

## Colourscape Investments Limited

# The Lodge

### Inspection report

The Lodge Residential Care Home  
Heslington  
York  
North Yorkshire  
YO10 5DX

Tel: 01904430781

Date of inspection visit:  
26 January 2016  
02 February 2016

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Inadequate** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

The Lodge is a residential care home in Heslington, a village on the outskirts of York. The home provides personal care and accommodation for up to 30 older people who may also be living with dementia. The Lodge has thirty single bedrooms and communal facilities spread across two floors. There is limited car parking on site.

We inspected this service on 26 January and 2 February 2016. This inspection was unannounced. One of our visits was carried out between 5:30am and 11:30am so we could speak with night staff. At the time of our inspection there were 28 people using this service.

The service was last inspected in June 2014 at which time it was compliant with all the regulations we assessed.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

During this inspection we found that the home was not safe. We identified concerns around the systems in place to ensure that shifts were covered in the event of sicknesses and absences and concerns around unsafe staffing levels at night.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Night staff did not receive training on medication management despite being responsible for administering medication when needed. We identified concerns that tablets were not always stored in their original packaging and this increased the risk of medication errors occurring.

This was a breach of Regulation 12 (2) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had care plans to guide staff on how best to meet their needs. However, we found these were often task orientated and contained limited person centred information. Staffing levels impacted on staff's ability to provide person centred care.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified that records were not always well maintained and the systems in place to monitor the quality and safety of the home were not robust enough.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take in respect of these breaches at the back of the full version of this report.

Risks around fire safety were not effectively assessed and the registered provider did not have a business continuity plan to ensure people's needs would continue to be met in the event of an emergency. There was not a robust system in place to identify and respond to risks following accidents and incidents and this placed people at increased risk of avoidable harm.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had other concerns about how risks were being managed at The Lodge and are carrying out further enquiries in relation to this. We will report on our findings at a later date.

Despite these concerns people we spoke with were generally positive about the home, staff and the management of the service.

Staff had training and supervision to support them in their role. Staff sought consent before providing care and support and there were systems in place to assess people's capacity to make decisions.

People were supported to eat and drink enough and access healthcare services where necessary.

People were generally positive about the kind and caring nature of staff. We observed that staff supported people to make decisions and respected people's privacy and dignity.

People were not supported to go on outings or trips outside the home and improvements were needed in the support provided throughout the day to ensure people were meaningfully occupied. We have made a recommendation about this in the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

Risks were not always effectively managed and this impacted on the safety of people using the service.

Staffing levels were not always safe and the systems in place to cover short-term sickness and absences needed to be improved.

Not all staff had the training needed to ensure they could administer medication safely and medications were not always stored in their original packaging increasing the risk of medication errors.

**Inadequate** ●

### Is the service effective?

The service was effective.

Training was provided to equip staff with the skills and experience need to carry out their roles. We have addressed our concerns regarding medication training in the Safe domain.

People were supported to make decisions and staff considered people's mental capacity to make decisions when providing care and support.

People were supported to eat and drink enough and to have access to healthcare professionals where needed.

**Good** ●

### Is the service caring?

The service was caring.

We received generally positive feedback about the caring nature of staff.

We observed a number positive caring interactions and saw that people using the service were encouraged to be involved in decisions and supported to express their wishes and views.

We observed that people using the service were treated with respect and staff knew the importance of maintaining people's

**Good** ●

privacy and dignity.

### **Is the service responsive?**

The service was not always responsive.

People's needs were assessed and care plans put in place to support staff to meet those needs. However, person centred information was not always recorded and used effectively.

People we spoke with commented about the limited range of activities available. People were not supported to go on trips or outings and improvements were needed to ensure people were able to engage in meaningful activities.

People felt able to make comments or raise concerns.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

People told us that the service was well-led and we received positive feedback about the management of the home.

We found that records were not always well maintained.

Concerns, for example, around staffing levels at night had not been addressed.

**Requires Improvement** ●

# 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. The inspection was planned to check whether the registered 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 26 January and 2 February 2016 and was unannounced. One of our visits was carried out between 5:30am and 11:30am so we could speak with night staff.

On the first day, the inspection team was made up of one Adult Social Care (ASC) Inspector and an Expert by Experience (ExE). An ExE is someone who has personal experience of using or caring for someone who uses this type of service. The ExE who supported with this inspection had experience of supporting older people with dementia. On the second day, the inspection team was made up of one ASC Inspector.

Before the inspection we did not ask the registered provider 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. We looked at information we held about the service, which included information shared via the Care Quality Commission's public website and notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also met and shared information with City of York Council's safeguarding and commissioning teams.

Before this inspection we had concerns about low staffing levels and a high number of accidents and incidents within the home. We used this information to plan our inspection and we have recorded our findings in the body of this report.

As part of this inspection we spoke with 11 people who used the service and six visitors who were relatives or friends of people living at The Lodge. We spoke with the registered manager, the deputy manager, seven staff, the chef, the activities coordinator and the handyperson. We also spoke with a visiting healthcare professional.

We looked at four care files, three staff recruitment and training files and a selection of records used to monitor the quality of the service. We observed interactions between staff and people using the service; this included observations of planned activities and lunch being served. We also observed a staff handover meeting.

# Is the service safe?

## Our findings

People using the service told us they felt safe living at The Lodge and with the care and support provided. Comments included "No one's ever hurt me here" and "I have never not felt safe here." A visitor said "[Name] is basically safe here. There are one or two residents, who rile them, but overall they're protected here, you can't follow them round all the time."

Before our inspection we received concerns about staffing levels within the home. The registered manager used a dependency tool to determine staffing levels and from this, we saw that four care staff were scheduled to be on duty during the day and two care staff on duty at night.

During the inspection people told us "I suppose they could do with more staff, but I get everything I want" and "Staffing can be a bit of an issue. Yesterday for example they were pushed a bit. They were one carer down I think." We reviewed rotas for the three week period before our visit and found that on a number of occasions the registered manager or deputy manager had covered shifts to maintain staffing levels. We also noted a small number of occasions where shifts had not been covered. Staff we spoke with said "They do everything they can to cover shifts, but they run out of staff to call" and told us it was not uncommon for shifts not to be covered when staff rang in sick. Staff explained that this impacted on the time available to spend with people using the service, with comments including "There's not really time to sit and talk to people, because we're short staffed", "We're not giving people our full attention; I can't split myself in two" and "I don't think it's fair, some people want you, but you can only be in one place at a time, it's as if we're ignoring them. I feel I am ignoring them." The registered manager told us that they did not use agency staff, but tried to ring other members of staff or bank staff to cover shifts. We were concerned that this system needed to be developed to ensure all shifts were covered and reduce the reliance on management staff to cover carer's shifts.

We reviewed staffing levels at night. Staff we spoke with said "On nights there's only two people in the whole building, which is quite unsafe", "I think night shifts are unsafe" and "At night there's two people and that's hard with all these residents, buzzers keep going off and you don't know which one to go to... a lot of people are unsettled through the night." The registered manager told us that they had reviewed records relating to the care and support provided on the night shift and found these indicated that people using the service were mostly settled during the night. However, we were concerned that five out of seven staff that we spoke with raised concerns about it being "Absolutely hectic" or "Quite manic with buzzers going off left right and centre" during periods of the night shift.

We visited during the night shift and saw that there were only two staff on duty and rotas confirmed that this was routinely the case. Staff told us that four or five people using the service required assistance from two people with personal care and that a significant number could be unsettled at night and require supervision when mobilising due to a high risk of falls. Care plans we reviewed confirmed that there were people using the service who were at risk of falls and had unsettled or disturbed sleep patterns.

We saw that people at high risk of falls had pressure mats in place, which triggered an alert if they tried to



get out of bed. We observed that if a person using the service required assistance from two staff, there was no one to supervise people in communal areas or to respond to these alerts if someone at high risk of falls tried to get out of bed. We noted that there had been a number of recent falls at night, including one person who had an unobserved fall in a restricted area of the home despite their care plan documenting that staff needed 'To be aware of [Name's] whereabouts in the home'. We were concerned that the person using the service should not have been able to gain access to this area of the home as the registered manager told us this door should have been locked. This showed us that staff were not providing the level of support identified as necessary to keep people safe. Staff we spoke with told us it was not always possible to provide the level of supervision required to keep people safe at night with only two people on shift.

We observed that rooms were spread across two floors and there were a number of interconnecting corridors and blind spots. This meant that it was difficult to observe what was happening in different parts of the home. In addition staff told us "You cannot always hear the buzzer. If you're in a bedroom you might not hear it going off." We observed that night staff repeatedly had to return to the lounge/dining room to check whether there were any alerts, but could not do this if they were providing personal care to someone who required assistance from two staff.

The registered manager told us that they were aware of the concerns about staffing levels at night. However, told us that they did not work night shifts and had not done any visits to the home during the night to explore the concerns raised or assess the level of risk. The registered manager told us they were recruiting new staff to enable them to rota three staff on each night shift. We asked about interim arrangements whilst new staff were recruited, the registered manager told us "To be safe we need to be looking at agency staff."

We concluded that the systems in place to cover short-term sickness and absences were not always effective. We concluded that staffing levels had not been properly risk assessed and staffing levels at night were not safe because of the size and layout of the building and the range of needs of the people living at the home.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the registered manager told us that three staff had been scheduled to work each night shift in response to these concerns.

We reviewed four people's care plans and saw that their needs were assessed, risks identified and risk assessments put in place to guide staff on how to manage and minimise risks. Risk assessments were in place to manage the risks associated with moving and handling, falls, maintaining skin integrity and managing challenging behaviours. Although we saw some examples of good proportionate risk assessments, we found that risk were not always effectively managed and identified specific concerns about the management of the risks around falls.

We found an example where one person using the service had an unobserved fall despite a significant history of falls and their care plan and risk assessment recording that staff needed to be aware of the person's whereabouts and provide supervision and support when walking. This showed us that staff were not consistently providing the level of support identified as necessary to keep people safe.

We reviewed records of accidents and incidents and saw that these contained details about what had happened and the immediate action taken. However, we found that there was limited evidence of effective risk management following an accident or incident to minimise risks and prevent similar occurrences. For

example, one person using the service had fallen three times in June 2015, but their falls risk assessment not updated until the end of July 2015. It is important to review and update risks assessments to alert staff to an increased risk and to ensure that the risks are being effectively managed. Other accident and incident forms did not record what action had been taken following a fall to reduce or manage the increased risk. We were concerned that opportunities to reduce risks were being missed.

We reviewed collated information about falls and saw that there had been eight falls in October 2015, seven in November 2015, seven in December 2015 and 10 in January 2016. Although a falls action plan had been implemented following four recent falls, we were concerned that more robust and proactive action had not been taken sooner.

We also identified that there was no formal policies in place to guide staff about what observations were needed following an accident or incident. Following one fall, a person was put back to bed and not checked again until the beginning of the day shift. This was over an hour later, at which time, the person was found to be in pain and in need of medical attention. We were concerned about the unnecessary delay in this person receiving appropriate medical attention.

We noted that a number of boxes of storeroom material, a Hoover and a mop and bucket had been left in communal corridors partially obstructing walkways. We spoke with the registered manager about appropriately storing these items and maintaining free walkways to reduce trip hazards.

We reviewed how other risks were managed. The registered manager told us they did not have Personal Emergency Evacuation Plans (PEEPs) for people using the service. PEEPs are used to document individual evacuation plans for people who may require support to leave the premises in the event of a fire. Although PEEPs are not a mandatory requirement, it is necessary that registered managers assess people's needs and consider associated risks in relation to fire safety. We saw that the registered manager had completed a fire risk assessment; however, this was last updated on 28/05/2013. The registered manager told us they would address this and it would be updated annually in future.

We also noted that the registered provider did not have a documented business continuity plan detailing how they would continue to meet people's needs in the event that an emergency, such as a power cut, flooding or a fire. The registered manager acknowledged the need to consider contingency planning for circumstances such as these.

We concluded that the risks were not always thoroughly assessed and effectively managed including risks in relation to fire safety, with regards to business continuity and the risks associated with falling and this placed people using the service at risk of otherwise avoidable harm.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are carrying out further enquiries in relation to these and other concerns around risk management and this will be reported on at a later date.

Where necessary, staff supported people using the service to take their prescribed medication and the level of support required was documented in their care plan. We observed medication being administered in line with guidance on best practice. Medications were securely stored in a locked treatment room, which was clean, tidy and well organised. A daily record was kept of the treatment room and fridge temperatures and although there were minor gaps in these records, they showed that medication was stored within safe limits.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were securely stored and records showed these were checked and recorded when given.

Medications were supplied in blister packs along with printed Medication Administration Records (MARs). Blister packs are a monitored dosage system containing a 28 day supply of that person's medicines. MARs are used to document medication given to people who used the service. MARs we checked were filled in correctly and there were no gaps in recording. We noted that where new medication had been prescribed, staff did not always countersign handwritten records and we discussed the importance of this in reducing the risk of transcribing errors. We checked the level of medication in stock against records held by the home and found that these were accurate.

We found six loose tablets had been put in a bag labelled 'Paracetamol' in a box with a person's medication. Removing medication from its original packaging is called secondary dispensing and can lead to accidental mix-ups and errors. There was no information on this bag about whose tablets these were, the dose or any instructions about when they should be administered.

The registered provider had a medication administration policy and staff received training on how to safely administer medication. However, training records showed and the registered manager confirmed that night staff did not receive medication administration training. Although no routine medications were administered during the night shift, some medication was prescribed to be taken when needed, this included medication for pain as well as restlessness and agitation. Night staff told us that they administered this medication when needed despite not having had formal training to do this. This was poor practice and could put people using the service at risk of harm.

This was a breach of Regulation 12 (2) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment and the maintenance of the home environment. These records showed us that agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. There were current maintenance certificates for the fire alarm system, the electrical installation, portable appliances and gas installations. Environmental and visual inspections were carried out each month.

Staff completed safeguarding vulnerable adults training and the registered provider had an up-to-date safeguarding policy in place to guide staff in identifying and responding to signs of abuse. Staff we spoke with showed a good understanding of the types of abuse they might see, the signs and symptoms that might indicate someone was being abused and appropriately described what action they would take if they had concerns. Comments included "We go to [the registered manager] if there's a problem or the Care Quality Commission if needed, there's a whistleblowing helpline." Records showed that safeguarding concerns were referred to the local authority and notifications sent to the Care Quality Commission. This showed us that there were systems in place to manage and respond to safeguarding concerns.

Staff we spoke with told us they had an interview, submitted references and had to complete a DBS check before starting work at The Lodge. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We reviewed three staff files and confirmed that these systems were in place to ensure that only people considered suitable to work with

vulnerable adults were employed.

We observed the home to be generally clean, tidy and odour free. We saw that the service employed domestic staff and had a system in place to clean and deep clean the home. A visitor told us "It's always clean and tidy." However, we spoke with the registered manager about managing the risk of cross contamination with regards to care staff using the kitchen.

## Is the service effective?

### Our findings

We looked at the registered provider's induction and training programme. We saw that all new staff completed one week's induction training to equip them with the skills and knowledge to carry out their roles. Staff we spoke with told us that induction training included moving and handling, health and safety, food hygiene, infection prevention and control, first aid and safeguarding adults. In addition to completing induction training staff told us they had to shadow more experienced workers, commenting "I had a few, two or three shadow shifts until I felt 100% comfortable on my own." We saw that where staff were shadowing, this was recorded on the rota. Training records showed that new staff had one to one meetings with the registered manager to discuss their progress as part of their probationary period.

In addition to induction training, staff were required to complete refresher training on topics the registered provider considered to be mandatory. These included safeguarding of vulnerable adults, moving and handling, food hygiene and infection control. We reviewed individual training records and saw that these contained certificates of courses completed. The registered manager showed us a training matrix they used to keep track of training staff had completed and to identify where training needed to be updated. Although we noted some gaps in staff training, for example four staff had not completed safeguarding vulnerable adults training and three staff needed to complete emergency first aid training, the training matrix showed that staff received on-going training throughout the year.

Staff files we looked at showed that staff had regular supervision meetings to discuss their personal development and any support needs. Staff we spoke with were positive about the support provided to them in their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and DoLS. We saw that potential deprivations of liberty were appropriately identified and requests for authorisations submitted on the appropriately completed documentation. The registered manager showed us a list they kept of when requests to authorise a deprivation of liberty were submitted, when an assessment had been completed, any conditions on the DoLS and the date it expired. This enabled the registered manager to review DoLS and request further authorisation where necessary.

People using the service had signed to show that they consented to the care and support provided and

consented to having their photograph taken. Care plans demonstrated that staff had considered people's ability to make informed decisions when seeking consent. Care plans contained mental capacity assessments and best interest decisions. Mental capacity assessments are used to assess people's ability to make a particular decision and are governed by the MCA. Best Interest Decisions are decisions made on a person's behalf when they have been assessed as lacking mental capacity. However, mental capacity assessments did not consistently record the decisions for which staff were assessing someone's capacity and best interest decisions did not record the specific decision made when the person had been assessed as lacking capacity. We spoke with the registered manager about improving the way decisions were recorded.

Despite this, staff we spoke with understood the basic principles of the MCA. Staff explained the importance of seeking consent and described how they supported people to make decisions by, for example, using picture cards and non-verbal communication. One member of staff told us "We offer choices and show options. We try and give people as much choice as we can." Another member of staff said "We promote independence and decision making; we have to let people make unwise decisions."

The registered manager told us that one person who used the service had an Independent Mental Capacity Advocate (IMCA) who visited them on a regular basis. An IMCA is someone who supports a person so that their views are heard and their rights are upheld. IMCA's are independent: they are not connected to the carers or services that are involved in supporting the person. The registered manager also had contact details of general advocacy services to ensure that people, particularly those who are most vulnerable in society, had access to support to ensure that their voice was heard on issues that were important to them. We spoke with the registered manager about ensuring this and other information about advocacy services were made more prominently available to people using the service.

People using the service received appropriate support to ensure they ate and drank enough. Care plans contained information about people's specific nutritional needs as well as details about the foods they liked and disliked. Where concerns were identified about the amount people ate or drank, food and fluid charts were used to record this. These showed that people were being supported and encouraged to eat and drink regularly. However, we spoke with the registered manager about maintaining a running total or adding up people's total fluid intake for a 24 hour period to ensure that concerns would be identified if someone was not drinking enough.

People we spoke with said "The food's good", whilst visitors told us "The food is good here, but they give them too much of it" and "[Name] likes the food."

We observed lunch being served in the dining room. We saw 20 people had lunch here with other people choosing instead to eat in their rooms. We observed that there were good staffing levels in the dining room during lunch time and staff were attentive and caring in the support they provided.

We noted that staff used coloured photos of each course or showed people alternative meal choices to assist them to choose what to eat. We spoke with the chef who told us that all meals were freshly cooked or otherwise prepared on the premises. The chef showed a good understanding of people's specific nutritional needs including food allergies, diabetic diets, fortified diets and people who required soft or pureed meals due to swallowing difficulties. The chef told us "We make enough food for everyone, but leave residents choice about meals to the last minute, because they can change their minds so easily. It's silly for us to ask them earlier. That way I can also always ensure they get the meal they then want and that it's hot rather than cold when it gets to them. That's important for the residents." We asked staff what happened if a resident didn't like the food choices, a member of staff responded "There's always something else for them to eat like sandwiches, soup or crisps."

We observed that the food served looked and smelt appetising and menus and food charts showed that people were supported to eat a wide range of nutritious meals. Staff offered people drinks and snacks throughout our inspection to ensure that they ate and drank enough. People were weighed regularly and a Malnutrition Screening Tool (MUST) was used to record and identify risks around nutritional intake.

Care plans contained information about people's medical history, current health needs and contact details of healthcare professionals involved in supporting them. People using the service and visitors we spoke with told us that staff provided support to access the doctors, dentist, opticians and chiropodists when needed. We observed staff during our inspection making phone calls to the district nursing team and people's G.P's to arrange for them to visit and records in care plans showed evidence that people were supported to or seen by a wide range of healthcare professionals. A visitor we spoke with commented "The doctor arrangements are okay. They take [Name] to the dentist and their hair is done regularly."

We observed that some steps had been taken to maintain a dementia friendly environment. We were shown a room that had been converted into a Café. We were told "We've done it up as a nice place for residents to bring their relatives and have a cup of coffee." Other areas of the home had been decorated with memorabilia or scenes to prompt reminiscence. We saw some people's rooms had people's names on or decorative wall boxes next to their doors displaying personally relevant items such as photos to help people identify their rooms.

However, we noted that there was limited dementia friendly signage to support people using the service to find their way around the home. We observed a number of occasions where people appeared disorientated or asked staff "Do you know where the toilet is?" despite the toilet being close by and "Where's the living room?" We discussed this with the registered manager and noted that on our second unannounced visit they had printed temporary picture signs to go on the bathroom and toilet doors as well as doors into the living and dining area. The registered manager told us they had ordered permanent dementia friendly signage.



## Is the service caring?

### Our findings

People using the service told us that staff were kind and caring with comments including "The staff are very friendly. If you want something all you've got to do is ask" and "I'm looked after." Although one person we spoke with said "Some of the staff are nice, but some of them are horrible." The person we spoke with did not provide further details and did not want us to look into this; we did not receive any other negative feedback from people using the service about the staff supporting them.

Visitors we spoke with said "[Name] loves the staff" and "[Name] is well looked after here. It takes some of my worries away. It's not perfect, but nowhere is. They work admirably with residents in some very difficult circumstances. But they do it in a very kindly way." Other visitors said "The staff seem very friendly and nothings too much trouble", "This home is a fair, happy place and [Name] is well treated" and "The staff don't do this job to fill in the hours. They do it because they care. We've seen other homes and they're okay, but they're nothing like this. It's a very nice place."

Staff we spoke with said "We look after residents as we would look after our own mothers or grandmothers" and "Everyone has a caring attitude." Other staff told us "The majority of staff do care, the odd ones don't, they are not abusive, but you can see who has got it, they mingle with the residents and do things with them" and "There is a lot of very good staff who genuinely care. Some of the other people, it's just a job."

During our inspection we observed some very positive interactions between staff and people using the service. For example, on the day of our inspection it was a person's birthday. We observed that staff brought cards and presents to this person's table at lunchtime and they were supported to open them. The chef had baked this person a cake and brought it out and the staff gathered round to sing 'happy birthday', this was clearly a positive experience for this person and they responded well to the kindness shown by staff. However, we also noted that staff appeared very busy at times and this meant they were engaged in practical tasks associated with supporting people using the service.

We asked staff how they got to know people using the service, they told us "I read the care plans to get to know people and talk to families. The care plans are useful; they have information in them like what they used to do when they were younger." Other staff told us "I get to know people by talking to them."

We noted that care plans contained basic information about people's wishes and views. We observed staff supported people wherever possible to make decisions and actively encouraged them to express their wishes and views. We visited the service early in the morning and saw that people were supported to get up when they wanted. We observed that at lunchtime, the staff were proactive in supporting and encouraging people to make decisions and used picture cards or showed them options available to help decide. We asked staff how they supported and encourage people to express their views, they told us "I talk to them and ask them questions."

People we spoke with did not raise concerns about the support provided to maintain their privacy and dignity. We observed that people using the service were dressed according to their own preferences. We saw



that people took pride in their appearance and staff provided support with this where necessary.

We asked staff how they maintained people's privacy and dignity, comments included "I give them respect, I ask don't just do" and "We have to respect people's choices." We observed that the care and support provided in communal areas was appropriate and maintained people's dignity. Personal care was provided in people's rooms with the doors shut and we saw staff knocking on doors before entering, this maintained people's privacy and showed that staff treated people using the service with respect.

## Is the service responsive?

### Our findings

Staff assessed people's support needs and these formed the basis of their care plan. Care plans provided guidance to staff on how best to meet assessed needs. We saw that care plans contained some examples of good person centred information including information about people's family history, important relationships as well as likes, dislikes and personal preferences. These records showed us that people using the service and their relatives or carers had been involved in care planning. However, we found other examples where care plans contained less detailed or brief information and were more task orientated; describing what support was required, but limited information about people's individual preferences in relation to those support needs.

We saw that care plans and risk assessments were generally reviewed and updated regularly, but also identified concerns that risk assessments had not always been updated particularly following accidents and incidents. This meant relevant information was not always available to staff providing care and support. We also found examples where assessments had been completed to gather information about people's likes/dislikes and personal preferences, but that this information had not been transferred into the relevant care plans and therefore would likely be missed by staff providing the person's care and support.

We found other examples where poor recording could have impacted on the care and support provided. We found one person's care plan contained an exercise programme from the physiotherapy team. This had been provided following a recent discharge from hospital to support that person to improve their mobility. We reviewed their care plan and records, these did not evidence that staff had been supporting or encouraging this person with their exercises. The registered manager was unsure whether staff had been assisting this person. This was not person centred care.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us "I tried to read the care plans, but I don't get time to sit and read them", whilst others raised concerns about not having time to sit and talk to people using the service. We found that some of the staff we spoke with were knowledgeable about the needs of the people they were supporting; however, others were only able to provide very basic information about that person's likes, dislikes and personal preferences.

The registered provider employed an activities coordinator and had a 'resource cupboard' with supplies from which to organise and run activity sessions. We saw that an activities rota was available although this had not been updated for the coming week and showed the previous weeks' schedule. This included karaoke, a choir group, pamper day, bingo and a worship session on Sunday. We spoke with the activities coordinator who told us the home also had a chair exercise class and they supported with board games, drawing and a knitting club.

On the day of our inspection, we observed people being supported to play board games and a choir session.

We spoke with one person about the choir session who said "We've only started doing this in recent months. We love it." However, outside of these activities we observed residents sitting for long periods in the morning and afternoon with little to do. We observed that staff spent long periods of the day engaged in practical tasks and staff we spoke with said "It is a busy job, lots of tasks that need doing... I thought carers would have more time to spend with people, they [people using the service] end up sitting around a lot watching TV."

We saw that for the last 'Service User and Residents Questionnaire' completed in July 2015 people had commented "There isn't enough to do. I would like to go on walking meetings", "More outdoor [activities]. Anything outdoors" and "Maybe there could be a few more outings." The activities coordinator told us the home did not organise trips out. The registered manager said that they looked at trips out of the home when the weather was better and told us that they were working to improve the activities on offer and explained that this is why they had hired an activities coordinator.

We asked people using the service about the activities within the home; one person told us "It's nice here. I can join with my friends and do things I like doing." However, another person we spoke with told us "There's not enough to do." Visitors we spoke with said "Probably my only issue with the home is that there are not enough activities as in other homes. There, they go on trips out to the university, organised dancing and things, even though [Name] wouldn't be able to join in much if they did that here." Another visitor told us "The staff always seem busy. I wish they could sit and chat to people more than they do. There's nothing to occupy them. There's not even a lot of casual conversation going on. But this is a very mild criticism."

We observed that friends and relatives visited the home throughout our inspection and staff and the registered manager were warm and welcoming towards them. Visitors told us they were made to feel welcome, with one person commenting "I've got a standing invite to stay for lunch and tea. There's no payment involved. I don't abuse it though, just occasionally stay and eat with [Name]." This showed us that the service was supporting and encouraging people to maintain contact with friends and family. However, we noted that the home had extremely limited parking available and there was no local permit free parking available. Whilst we recognise that this was outside of the registered provider's control, we felt that the limited parking made visiting more difficult.

The registered provider had a complaints policy and procedure in place and we spoke with them about making this information visible and accessible to ensure people living at the home and visitors had information about how to raise concerns if needed. Records showed that there had been no written complaints about the service since our last inspection. The registered manager said that minor issues were resolved immediately and not recorded. The registered manager told us that they tried to be open and approachable and actively encouraged people to raise any issues or concerns. We observed that the registered manager was a visible presence within the home and people we spoke with confirmed that this was the case, with comments including "[The registered manager] is so approachable and if you ask for something it's there" and "The staff are good. Problems here are talked about openly and ways around them tried by the staff... I come at different times of the day and night and staff are always the same." The registered manager also showed us that they had recently installed a suggestion box, recognising that people may not feel comfortable raising complaints or concerns directly.

The registered manager told us they completed an annual 'Service User and Residents Questionnaire' canvassing opinions and seeking feedback. This was last completed in July 2015 and contained responses from 12 people using the service and 18 visitors. We saw the information had been collated, the feedback summarised and information provided about how any issues raised would be addressed. This information was presented in a letter to communicate the outcome to people using the service, family and friends.

We saw that the feedback was extremely positive. With 100% satisfaction reported with the support and encouragement provided to make decisions, the helpfulness and courtesy of staff, the care received, the safety and security of the home and the food choices. Comments recorded here included "I am very happy to live here", "They help me lots to find my way and they talk to me a lot" and "Everything is very good and I feel very safe here." The visitor feedback was similarly complimentary with above 90% satisfaction with the way people were looked after, the welcome they received, assistance given during visits and management/staff communication with them.

We recommend that the registered manager continues to develop the support provided to enable people to engage in meaningful activities of their choosing.

# Is the service well-led?

## Our findings

The registered provider is required to have a registered manager as a condition of registration. There was a registered manager in post on the day of our inspection and as such the registered provider was meeting the conditions of registration. The registered manager was supported by a deputy manager and senior care staff.

During this inspection, and documented in this report, we identified a number of concerns relating to the safety of the care and support provided at The Lodge. Alongside this we identified concerns about some of the records kept by staff and concerns about the lack of a sufficiently robust and timely management response to concerns, particularly around falls.

We asked for a variety of records and documents during our inspection. We found these were stored securely and available on request. However, we found that records were not always well maintained. For example where people using the service had a pressure mat, used to alert staff when a person got out of bed, records were in place to record what time the mat was turned on, what times the alerts went off and when the pressure mat was switched off. We found that these records were not always completed and we found multiple examples where there were gaps in these records. This meant we could not be certain that pressure mats were being used consistently and appropriately to manage the risk of falls.

On the first day of our inspection we observed a healthcare professional giving advice and guidance to two staff on how best to support a person using the service. We saw that staff did not take any notes. On the second day of our inspection we reviewed the person's file and found only brief reference to the healthcare professionals visit and no details recorded about the advice and guidance given. This was evidence of poor recording and could have impacted on the care and support provided to maintain this person's mobility.

We saw that daily records of the care and support provided to each person using the service consistently did not document the specific time the entry was written or the time that the care and support had been provided; instead daily records documented the shift time, for example, 7am-3pm. This was not good record keeping as it made it difficult to get a clear picture of what support was provided at what times and it did not provide an accurate chronology of events.

We could see that the registered manager completed numerous monthly audits of care plans, medication administration records, infection control within the home and audits of the kitchen and home environment. However, these did not always effectively evidence what was found or the remedial action taken. For example, a full care plan audit recorded that no concerns were identified and no remedial action was needed. The registered manager subsequently told us where issues had been identified notes were put in the front of care plans of what action was needed. This was not an effective system as there was no central record of action required making it more difficult to monitor and sign off once actions had been completed. Audits of records had not identified and addressed the issues with recording that we identified.

Although there were a range of management systems in place, our findings during the inspection

demonstrated that these systems were not always effective in addressing the safety concerns we identified in relation to staffing levels, management of medication and the lack of an appropriate and timely management response to concerns around the high number of falls.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns people using the service told us "[The registered manager] is such a nice person. Very popular" and "There's nothing not to like here. I'm happy." Visitors told us "This is such a good home" and "This home is good. The staff are happy, and that tells you a lot about a place...There's nothing I can really fault. I could recommend this home." Other visitors said "I met [the registered manager] the first time I visited and they've always been the same since – a caring person, approachable, available and wants to get it right for [Name]."

We asked staff if they thought the home was well-led, comments included "[The registered manager] is a fantastic manager, I've felt really welcome here", "[The registered manager] deals with problems" and "If I have any concerns I know I can go to my seniors, they are brilliant, it's nice to be listened to and I like the reassurance."

We found that there was an informal and friendly atmosphere within the service. Staff we spoke with said "Everyone is lovely and the residents all seem happy" and "It's such a friendly place to work and that comes from the top – it's a lively environment." The registered manager told us "We strive to make people's lives happy." We could see that the registered manager was a visible presence within the home and that they had a good working relationship with people using the service, staff and visitors.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

Staff we spoke with told us "We had a team meeting last week, the one before that was last summer, seniors have meetings." Records showed that the registered manager held senior staff meetings in June and August 2015 and we were shown an agenda for a staff meeting held in January 2015. Senior staff meetings were used to discuss care plans, care reviews, audits and updates within the home.

We asked the registered manager how they kept up-to-date with changes in legislation and guidance on best practice. They told us they were an active member of the Independent Care Group (ICG), an organisation that supports and represents care providers in North Yorkshire. The registered manager told us they received updates from the ICG and could also contact them for further advice and guidance. The registered provider also had an in-house trainer who provided training to update staff's and the registered manager's knowledge.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People who use services did not always receive person centred care which was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1).</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered manager did not ensure the safe management of medication. Regulation 12 (2) (c) (g).</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered manager did not establish and operate systems or processes to effectively: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated. Regulation 17 (2) (a).</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The registered manager did not ensure that sufficient numbers staff were deployed. Regulation 18 (1).</p>

