Valeo Limited

The Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection of The Lodge took place on 11 and 18 October 2017. The inspection was unannounced on the first day and announced on the second day. We previously inspected the service on 20 July 2016 and at that time we found the provider was not meeting the regulations relating to safe care and treatment, premises and equipment, and good governance. On this inspection we checked and found improvements had been made, however we found one new breach of the regulations.

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

The Lodge provides a service for up to seven adults who have a learning disability and behaviour that may challenge others. The home provides accommodation and support over two floors; one floor for three men and the other for four women. Bathroom and toilet facilities on each floor are shared. The home is close to community facilities including, shops, cafes, a bank, post office and garden centre.

There was a registered manager in post who had been registered since January 2016. 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.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse.

Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence. Detailed individual behaviour support plans gave staff the direction they needed to provide safe care.

Building maintenance and hygiene had improved and some areas of the home had been refurbished.

Safe recruitment and selection processes were in place. We reviewed the systems for the management of medicines and found that people received their medicines safely.

Sufficient staff were deployed to provide a good level of interaction. The required number of staff was provided to meet people's assessed needs, although one person, whose support needs had changed, was unable to access the community on occasion while they were awaiting a re-assessment of their support needs.

Staff told us they felt supported, however we found they were not always supported with regular

management supervision. Staff had received an induction and role specific training, which ensured they had the knowledge and skills to support the people who lived at the home.

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 supported this practice, although some best interest processes had not been evidenced.

People were supported to eat a balanced diet, and meals were planned around their tastes and preferences.

People were supported to maintain good health and had access to healthcare professionals and services. They were supported and encouraged to have regular health checks and were accompanied by staff to health appointments.

Positive relationships between staff and people who lived at The Lodge were evident. Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs.

People were involved in arranging their support and staff facilitated this on a daily basis. People were supported to be as independent as possible throughout their daily lives.

Care records contained detailed information on how to support people and included measures to protect them from social isolation. People engaged in social activities which were person-centred.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

People told us the service was well-led. The registered manager was visible in the service and knew people's needs.

Records at the home could not evidence regular staff supervision was in place. This was the only breach of regulation identified at this inspection, and showed that whilst much improvement had been made since the last inspection, some concerns relating to governance remained.

Improvements had been made to oversight and audit within the service, although there were some recent gaps.

The registered provider's system of oversight had not identified and addressed the problem we found with staff supervision. Management input at the service had been reduced to three days a week in July 2017, which appeared to have impacted on the sustainability of recent improvements in governance.

Feedback from staff was positive about the registered manager and they told us they felt supported. People who used the service and their representatives were asked for their views about the service and they were acted on.

We found one breach of the health and social Care Act (Regulated Activities) Regulations 2014. 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?

Good

The service was safe.

Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence.

The building was maintained and managed in a safe way and emergency plans were in place.

Medicines were managed in a safe way for people.

Staff had a good understanding of safeguarding people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive supervision and appraisal to support their professional development needs.

Staff had received specialist training to enable them to provide support to the people who lived at The Lodge.

People's consent to care and treatment was always sought; however, some best interest decision-making had not been recorded.

People were supported to eat and drink enough and maintain a balanced diet. Healthy eating was promoted.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy, dignity and diverse needs.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

People's care plans were person-centred and individualised.

People were supported to participate in activities both inside and outside the service.

People told us they knew how to complain and that staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had improved since the last inspection, however a new breach of regulation showed some issues with governance remained.

The registered provider had an overview of the service, although this system had not identified and addressed the issues we found.

The culture was positive, person-centred, open and inclusive. The registered manager was visible in the service and knew the needs of people.

The registered manager used good practice and partnership working in addition to audit to drive improvement at the home.

The Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 18 October 2017 and was unannounced on the first day and announced on the second day. The membership of the inspection team consisted of one adult social care inspector 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 area of expertise for the expert by experience on this inspection was learning disabilities.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioning teams. After the inspection we received feedback from two community health professionals. The registered provider was asked to complete a Provider Information Return, however this was not completed. 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 used a number of different methods to help us understand the experiences of people who used the service. Some people communicated non-verbally and as we were not familiar with everyone's way of communicating we used observation as a means of understanding their experience. We spent time in the lounge areas and dining rooms observing the care and support people received. We looked in the bedrooms of four people who used the service. We spoke with five people and three relatives on the telephone. We spoke with the registered manager, two senior support workers and two support workers. We looked at four care records, four staff files, accident and incident records, medicines administration systems, maintenance records and quality monitoring systems

Good

Is the service safe?

Our findings

People told us they felt safe at The lodge. One person said, "I feel safe here and there are enough staff to help me when I need them."

Relatives we spoke with said, "Yes, I feel my [relative] is safe at The Lodge. [My relative] seems a lot happier when [they] come home nowadays, so that tells me that [my relative] is settling well there." Another relative said, "I certainly do feel that my [relative] is safe there. I am not too sure about the staffing levels at the moment as some have recently left due to the renovations. I think there are more agency staff on as a result of this so I will reserve judgment on that question for the time being." A third relative said, "I feel my [relative] has changed so much for the better since being at The Lodge. [My relative] looks so much better in [themselves] and is very happy with the staff and very happy with [their] housemates. We certainly think [my relative] is safe living there."

At our last inspection in July 2016 we found the registered provider was not meeting the regulation related to safe care and treatment because some risks had not been identified so they could be reduced and managed safely. We also found behavioural incidents were not always recorded and reviewed in order to reduce incidents and keep people safe from harm. At this inspection we checked and found improvements had been made.

Systems were in place to manage and reduce risks to people. In people's care records we saw comprehensive risk assessments to mitigate risks in relation to behaviour that may challenge others, self-harm, falls, choking, physical health, financial capability, decision making, refusal of medication, hot weather, and transport. Risk assessments were detailed and contained clear directions for staff to ensure risk was managed well. We saw these assessments were reviewed regularly and up to date. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence. This showed the service had a risk management system in place which ensured risks were managed without impinging on people's rights and freedoms.

Care plans and incident records showed physical intervention was only used as a last resort to prevent harm to the person concerned or to those close by. All such incidents were clearly documented and records showed each incident was subject to senior staff review with any lessons learned translated into care plans. Staff we spoke with were able to describe de-escalation techniques and how they minimised the use of restraint.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety in the home.

At our last inspection we found the registered provider was not meeting the regulations related to premises

and equipment because some of the systems in place to ensure maintenance and cleaning tasks were completed were not effective. At this inspection we checked and found improvements had been made.

At the time of this inspection the home was being refurbished and improvements had been made to the carpets, bathrooms, one kitchen and décor at the home. One extra bedroom had been completed on the upper floor and a small office was awaiting decorating, which meant many records were being held next door at a different home managed by the same provider.

The service was generally clean and odour-free, with some crumbs and debris on the upper floor prior to the cleaner completing their tasks there. The service employed a cleaner for communal areas and night staff also completed cleaning tasks. We found cleaning schedules were now being followed, although the kitchen floor on the upper floor was sticky prior to the cleaner commencing. People were supported to clean their own flats or rooms and there was a good supply of personal protective equipment to prevent the spread of infections. Hand soap was not immediately available to staff throughout the home due to wall mounted dispensers awaiting replacement. We raised this with the registered manager and she addressed this immediately.

At our last inspection in July 2016 we found the registered provider was not meeting the regulation related to safe care and treatment because people did not have personal evacuation plans (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. At this inspection we checked and found improvements had been made and people had a PEEP in place. Regular fire drills were completed and people and staff were aware of the procedure to follow. This showed us the home had plans in place in the event of an emergency situation.

We reviewed staffing levels at the service. At our last inspection on each night shift there was one waking night staff member and one sleep in staff member. We found the member of staff on sleeping night duty was frequently woken due to the needs of people using the service. This meant they were more likely to be working whilst tired and at risk of making mistakes. At this inspection we found improvements had been made and the registered provider had changed the night staff rota so two waking night staff were on duty.

Most people and three out of four staff we spoke with told us there were enough staff on duty. One staff member felt more staff would enable them to take a person out whose behavioural needs had changed. The registered manager told us each person who used the service was allocated staff according to their assessed needs and we saw this was reflected in their care records and tallied with the number of staff on duty. We observed there were appropriate staffing levels on the days of our inspection which meant people received sufficient support, although one person was unable to go out as they were awaiting a reassessment of their increased support needs in the community.

The registered manager told us she was currently recruiting for three new care staff members as some staff had been moved to another service. The provider had their own bank of staff to cover for absence and asked regular bank staff to do extra shifts in the event of sickness, as well as using occasional agency staff. This meant people were normally supported and cared for by staff who knew them well.

We reviewed the system used to support people with their medicines. Blister packs were used for most medicines at the home, with some dispensed in bottles and boxes. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. We saw a stock check was completed three times a day and signed by two members of staff. Senior staff completed weekly and monthly audits. This demonstrated the home had good medicines governance.

People's medicines, including topical creams, were stored safely in a locked cupboard in each person's room or in the medicines room on the lower floor. Body maps were in place to guide staff where to administer topical creams in the medicines records we sampled.

Staff we spoke with had a good understanding of the medicines they were administering and we saw medicines being administered as prescribed. Medicines care plans contained detailed information about medicines and how the person liked to take them, including care plans for medicines prescribed 'when required', such as pain-killers. Having a 'when required' care plan in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

The registered manager told us all staff at the home completed training in safe administration of medicines every year and we saw certificates to confirm this. We saw staff competence in giving medicines was also assessed regularly. This meant people received their medicines from staff who had the appropriate knowledge and skills.

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. We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and CQC had been notified. This showed the registered manager was aware of her responsibilities in relation to safeguarding people at The Lodge.

Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. We saw information around the building about reporting abuse and whistleblowing.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. For example, the registered manager ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed staff had been properly checked to make sure they were suitable and safe to work with people.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing (PAT). A series of risk assessments were in place relating to health and safety.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they felt confident staff had the skills and knowledge required to support their family members. One said, "My [relative] is on a diet and The Lodge are good at helping [them] stay on it. [They have] done well in keeping to it with help from the staff." Another relative said, "They support [my relative] to hospital and for other appointments. [Another relative] goes along too and gets on well with the staff and thinks they do a good job too."

Staff we spoke with told us they felt appropriately supported by managers and had supervision every three months or so, an annual appraisal, and regular staff meetings.

Regular supervision of staff is essential to ensure people are provided with the highest standard of care. We looked at four staff supervision records and found not all supervision was delivered in line with the registered provider's policy of two monthly. For one staff member there was no record of supervision in 2016 and only an ad hoc supervision around the specific issue of cleaning in March 2017. A second staff member had no supervision in their records between September 2016 and October 2017, with the exception of an ad hoc supervision around the specific issue of food hygiene in December 2016. Neither had an annual appraisal completed. Following our inspection the registered manager sent us a record of supervision for the second staff member from May 2017, which still left a gap of five months. This showed staff were not always receiving regular management supervision to monitor their performance and development needs.

This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us she was aware of gaps in supervision and appraisal for some staff and showed us the supervisions they had planned in October and November 2017. A recent senior staff meeting record showed senior staff had been asked to add supervision dates to the staff rota.

We saw evidence in staff files to show new staff completed an induction programme when they commenced employment at the service. Staff told us they completed e-learning and face to face training and then shadowed a more experienced staff member for up to a month if needed. The shadowing focused on getting to know people's individual needs and preferences. A new staff member told us they had been allocated a learning buddy, who showed them around and provided support. We saw new staff also completed the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. This demonstrated new employees were supported in their role.

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We looked at the training records for four staff members and saw they had completed training in areas such as, infection prevention and control, first aid, food hygiene, autism awareness, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and safeguarding adults. Staff told us and we saw from records they also completed three days of face to face training in preventing and managing behaviour that

challenges, and this was updated annually. Staff told us they were supported to update their training and complete nationally recognised level two and three qualifications in health and social care. The training matrix showed which staff had undertaken training and highlighted training that was due to be refreshed and we saw certificates in staff files to confirm the relevant training had been completed. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

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

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 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. Six people were subject to DoLS authorisations, some of which had conditions attached, and one person had been assessed as having the mental capacity to decide to live at the home.

Staff at the service had completed training and had a good understanding of the MCA. One staff member told us about one person, who had been assessed as having mental capacity to choose to go out alone. They said staff could explain the risks but if they chose to go they could not stop the person, as they understood the risk and could make their own decisions. The service had also requested a mental capacity assessment and best interest discussion with the person's social worker, to ensure the person understood a particular decision related to their visits to a friend's house, and to ensure appropriate decision-making support and information was provided for the person.

It was clear from observations people's autonomy, choices and human rights were promoted. We saw in the care records we sampled mental capacity assessments had been completed for people in relation to the decision to live at the home, the administration of medicines, and the decision to accept personal care. We saw examples of good practice in mental capacity and best interest processes where representatives had been consulted in relation to health interventions, restrictions in a person's diet due to health conditions, and whether to reduce or stop smoking.

Two people's mental capacity assessments stated they lacked capacity to consent to the administration of their medicines by staff, however there was no record of their representative being consulted in their best interests and the assessment was signed by the registered manager only. The registered manager told us this decision had been discussed with people's representative and they would record best interest discussions with the person and their representative to evidence this.

People at The Lodge were supported to have sufficient to eat and drink and to maintain a balanced diet. One person said, "I like the meals that I get here. I get a choice if I don't like something."

A relative said, "My [relative] enjoys the food. [My relative] prefers home cooked food to takeaways. The Lodge does provide for [my relative's] religious needs though."
Staff told us they cooked the main meals and some people who used the service joined in with preparation. Some people were able to help themselves to a drink or a snack, whilst others needed careful monitoring of all dietary in-take due to health conditions.

Meals were planned around the tastes and preferences of people who used the service. Each person had a list of food likes and dislikes in their care records, which was used to inform meal planning. We saw the individual dietary and cultural requirements of people were catered for, for example, one person was living with diabetes and one person required specific food-stuffs to meet the requirements of their faith.

Meals were recorded in people's daily records. This included a record of all food consumed, including where food intake was declined and details of the food eaten, although there were some minor gaps in recording. People were weighed regularly to keep an overview of any changes in their weight and we saw action was taken if there were any changes. This showed the service ensured people's nutritional needs were monitored and action taken if required.

Kitchen refrigerator temperatures were higher than recommended on the two days prior to our inspection and the action taken to reduce these had not proved effective. The registered manager told us she was trialling a system recommended by their estates advisor to use bottled water to check fridge temperatures, however the recorded temperature remained above that recommended, even though in one refrigerator the bottled water had iced up. The registered manager told us she would continue to liaise with their estates team to find an effective system to ensure fridge temperatures were within recommended limits and purchase new equipment if required.

People had access to external health and care professionals as the need arose. On the first day of our inspection one person was supported to attend a hospital appointment and another person was visited by an independent mental capacity advocate. Staff said people attended healthcare appointments and we saw from people's care records a range of health professionals were involved. This had included GPs, psychiatrists, community nurses, chiropodists, dentists, speech and language therapists, and psychologists. People also had an up to date health action plan in their care records and a hospital passport. The aim of a hospital passport is to provide hospital staff with the information they need to know about a person with a learning disability when they are admitted to hospital. This showed people received additional support when required for meeting their care and treatment needs.

The atmosphere of both floors of the home was comfortable and homely. There were pictures and photographs in the communal areas. Maintenance tasks had been completed since the last inspection and further work was planned. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service. Some areas were in need of updating, for example, the kitchen on the upper floor was in need of refurbishment and this had been flagged up with the registered provider on regular maintenance audits to promote the dignity of people using the service. The registered manager told us she hoped this would be replaced in the near future.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "I like it here." Another person said, "The Staff are kind to me. They are taking me to see my [relative] today. They talk nicely to me as well."

One person's relative we spoke with said, "The staff seem caring. They regularly ring, even if there's just a sign of a problem." Another relative said, "I've met almost all of the staff and they all seem nice. They must treat [my relative] well because [my relative's] behaviour has improved so much and that is the first place we see it if [they aren't] happy, or they weren't looking after [my relative] properly." A third relative said, "The staff are very, very nice. They are extremely pleasant. My [relative] loves their room and we have nothing but praise for The Lodge and its staff team."

One person told us they did not like living at the home and wanted their own flat. We saw from records this had been explored with the person in conjunction with community professionals. They also chatted about all the things they enjoyed doing with staff at the service and clearly had a good relationship with the staff, who showed empathy with their situation.

Positive caring relationships were developed through staff understanding people's needs and their personalities. It was clear from our discussion with staff they knew all about the people they supported and enjoyed supporting them. One staff member said, "Yes I like it. I enjoyed going abroad with [name of person]. It was lovely to be able to do that with [person]." Another staff member said, "I love it." And a third staff member said the best thing about the service was, "These guys [who live here]" A fourth staff member said, "Yes I enjoy it. Making residents happy. The residents are all happy. Even [name of person] on a good day. They all like living here. The residents give you a hug."

People told us they had been consulted about the care provided for them and we saw staff asked permission before delivering care. People or their representatives were involved in care planning and reviews where possible and staff used their knowledge of peoples' individual preferences to plan their support.
There was a friendly and homely atmosphere and some people enjoyed banter, chatting, laughing and singing with staff. Staff spoke with people respectfully, as equals and people were included in conversations and discussions.

Staff were respectful of people's privacy; they knocked on people's doors and asked permission to enter. Staff told us they kept people covered during personal care and ensured doors and curtains were closed. People wore clothes and accessories in keeping with their personal style and preferences and staff complemented them on their appearance or clothing to promote self-esteem.

People were supported to make choices and decisions about their daily lives. Staff used speech, gestures, sign language, photographs and facial expressions to support people to make choices according to their communication needs. Information was presented in easy read formats to promote good communication, and care plans contained details of how to recognise when a person was unhappy or happy using non-

verbal cues. One staff member said they showed people food items from the kitchen to support them to choose what they might like to eat.

People's individual rooms were personalised to their taste, for example people had their personal items, photographs, DVDs and games arranged in a way they liked and had chosen their own bedding and wall colour. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

People were encouraged to do things for themselves in their daily life. We saw from records people took part in their laundry and cleaning their own rooms; they also helped to prepare snacks and drinks, and cook main meals on occasion. Care plans detailed what people could do for themselves and where they might need prompting or support. This showed people were encouraged to maintain their independence.

People's diverse needs were catered for and equality was promoted within the service. One person was supported to take part in festivals with their family, as well as enjoying their cultural heritage.

Care plans showed people were supported with their gender and sexuality choices. We saw staff had completed equality and diversity training and staff demonstrated an understanding of people's diverse needs and personal preferences and the difficulties they may face in expressing these. Staff told us they would respect people's diverse needs by ensuring they understood the person through their care plan, talking with them or their families and supporting their cultural and personal life choices. Each of the care records noted if people had a preference for the gender of the care worker who supported them. This demonstrated the service respected people's individual preferences.

Staff were aware of how to access advocacy services for people if the need arose and some people had an independent mental capacity advocate (IMCA). An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People and their representatives had been consulted regarding end of life plans and wishes, where appropriate, and these were recorded if they wished.

Good

Is the service responsive?

Our findings

People told us they were supported to make decisions about their daily life and were consulted on every aspect of their support. One person said, "I like going out for walks, or a drive up to my [relatives']. I also like going out on my bike." Another person said, "I'm going on holiday soon. Blackpool."

The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. We found care plans were person-centred and explained how people liked to be supported. Entries in the care plans we looked at included, "What's important to me", "It is important that I am given time to get ready on a morning as I like to take pride in my appearance and I like to smell nice." This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering their care. We found staff were aware of this information and people were supported according to their preferences.

We looked at four people's care plans. Care plans were very person-centred and contained detailed information covering areas such as evening routine, mobility, living safely and taking risks, hygiene, communication, medication, everyday tasks, decision-making, money, family and relationships, and sleep. They included long term goals the person was working toward, such as 'Use the bus with staff support.' The person whose care plan this was told us, "I had a [health] check today. I came back on the bus. I went with [name of staff]." Care plans contained information in an accessible format with photographs of staff and the person to support involvement.

Care plans also contained detailed information about people's individual behaviour management plans, including details of how staff would care for people when they exhibited behaviours that challenged, and the de-escalation techniques staff should use. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

The manager told us, and we saw from records, reviews were held regularly and care plans were reviewed and updated regularly or when needs changed. These reviews helped monitor whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage. We discussed two minor recording issues regarding nutrition and the consistency of foods which required clarification and the registered manager told us she would clarify this with the professionals involved. The staff we spoke with knew about people's nutritional needs and the consistency of their food.

Daily records were also kept detailing what activities people had undertaken, what food had been eaten, their mood and any incidents.

One person's relative said, "My [relation] goes out most weeks. They take [them] out here, there and everywhere. [They] could probably do with more activities and exercise though as [they're] putting weight on. [They] definitely have more of a social life living at The Lodge and [they're] living with other service users, which has really helped [my relative]. [They go] out for lunch and [they] love to shop." Another relative said,

"My [relative] does woodwork, [they] go out for walks, and on their bike. They (the staff) take [my relative] out for meals sometimes as well."

We saw staff at The Lodge were responsive to people's needs, asking them questions about what they wanted to do and planned future activities. Staff were patient with people, and listened to their responses. This meant that the choices of people who used the service were respected.

Staff spoke with good insight into people's personal interests and we saw from people's support plans they were given opportunities to pursue hobbies and activities of their choice. For example one staff member told us they had a season ticket to support a person to go to football matches and they had helped them to get their own bike from a local charity that recycles bikes for people to use. We heard how people were being assisted to lead fulfilling lives and picked the things they wanted to take part in.

On the first day of our inspection one person was being supported to visit family members; another person was going to an appointment and lunch, a third person was out at day centre, a fourth person was out visiting friends without support, and a fifth person was listening to music in their room and then went for a long walk in line with their recorded preferences.

Two people didn't go out of the home on the first day of our inspection. One person was using table top items in the dining area with staff support and the other person spent time chatting with staff and resting in their room. This person asked to go out and their care plan stated they enjoyed accessing the community. Their activity time table for the day of our inspection said, "Outing/lunch out/picnic." We looked at the person's activity records and found they had not been out of the home in the six days prior to our inspection.

We asked the registered manager about this and she told us the person was awaiting a social work assessment for extra support hours, as their behaviour had deteriorated when out of the house and they now needed two staff or one staff member very familiar and experienced with their needs, to accompany them to maintain safety. This meant the person could not go out that day as the experienced staff member had to stay in the building to support the other two staff members. The registered manager walked with the person to the local garage to buy some sweets after our discussion and told us she would again follow up the re-assessment.
We looked at three other people's activity records and saw they were involved in regular activities inside and outside the home in line with their care plans.

Records showed each person had an individually planned holiday. One person's care plan detailed their goal of going abroad on an aeroplane for the first time and we found this had now been achieved and they had enjoyed their holiday.

One person said, "[My relatives] visit me here." Care plans contained a relationship circle for each person, so staff knew which people were important to them. Staff told us and we saw from records how they enabled people to see their families as often as they desired. This meant staff supported people with their social needs.

The relatives we spoke with told us staff were always approachable and they were able to raise any concerns. One relative said, "The staff answer queries promptly." People's views were sought by the registered manager through meetings and one-to one conversations. We saw there was an easy read complaints procedure in people's care files. Staff we spoke with said if a person wished to make a complaint they would facilitate this. The registered manager showed us there had been no formal complaints since our last inspection. They were clear about their responsibilities to respond to and investigate any concerns

received. Compliments had been received from family members and community professionals and fed back to staff at team meetings

Requires Improvement

Is the service well-led?

Our findings

People told us the service was well-led. One person said, "The manager is [name] and she's nice to me."

A relative said, "There is always a nice atmosphere when I've visited The Lodge. The manager is approachable, in fact, all the staff are. We have no concerns at all." A second relative said, "No, I don't know the manager sorry. My [relative] hasn't been there very long. The three or four staff I have met have all seemed very nice though." A third relative said, "I've not spoken to the manager so I don't know who it is. There has always been a nice atmosphere when I've visited and we are made to feel welcome by the staff. They've had renovations recently and [my relative] likes things like that so [they're] happy."

There was a registered manager in post who had been registered since June 2016. She had been asked by the registered provider to manage two services since July 2017 and now spent two days at the other service and three days a week at The Lodge. As a deputy manager was no longer in post at the second service the registered manager had minimal management support with either service. The registered manager told us she was finding it difficult to complete all the management tasks required for both services. The registered provider had arranged for a temporary deputy manager to provide some management support at the second service the week after our inspection for three days a week.

Each shift at The Lodge was led by a senior support worker, who completed some management tasks such as medicines and financial audits.

Staff told us they felt supported by the registered manager and senior team, who always acted on their concerns. One staff member said, "[The registered manager] is a very good manager. Very approachable." Another staff member said, "She is a good one. She looks after us." Staff told us representatives of the registered provider were also approachable.

At our last inspection in July 2016 we found the registered provider was not meeting the regulation related to good governance because an effective system to improve the quality and safety of the service was not in place, and the home was in a poor state of repair. At this inspection we checked and found improvements had been made, although we found a new breach of the regulation related to staff supervision. This meant an improvement in governance was still required.

The registered provider had introduced a new system across all its services to ensure all management information was kept in one place and was easily accessible. The new system included a walk through audit of the building. We saw audits were maintained in relation to premises and equipment. There was evidence of internal daily, weekly and monthly quality audits and actions identified who was responsible and by which date. Care plans and documents were also reviewed and audited regularly. Daily audits were completed on finances, and medicine stocks were checked three times a day. Building safety and cleaning audits had been improved and we saw action was taken when issues arose.

The registered manager had an overview of audits and regularly recorded checks to ensure action had been

taken if required. There were gaps in some recent weekly and monthly medicines audits and checks on the contents of first aid kits. The registered manager told us this was due to a reduction in management time and said she would address this as soon as possible. Following our inspection the registered manager showed us they had addressed the gaps with staff and ensured audits were completed. This meant they were taking action to improve the service.

The registered provider had recently introduced policy knowledge checks with staff in areas such as medicines, confidentiality, fire safety and safeguarding policy to ensure staff knowledge was up to date. This showed staff compliance with the registered provider's procedures was monitored.

Information was passed to the registered provider in a monthly report in areas including incidents and accidents, safeguarding, training compliance and staff supervision. The locality manager visited the home regularly to provide support and to complete audits and ensure compliance with the provider's policies and procedures.

The registered manager had addressed issues as they arose, such as the recording of fridge temperatures and cleaning up spillages, in ad hoc supervision with staff and at staff meetings. We saw from a medicines audit in September 2017 gaps in recording had been followed up with staff. A monthly kitchen audit was completed however on the second day of our inspection we found there were gaps in the recording of fridge temperatures in the upper floor kitchen for the last five days. The registered manager said they would address this with staff.

The registered manager told us she felt supported by the provider, and was able to contact a senior manager at any time for support. The registered manager worked to an action plan completed in conjunction with the locality manager and we saw action had been completed within the timescales set. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation, although this system had not effectively addressed the issue we found in relation to staff supervision.

The registered manager could demonstrate an in-depth knowledge of the needs and preferences of the people at The Lodge. She said her aim was for people to "Live an independent and normal life and to do what they want to do." The registered manager told us she attended monthly managers' meetings, training and events to keep up to date with good practice, and they were currently completing a level 5 qualification in care management. This meant they were open to new ideas and keen to learn from others to achieve the best possible outcomes for people using the service.

The service worked in partnership with community health professionals and commissioners and we saw they worked together to meet people's needs and drive up the quality of the service. Two compliments had been received from health professionals regarding the detailed care plans and health records kept by the service, although we received feedback from another community professional following our inspection that sufficient information was not available in records for them to complete an accurate assessment for one person.

People who used the service and their representatives were asked for their views about the service and these were acted upon. A house meeting had been held in June 2017 and topics discussed included safeguarding, holidays, food choices, happiness with the service and having a barbeque. Photographs of meals and holidays were used at meetings to support people's choices. Staff told us they struggled to get some people to take part in group discussions and house meetings were infrequent.

People who used the service and their families were also consulted about the service on an individual basis. Questionnaires were no longer sent out to family members every year by the registered provider and the registered manager said it was now the individual home that sent these out and this had not yet been completed, although feedback had been received verbally and by email from relatives in the form of compliments. The registered manager said they would be sending out questionnaires to families in the near future.

Staff meetings had been held on average every three months. Topics discussed included staff training, completing kitchen checks, individual resident's needs, safeguarding, medicines policy, staffing and the rota, and the last Care Quality Commission (CQC) inspection. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people living at the home.

The registered manager understood her responsibilities with respect to the submission of statutory notifications to the CQC. Notifications for all incidents which required submission to CQC had been made.

The previous inspection ratings were displayed at the home and a link to the ratings and last inspection report was available on the registered provider's website. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive regular management supervision to monitor their performance and development needs. Regulation 18 (2) (a)