record the date or the amount of food people had been offered on people's food records.

People told us staff were caring. During the inspection we also observed staff to be kind and helpful. Where people became upset, staff intervened, supporting them and de-escalating the situation. Staff were knowledgeable about people's needs and the routine of the home was led by the needs of the people and not the staff. Staff respected people's right to privacy and maintained their dignity.

People told us there was a range of activities provided at the home. The regional activity co-ordinator organised the activity programme and events but care staff were responsible on a day to day basis for providing activities for people.

Care records and other related documentation were not always an accurate reflection of people's current care needs. The records staff completed to evidence the support they had provided for people who were at risk of pressure sores lacked relevant information and were not always an accurate reflection of the time staff attended to people's needs.

There was a complaints procedure in place and we saw that where a concern had been raised, the registered manager had taken action to address the issues.

People spoke positively about the registered manager and staff felt the registered manager was supportive and listened to them. The registered manager was experienced and understood their role and responsibilities.

Meetings were held on a regular basis with staff and people who lived at the home to gain feedback from them about Lydgate Lodge.

A number of audits were completed on a regular basis but it was not always clear if identified actions had been addressed. A quality monitoring report was also completed by the regional director, clearly identifying areas for improvement and an action plan was generated to evidence the action taken to address those improvements. However, as is evidenced within this report there were still a number of issues which need to be addressed in order to ensure people received safe, effective and responsive care.

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

Not all aspects of the service were safe.

Risk assessments were not always robust or reflective of people's current needs.

Internal maintenance checks were not available for us to review on the day of the inspection.

There were not enough staff to meet people's needs.

Records regarding the administration of medicines were not consistently robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were provided with a corporate induction, on-going training and supervisions, although the records to evidence staff induction were not always able to be located.

Staff understood the principles of the Mental Capacity Act 2005.

People spoke positively about their meals, but we found inconsistencies in how staff provided meal time choices and support to people.

People were supported to access external healthcare professionals if required.

Is the service caring?

Good

The service was caring.

People told us staff were caring and kind.

Staff responded to people's needs in a professional, but kind manner.

Staff took steps to maintain people's dignity and privacy.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

There was a variety of activities provided at the home, although staff told us they did not always have the time to support people with them.

People's care records were not always an accurate reflection of their current care and support needs.

There was a complaints process in place.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

Our inspection identified a number of areas where improvements are needed at the home, including staffing and records.

People and staff spoke positively about the registered manager.

Meetings were held with staff and people who lived at the home.

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 over two days on 25 and 26 January 2017. On 25 January 2017 the inspection was unannounced. An unannounced inspection is where we visit the service without telling anyone. 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. The expert by experience on this occasion had experience of working in health and social care. On 26 January 2017 one inspector visited the home again. This visit was announced and was to ensure the registered manager would be available to meet with us.

The registered provider had been asked, during January 2017, to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We contacted commissioners of the service, safeguarding and Healthwatch to ascertain whether they held any information about the service. This information was used to assist with the planning of our inspection and inform our judgements about the service.

Not all the people who lived at the home were able to communicate verbally, so we used a number of different methods to help us understand the experiences of people who lived in the home.
We spent time in the lounge and dining room areas observing the care and support people received. We spoke with fourteen people who were living in the home and nine visiting relatives. We also spoke with the regional director, the registered manager, care manager, two senior care staff, five care assistants, a cook, the regional activity co-ordinator and a visiting external healthcare professional. We reviewed four staff

recruitment files, eight people's care records and a variety of documents which related to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes I feel very safe, the staff always come when I call." Another person told us, "Yes I feel safe living here, the staff always help me, and they are very helpful here." When we asked a relative, they said, "Yes, (person) is safe, I feel less stress as (person) is being looked after".

Each of the staff we spoke with were able to describe the different types of abuse and potential signs someone may be being harmed, for example, unexplained bruising or changes to their character. Staff were aware of their responsibility in reporting any concerns to a more senior manager and were confident appropriate action would be taken.

We observed staff were quick to respond and intervene where they saw interactions between people were beginning to escalate. For example, we observed a person getting angry with another person, staff responded and distracted the individual and de-escalated the situation effectively. This helps to reduce the risk of either physical or verbal altercations between people who live at the home. We also heard staff remind people about safety for example, to slow their pace when walking and to use relevant equipment such as walking aids and to take care with hot drinks. This showed staff were aware of potential risks to people who lived at the home.

Accidents and incidents were recorded, logged and analysed on a monthly basis. The registered manager told us the method of analysis had changed in recent months and was now more robust. We reviewed the analysis and saw this included a record of the action taken by staff to reduce the risk of harm where people had fallen. This included a district nurse reviewing the person, referrals to the falls team and using equipment, for example sensor mats. This showed the home analysed incidents that may result in harm to people living there and made changes to their care and support as necessary.

Each of the care plans we reviewed contained a variety of risk assessments, for example, mobility, falls, skin integrity and malnutrition. In three of the care plans we reviewed we found the risk assessments were not always an accurate reflection of people's current needs and staff had not always assessed people's risk correctly. For example, one person's care needs had changed significantly within a short period of time and they were being cared for in bed. Neither the skin integrity nor the falls risk assessment had been updated to reflect this change and the skin integrity risk assessment therefore incorrectly identified them as being at low risk of developing pressure damage. We reviewed the risk assessments for another person who lived at the home. We found their skin integrity risk assessment had not been updated after staff had documented a break in their skin and their falls risk assessment referred to them requiring a hoist to support them to transfer, but on the day of the inspection we saw them walk with a member of staff. This demonstrated a failure to ensure risk assessments were a robust and accurate reflection of people's needs. Following the inspection we brought these matters to the attention the registered manager.

There was a handover report document for each of the four units, which provided staff with a brief summary of people's risks, for example, their level of mobility. We checked the handover record for one of the units and saw the record had not been updated to reflect the current risk for one of the people's care plan we had

reviewed. It still recorded they were 'mobile with zimmer and assistance'. We also noted another person had not been added to the handover sheet and the section where their bedroom was listed was blank. Inaccurate records put people at risk of receiving poor or inappropriate care. We discussed this with the registered manager after the inspection had been completed.

These examples demonstrate a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence the premises and equipment were serviced and maintained by external contractors. This included checks on electrical wiring, gas safety, fire system and nurse call alarms. We also saw that lifting equipment, for example, hoists and slings had been checked in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). However, the LOLER for the passenger lift could not be located on the day of the inspection, although we saw evidence of regular maintenance work by external contractors. We asked the registered manager to obtain a copy of this document, and they emailed it to us after the inspection. It is important to ensure these documents are readily available for inspection to demonstrate compliance with risks associated with equipment.

We asked if we could review the internal maintenance checks, for example, on the fire system and water temperatures. The registered manager told me the home did not have a dedicated maintenance person and the maintenance person from another home was coming to Lydgate Lodge on a regular basis to complete these checks until the position was filled. On the day of the inspection, the maintenance person was present at the home but neither they nor the registered manager were able to locate the records relating to these checks. The maintenance person assured us the maintenance checks were regularly completed and they said the purpose of this visit was to complete the relevant checks for the current week.

These examples further demonstrate a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information available for staff in the event of an emergency situation. A file contained a variety of contact information for staff in the event they had a problem with the gas, electric or water supply. There was also information as to how staff could contact key contractors, for example if there was a problem with the fire system or the passenger lift. Each person who lived at the home also had a personal emergency evacuation plan (PEEP). This is a document which details the safety plan, such as equipment and staff support, for a named individual in the event the premises have to be evacuated.

We asked the registered manager if all staff regularly attended a fire drill. This helps to ensure staff have the knowledge and skills necessary to keep people safe in the event of a fire. The manager showed us a record of fire drills held at the home although this did not clearly evidence all staff had attended. The registered manager told us they were aware of this and as a result they had started a matrix on which they had begun to log staffs attendance to enable them to identify staff who may not be up to date with this aspect of their training. They emailed the matrix to us after the inspection and we saw of the 50 staff listed, 39 staff had attended a fire drill within the previous nine months. This showed us the registered manager had plans in place to ensure staff routinely attended fire drills.

Relatives told us there were not enough staff on duty. One relative said, "There doesn't seem to be enough staff here, there have been a lot of staff leaving and so there are new staff and they seem to be let down by temporary ones. There are two carers for twelve residents but if one goes off to do medicines then they have to ring to get someone else to help them. (Person) has a bath once a week and I don't think it's enough". Another relative told us, "You can't always find them (staff) when I am visiting (relative)." A person who lived

at the home said, "The difficulty is, I have to have two people and that can be a problem at times. They have to ring round and get extra help but they do their best. The problem on this floor is the people are getting older and deteriorating and need two staff."

On one of the units staff were too busy to spend any time to sit and talk with us. However, where staff were able to speak with us, they consistently expressed concerns regarding staffing levels at the home. Comments included; "We do need more staff, definitely", "People have to wait; sometimes people don't get up until 11am as staff are busy. We are able not able to supervise people" and "If we had more staff we could spend more time with them, they need emotional help as well as practical." We overheard a member of staff saying after the lunchtime period, "I started at 7.45am this morning and have not sat down once today yet. I'm working a twelve hour shift; it's a long time to be on my feet". Another staff member told us on the unit they were working on, there were 16 people, three were cared for in bed and required at least two hourly intervention and support, and a further six people needed staff to support them with mobilising around the home. They also said, the registered manager had spent time on the unit that day to enable two of the staff to take their break, adding, "People have to wait longer than they should."

We also spoke with a visiting professional who expressed concern in regard to staffing levels at the home. They said, "I came yesterday and on one of the units both staff were in a bedroom supporting a person. This meant there was no other staff available on the floor, with seven people who were sat in the lounge."

Throughout the inspection we heard staff arranging cover for the units to enable them to complete their duties. At approximately 10.30am on one of the units we heard staff say, "I'll ring round the units and ask someone to watch the floor while I do repositioning with (name of staff)". Around the same time, the telephone rang and we heard the staff respond to the caller saying, "Sorry, I can't help, I am on my own, the others are seeing to people. I'll come when I can." After lunch a member of staff came onto one of the units to request a staff member go with them to assist with entertainment on another unit.

We observed tea time on one unit, between 5pm and 5.25pm. There were only two staff present to serve the tea, provide drinks and support sixteen people, ten of whom were in the dining room. We saw five people get up and begin to wander off in different directions, two people became verbally agitated, one of whom said three times, "I want to go to the toilet." When a member of staff assisted them to go to the toilet, this left only one member of staff available for people.

Staff told us there were two care staff on each unit during the day with two senior care satff supporting two units each. However, the senior care staff were responsible for managing the shift, administering three medicine rounds on two units, supporting with care tasks as well as addressing the needs of visiting professionals and family members. There were three staff who started their shift at 7am each morning and three staff remained until 10pm to provide extra support to the night staff at their peak activity time. Between 10pm and 7am there were five staff in the home. However, when we explored this further with the registered manager, each staff member was entitled to an hour break and only one staff member at a time was able to take a break. This meant that between 10pm and 7am there were only four hours when five staff were available to support people and there were at least 12 people in the home who required two staff to support them including through the night.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked staff had been recruited in a safe way and that all the information and documents as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were in place.

We asked two of the staff about the recruitment process. Both told us they had attended an interview and provided references and that a Disclosure and Barring service (DBS) check had been completed prior to their commencing employment. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. We reviewed four staff recruitment files, all of whom had been employed for less than 18 months. Each file contained a completed application form, references and a DBS check. Notes were also recorded from the interview although the document had not been fully completed in two of the files we looked at.

We checked to see if people's medicines were managed safely, we observed staff administering medicines to people. Staff ensured they put all medicines away in the trolley and locked the trolley doors between administrations, reducing the risk of unauthorised access to people's medicines. We also observed staff supporting people to take their medicines; this was done with patience and discretion and included asking, where appropriate if people required pain relief.

A monitored dosage system (MDS) was used for the majority of medicines while others were supplied in boxes or bottles. We checked three individual boxed medicines and found the stock tallied with the number of recorded administrations. We also checked two medicines where staff were able to administer a variable dose, for example, one or two tablets. We were unable to accurately tally these two medicines as staff had not clearly or consistently recorded the number of tablets administered. We also checked the medicine records for two people who were prescribed a medicine which was to be administered 'as needed' (PRN) but there was only a protocol in place for one of the medicines. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

We saw from the training matrix that all staff were expected to complete a medicines awareness course and the registered manager told us they had recently accessed a more in-depth training course for staff who had responsibility for administering people's medicines. An assessment of staff's competency to administer people's medicines was also completed. The registered manager had a matrix in place to enable them to monitor when staffs competencies were due to be re-assessed. This meant people received their medicines from staff who had the appropriate knowledge and skills.

One person said, "The staff wear gloves and aprons when they are doing anything with me in the bathroom and wash their hands when they have finished." We also observed staff using disposable aprons and gloves when completing certain duties. We found the home was predominantly clean and well maintained. In the morning we identified areas that were in need of cleaning, however, when we checked later we found them to be clean. Although we did note two rooms which had a strong malodour, despite their being no obvious cause and one of the bedrooms had the window open. This was brought to the attention of the registered manager following the inspection.

Requires Improvement

Is the service effective?

Our findings

Staff told us they attended a handover at the start of their shift where information about people's needs was shared. A handover record for each unit was retained on a daily basis, although, as already detailed earlier in this report the information in this document was not up to date. However, we also observed communication between staff throughout the day to be knowledgeable and evidenced they knew and understood people's needs.

Staff we spoke with told us they had completed a two week corporate induction programme when they commenced working for the registered provider, this included the completion of all mandatory training. We checked four staff files but found evidence of their induction was missing in two of the files we reviewed. Discussions with those staff confirmed they had attended the corporate induction programme. We spoke with the registered manager and they did not know why the induction paperwork was missing, but they assured us all staff did complete the induction programme and showed us evidence of a newly employed staff member's induction. An effective induction helps to ensure new staff learn the registered providers policies, processes and practices, helping them to acclimatise to their role and working environment.

Staff told us they received regular training updates. Staff said refresher training was completed online with face to face elements for moving and handling updates. We saw evidence in staff files of training certificates and the registered manager also maintained a training matrix which provided an overview of the training each staff member had competed. We saw some of the cells on the matrix were highlighted red. The registered manager told us this was to alert staff they needed to refresh their training in that particular subject. We saw staff training covered a range of topics, including safeguarding, infection prevention and control and food safety. Ensuring staff receive thorough training and regular updates mean staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

Staff also told us they received regular management supervision, although we found no recorded evidence in one of the staff files we reviewed. The registered manager showed us a matrix they had implemented to give them an overview of the supervision staff had received and to enable them to plot when staff were due to receive supervision again. They also told us the recent recruitment of a care manager and two deputy managers would help them in ensuring this programme was adhered to. Regular management supervision helps to monitor staff's performance, ensuring they have the skills and competencies to meet people's needs.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us seven people who lived at the home were subject to a DoLS authorisation. Paperwork relating to DoLS applications and approvals was kept in the office, including applications submitted to the local authority, but awaiting assessment and approved authorisations. There was a matrix in place which provided an overview of the information, for example, to summarise the names of people for whom a DoLS had been applied for, dates of applications, outcomes and when staff needed to re-apply for a DoLS if that was still appropriate. Having this overview helps to ensure senior staff have oversight of relevant information pertaining to DoLS authorisations.

Staff told us they had completed training in the MCA and this was also evidenced on the training matrix. Staff understood people's right to make decisions and understood some people may be able to make simple decisions but not more complex ones. One of the senior care staff we spoke with said, "Some people have variable capacity, it can vary from day today." Another staff member told us how one person struggled with decisions saying, "We help (person) and give them prompts." During our inspection we observed staff involving people in making decisions and respecting people's right to decline care and support. This showed staff respected people's right to make their own decisions.

Each of the care plans we reviewed, where the person lacked the capacity to decide they wanted to live at Lydgate Lodge, contained a capacity assessment and evidence of a best interest decision in their care plan. However, where people lacked capacity to manage other aspects of their care, for example their medicines, there were no mental capacity assessments or best interest documentation evident within their files. Without this documentation, the registered provider is unable to demonstrate due process has been followed when making decisions in people's best interests if they lack capacity in accordance with legislation. We discussed this with the registered manager on the day of the inspection.

People gave positive feedback about the meals provided at Lydgate Lodge. Comments included; "The meals are very good here, there is always a choice and the quality is good", "The food is pretty good, not bad at all. There is a choice of a good cooked meal or salad if you want" and "I enjoy my food here. There's snacks too if you want, yesterday we had chocolate eclairs. You can have a biscuit, cake, crisps, fruit, cheese and biscuits, toast. There's always plenty to eat." However, a relative said "Tea is nearly always soup and sandwiches which is often not enough."

We observed lunchtime on three of the four units, on the first day of our inspection. On one of the residential units, there was a pleasant, relaxed and informal atmosphere. People were asked where they would like to sit, some choosing to sit at the shared tables which were laid with clean table linen, condiments and fresh flowers present on the tables. People who remained seated in the lounge chairs had their table set with a doyley. As the meal was served staff gave people a visual choice of both meals, roast beef, Yorkshire pudding, cabbage, turnip, carrots, mashed potato and gravy or vegetable risotto accompanied by the same vegetables as the roast dinner. As people finished their main course staff offered a further helping before removing their plates. Staff offered people a choice of desserts; treacle sponge and custard, ice cream or yogurt. There were carafes of two flavours of cordial on the tables, which were poured by the staff although no hot beverages were offered either during or following the meal.

On one of the dementia units people were also offered a verbal or visual choice. Although when staff offered people their pudding, they were not offered a choice and people were not told what their pudding was. Staff

did not prompt anyone to see if they wanted to use the condiments and no-one was offered a hot drink at lunchtime, although we saw staff sit with people and provide both verbal and physical support to people with their meal. We also saw people were provided with adapted cutlery to enable them to maintain their independence. On the other dementia unit staff asked people which meal they would prefer but they were not offered a visual prompt. We also had concerns regarding the number of staff available to help people on this unit at tea time, which we have detailed earlier in our report.

People were provided with drinks and snacks between meals, this included at mid-morning and mid-afternoon and if people asked for them during the day. However, one person told us staff sometimes missed them when they went round with the mid-morning and mid-afternoon drinks.

Staff were predominantly kind and caring while supporting people with meals and drinks, asking people if they required support, for example, "Are you ok with that?" and "Would you like me to cut your meat?" but we observed one member of staff sit with a person who was sat alone to eat, but there was no verbal or nonverbal communication between them. Interacting with people at mealtimes can enhance the eating experience for people.

We reviewed a random sample of people's eating and drinking records and found the records did not consistently record the date. We also noted that although staff recorded the quantity people had eaten, for example, ½ or 3/4, the records did not detail the quantity people had been offered or provided with. This meant people's food diaries were not robust and lacked relevant details about people's eating habits and demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence in people's care plans that people received input from external health care professionals. For example, the GP, district nurse, dietician and speech and language team. This showed people using the service received additional support when required for meeting their care and support needs.

Lydgate Lodge is a modern, purpose built home. There is a large reception area along with four separate units over two floors. Bedrooms are single with en-suite facilities. There are also communal toilets and a bath on each unit. Each of the units was homely with a lounge and dining room as well as an additional lounge area, although we did not see this being utilised during the time we were at the home. There was signage on all the units to direct people to bedroom and communal areas. This can be helpful for people, particularly where people may have difficulty recollecting the directions to the various spaces.

Good

Is the service caring?

Our findings

Everyone we spoke with told us the staff were kind and caring. One person said, "The staff are very nice, so kind and quite loving sometimes. There is some wonderful staff at this place; they have fun with the residents. It's nice they have fun and talk with you." Another person told us, "The staff are very good here, in fact they are lovely and very sociable." We spoke with another person who told us how staff had supported them through a recent bereavement. A relative we spoke with said they were very happy with the care their family member received at the home. Another relative said staff knew their family member well.

Throughout the inspection we observed staff to interact with people in a friendly, caring and professional manner. Although staff were busy, their communication and response to people were consistently caring and kind. For example, we saw staff lower themselves to ensure they were speaking to people at their level and asking people if they were comfortable before they left them. Another staff member noticed when someone looked sad. They sat down and asked the person what was wrong.

When people became cross or upset with another person, staff intervened calmly, distracting them and providing reassurance. Staff also used touch in an appropriate manner, for example, touching a person's arm or hand and holding their hand when sitting with them or walking alongside them. The use of appropriate touch helps to nurture feelings of trust and connectedness and can reduce stress and agitation in people. We also noted when office based staff and ancillary staff passed people, they also smiled, acknowledged people and spoke with them.

Staff expressed a good knowledge of people. When we spoke with staff about people, staff were able to answer our questions. Staff told us they felt the daily routine of the home was planned around the needs of the people who lived there and not around the routines of the staff. Staff told us people were able to decide when they wanted to get up, go to bed, and if they wanted a bath or shower. During our inspection we saw people who remained in their bedrooms as well as people who were in the communal areas. We also noted people getting up at a variety of times throughout the day. Staff offered people choices, for example, where they would like to sit and what they would like to eat or drink. Although, as referenced earlier in this report, staff did not consistently provide choices at meal times in a way people could fully understand.

People's care plans had a life history section. We looked at the record for one person and saw this recorded a detailed summary of their life, family ties, work life and social interests. Recording this information can help staff gain greater insight into the people they support and enable staff to engage in meaningful conversations with people.

One person we spoke with said, "They always show respect and dignity to me. They knock on the door before coming in, close the door if I'm on the commode; cover me up with a towel." Staff we spoke with understood the importance of maintaining people's privacy and dignity and gave examples of how they would implement this. This included, closing doors and windows and using towels to cover people to prevent excessive exposure during personal care. We also observed staff taking steps to maintain people's dignity, for example, we saw a staff member say to a person "Can I help you wipe your mouth", as they

dribbled their soup.

We saw information on display in the reception area about how an advocate could be accessed in the event a person needed this service. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

It was not clear from people's care plans whether they had expressed any end of life care wishes. There was a section in people's care plans to record this but the content in the care plans we reviewed was minimal. For example, one person's care plan simply recorded they had a 'do not rescuitate' (DNACPR) instruction in place on the section 'future wishes'. Recording peoples preferences in regard to their end of life care helps to ensure staff know what is important to them and what their individual wishes are.

Requires Improvement

Is the service responsive?

Our findings

People who were able to speak with us, told us about the activities held at the home. One person said, "We socialise together, play cards, play board games, watch TV, and go out on day trips together, we all mix in." Another person said, "There's always something going off here, all the activities which are available for those who want. There is a wonderful selection of books in the quiet room and two shelves in reception full of books and DVDs. A lady had her private birthday party in the quiet room which was nice." People also told us about the gardening and knitting club.

During our inspection we spoke with the regional activity co-ordinator. They told us they were responsible for five care homes in the Yorkshire area and they visited Lydgate Lodge regularly. They said they held a monthly social committee meeting to find out what people would like to experience and a range of hobbies and interests were catered for including; knitting club, sing along, playing the piano, board games, film afternoons in the quiet lounge, drawing and painting, arts and crafts, baking and decorating cakes in the café, gentle exercise classes, pamper days and dementia champion reading groups. There were also theme based activities and meals held throughout the year, such as Chinese New Year, National Chocolate Cake Day and Burns Night. Trips out had also been organised as well as external entertainers visiting the home. A hairdresser visited the home twice a week and a church service was held weekly in a quiet lounge, by a visiting clergy.

We spoke with two staff and asked them how they supported people with activities. They said, "We are so hard pressed it's hard to fit anything in. The activity person isn't based here, we have no dedicated person, so there isn't much activity as there is no-one to do it" and "We don't have time to sit and do any activities with people. We are told 'do this, do that'. We would if we had time to do it." Over the two days of our inspection the activities we saw people engage in was an exercise class held on one of the units during the afternoon, although staff said they were not aware this was scheduled so they had not arranged the seating or supported people to move into a seat which would enable them to participate in the exercise class, should they choose to do so. We also observed a film being played on the television on another unit and a member of staff sitting with a person painting their nails and later on they had a game of dominoes with a person.

People's care records and other related documentation were not always accurate or up to date.

Where people were identified as being at risk of developing pressure sores, records did not always provide an adequate level of detail. For example, we saw the position changes for one person and saw the last entry made on their reposition chart was at 7pm on 23 January 2017 and for another person there was no entry after 7pm on 19 January 2017, despite the other position change records detailing staff changed their position throughout the 24 hour period. Many of the records also failed to record the position staff had moved the person either from or to and not all the records were dated. The position charts staff recorded their actions on already had the times typed on, for example, 1 o'clock, 2 o'clock, and staff made an entry adjacent to the relevant time but they did not adjust the document to record the actual time they changed the person's position, therefore the document was not an accurate record of the time staff delivered the

person's care.

Where people's needs had changed, care plans were not always up to date. For example, the mobility care plan for one person had not been updated to reflect their current needs and an eating and drinking care plan had not been updated following a recent speech and language assessment. The skin integrity care plan for another person had not been updated to reflect significant changes to their needs. Although staff had recorded the changes within the evaluation section, we had to read a number of entries before we were able to establish their current health status. We also saw an entry, which detailed the district nurse recommend the person to be cared for on an airwave mattress. When we checked the person's bed, they had a foam overlay in place. We asked the registered manager about this and they said they were not aware of this request. They assured us they would take immediate action to rectify this. Another example was for a person who now spent a significant amount of time in bed, but their care plan had not been updated to reflect this.

These concerns were shared with the registered manager on the day of the inspection. These examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted people's care plans were written in a person centred manner. For example, the care plan for one person detailed they had glasses but preferred not to wear them and they preferred their drinks of tea in a cup with a saucer. Another person's care plan recorded 'If staff see me rock side to side, ask me if I would like to stand up or sit elsewhere'. This helped care staff to know what was important to the people they cared for.

People knew who the registered manager was and said they could approach them if they had any concerns or complaints. One person said, "The manager is approachable and I wouldn't hesitate to approach them with any problems I may have." The complaint procedure was on display in the reception area. The registered manager told us complaints were logged and head office notified. Complaints were logged in a complaints file, at the front of which was a flow chart to guide staff of the registered provider's procedure for handling complaints. The registered manager told us they had received four complaints since they had commenced working at the service in June 2016 and these were all verbal. We reviewed one of the complaints which was in regard to a person's bedroom door being unlocked when they were not in their room. When we checked their bedroom door we found staff were now locking the door as requested by the complainant. This demonstrated there was a process for addressing complaints which were then dealt with by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

People knew who the registered manager was and spoke positively about them. One person said, "The manager is nice and very good. They look after everybody, their staff and their charges." Another person said, "The manager here is very good, I'm full of praise for their staff and everything is good here for those who need it." A relative, who specifically asked to speak with us, told us, "The home is much better with (name of manager). The staff are receptive. (Relative) is well cared for and there are some good staff." When we spoke with a visiting healthcare professional, they told us if they raised any issues with the registered manager they felt confident they would be actioned.

Staff also spoke positively about the registered manager, saying they ran the home well and supported the staff. An ancillary worker said, "I feel part of the team." A member of senior care staff said, "(Name of manager) is a people person, they will help you on the floor. Things are getting better, we are more settled with the new manager." Another staff member said, "(Name of manager) seems ok. They support us and listen to us. They will come on the floor and help if needed." Both the registered manager and the care manager said they felt supported by their regional director.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection who had been employed at the home since June 2016 and therefore this condition of registration was met.

Throughout the inspection the registered manager was open, honest and professional. They were knowledgeable about the people who lived at the home and the staff who worked there, they were able to tell us about their daily duties and understood their responsibilities as registered manager.

We asked the registered manager how they monitored the quality of the service people received. They told us they did a walk around the home on a daily basis, saying, "I have always been hands on. If I see something, I do it. It isn't a hierarchy here, it's a team and if it's not good enough for your mum, then don't do it. It isn't bad here, but it can be better."

We reviewed a monthly audit file, which contained paper copies of the audits completed each month. We saw these included, issues relating to the environment, housekeeping, medicines, monthly weights monitoring and an overview regarding the incidence of pressure sores. We saw six care plans had been audited in October 2016 and five in November 2016, but it was not clear from the audits if the actions identified had been addressed by staff.

The registered manager told us the regional director also completed regular quality monitoring reports at the home. They said the quality audit tool was robust and the regional director was thorough in their assessment. We saw the quality score for November 2016 was 60.56% but the most recent quality audit, dated 4 January 2017, scored the home at 69.9%, giving a quality rating of 'requires improvement'. We saw issues that needed attention were clearly identified within the audit, including matters identified in the previous quality audit which were still to be addressed. We also noted the regional director had reviewed a

care plan for a person we had also looked at and they had identified similar concerns to those we had raised, however, the registered manger had received the report within the couple of days prior to our inspection and therefore had not had opportunity to address the issues. Following the inspection the registered manager emailed the action plan to us, we saw this identified the issues to be addressed, the person responsible for each issue and a timescale for completion. This demonstrated there was a system in place to regularly monitor and review the service provided at Lydgate Lodge.

Staff told us regular staff meetings were held, although one staff member said not many staff attended them. Another staff member told us the meeting minutes were typed up and a copy was left in the staff room. A copy of the minutes from staff meetings was retained in the registered manager's office and we saw evidence meetings were held regularly. A variety of topics were discussed at the meetings and we spoke with the registered manager on the day of the inspection regarding adding staff comments and feedback during the meetings, to future minutes.

Resident's meetings were also held on a regular basis. A copy of the most recent meeting minutes were on display in the reception area. Topics discussed included activities and organised trips, and the laundry service. The minutes also recorded comments made by residents who attended the meeting. Meetings are an important part of the provider's responsibility in enabling people to express their views and be involved in making decisions about the home.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

It is clear from our findings at the inspection there are systems and processes in place to monitor the service at the home and it also evident the registered manager and regional director are thorough in their assessment of the home and the issues which need addressing. However, as evidenced within this report there were still a number of areas where improvements were needed, for example, assessing risk, staffing, end of life documentation and records. These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Future inspection will seek to evidence a sustained and consistent high level of quality has been achieved and that systems of governance are reflective, transparent and robust.

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 There was a failure to ensure risk assessments were a robust and accurate reflection of people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure peoples records were an accurate reflection of the care and support they received. Systems of governance were not robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably deployed staff to meet peoples needs.