Carlisle Lodge Limited

Carlisle 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

We inspected Carlisle Lodge on 15 February 2018 and our visit was unannounced. Carlisle Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Carlisle Lodge provides nursing and personal care and accommodates up to 19 people in one adapted building. At the time of the inspection there were 15 people living at the service. People were living with a range of complex health care needs and some people had a degree of memory loss associated with their age and physical health conditions. Most people required help and support from two members of staff in relation to their mobility and personal care needs. Accommodation was provided over four floors with a passenger lift that provided level access to all parts of the service.

There was a registered manager at the home. 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.' The registered manager was also the provider of the service.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLs) which applies to care homes. Robust systems were not in place to identify if people were unlawfully deprived of their liberty. Improvements were also needed to ensure the service was also consistently meeting the requirements of the Mental Capacity Act 2005. The system to ensure registered nurses held registration with the Nursing and Midwifery Council was not robust. Quality assurance systems were in place but these had not identified some areas that needed to be improved. We made a recommendation about this.

There was a calm and relaxed atmosphere in the service throughout the day of the inspection visit. We observed people had an excellent relationship with staff and staff interacted with people in a caring and respectful manner. The visions and values of the service were embedded into practice and both staff and people described the key strength of the service as its homely atmosphere.

Staff knew people really well. They had a good understanding of each person's needs and choices. They could tell us about people's personal histories including their spiritual and cultural wishes. Each person was treated as an individual and their choices were respected and upheld. Safeguarding procedures were in place and staff had a good understanding of how to identify and act on any allegations of abuse.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. People spoke highly of the food provided and the registered manager recognised the importance of meals as a highlight of people's days. Health care was accessible for people and appointments were made for regular check-ups as needed.

There were enough staff available to ensure people received continuous, attentive and discreet care and

support. Staff had time they needed to respond to people's choices as well as meeting their care and support needs in a way that suited the person. Staff had received the training they needed to support people and deliver care in a way that responded to people's changing needs.

There was an open and friendly culture at the service. The registered manager was well thought of by people, relatives and staff. She worked hard to include people and staff in decisions about the service, and was committed to improving and developing the service. Recruitment checks were carried out to ensure suitable staff were employed to work at the service. Staff were supported by a system of induction, supervision and appraisal.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people in their rooms, bingo, exercise, quizzes and reminiscence sessions. People were also encouraged to stay in touch with their families and receive visitors. Technology such as the use of Ipads was utilised to help people maintain relationships with their loved ones.

The premises were well maintained and equipment had been checked regularly to ensure it was suitable and safe. The provider ensured that the risk of infection in the service was assessed and managed. People received their medicines when they needed them and medicines were being stored and managed safely.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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

Carlisle Lodge was safe. People were protected from the risks of harm, abuse or discrimination.

Systems were in place to ensure there were enough staff, who had been safely recruited, to meet people's needs.

Risk assessments were in place and helped to keep people safe. There were systems in place to ensure medicines were ordered, stored administered and disposed of safely.

Is the service effective?

Requires Improvement

Carlisle lodge was not consistently effective.

The Mental Capacity Act 2005 was not consistently being followed and consideration had not been given as to whether people were deprived of their liberty.

People were cared for by staff who were well trained and supported. People were supported to eat and drink enough to maintain a balanced diet.

The service worked well with others to deliver effective care and support. People experienced positive outcomes regarding their healthcare needs. The service involved people in decisions about their environment.

Is the service caring?

Good

Carlisle Lodge was caring.

Staff knew people well and treated them with kindness, understanding and patience.

People were supported to make their own decisions and choices throughout the day. Staff were respectful at all times and had a kind, friendly approach.

Visiting was not restricted and people were supported to maintain relationships with people that mattered to them.

Is the service responsive?

Good

Carlisle Lodge was responsive.

People received care that was person centred and met their individual needs. Staff had a good understanding of providing person-centred care. They knew and understood people as individuals.

There was a range of activities taking place and people told us they had enough to do throughout the day.

There was a complaints policy in place and people and visitors told us they would raise any concerns with staff.

Is the service well-led?

Requires Improvement

Carlisle Lodge was not consistently well-led.

Quality assurance systems were in place, but these had not identified some areas that needed to be improved in relation to nurses NMC pin and other areas of care.

There was a positive culture at the service. People and visitors spoke highly of the staff team and their life at the service. The registered manager worked hard to improve and develop the service.

The provider promoted an inclusive and open culture and recognised the importance of effective communication.

Carlisle 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 15 February 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the service. These included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at six care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' people living at the service. This is when we looked at their care documentation in depth and obtained views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with nine people who lived at the service, two visiting relatives, the registered manager (who was also the provider), cook, activity coordinator, registered nurse and three care staff.

This was the first inspection of the service under the new provider with the CQC.

Good

Is the service safe?

Our findings

People and their relatives said they felt safe and well cared for by staff that had a very good understanding of their needs and preferences. One person told us, "I feel absolutely safe. At night they come and check on you and it's nice having a toilet right beside me. Before, when I was at home I would have to cross a landing and I never felt safe doing that during the night. Here, it is no problem. I feel as safe as anything here." A visiting relative told us, "I do believe my loved one is safe here. She's well attended to and doesn't seem as if she's left alone a lot, there's always someone around checking on her."

Systems and processes were in place to safeguard people from abuse and avoidable harm. Safeguarding policies and procedures were readily available and accessible to staff. Through the use of individualised person centred care planning staff promoted an equality of care for people who lived at the service. This ensured people were not discriminated against due to physical or mental health conditions and care needs. Staff had received training on safeguarding and had a good understanding of how to recognise what constitutes abuse and how to report concerns to protect people and prevent the discrimination and harassment of people.

Staff and the registered manager demonstrated a good understanding of their responsibilities in reporting safeguarding concerns to the local authority and investigating any concerns which were raised. Following any safeguarding concerns or safety incidents, lessons were learnt and action taken as a consequent of the incident. The registered manager told us, "We had one medication error which we raised as a safeguarding concern due to the correct medicine procedure not being followed. We were open and transparent and the incident and lessons were learnt."

Arrangements were in place to manage risks safely and appropriately. Risks associated with skin breakdown were assessed and actions implemented to mitigate the risk. Management of pressure damage is an integral element of providing safe care to people living in nursing homes. A number of people received care and support on an air mattress (inflatable mattress which could protect people from the risk of pressure damage) and it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. People's air mattresses were set in line with their assessed weight. Where people had open wounds, wound assessments were in place which identified that the dressing had been changed regularly. Staff were clear about the steps required to manage the risk of skin breakdown. Preventive measures had been introduced as part of people's care planning and people received support to re-position alongside the application of barrier creams.

Risks associated with moving and handling were assessed and plans of care devised and followed in practice. Moving and handling risk assessments provided guidance on the type of sling required and any factors which prevented a safe transfer. Risks associated with swallowing difficulties had been assessed and actions implemented to provide safe care. For example, one person with swallowing difficulties had been assessed by a Speech and Language Therapist (SALT), who had provided guidelines for how to prevent the risk of this person choking. There were also measures in place to prevent possible complications of poor nutrition, such as a skin integrity care plan and regular weight measurements.

Staff had recently received training on the management of behaviours which may cause distress or harm to a person or others around them. For example, some people presented with behaviours that challenge during personal care support. Guidance was in place to help aid staff on how to meet these people's needs in a least restrictive and distressing way. Staff told us how they used distraction and diversion techniques, such as the use of music. The registered manager told us, "We identify what calms people during personal care whilst also considering their safety. For example, if they are displaying behaviours that challenge during personal care, and are unsafe to be left, we will utilise distraction techniques but if they are safe to be left, we will provide them with space and return later." This was echoed by staff who reflected the need to provide people with space whilst ensuring their safety.

Arrangements were in place to ensure that the environment was kept clean and hygienic so that people were protected from infections. The service was clean and tidy with no malodours. The registered manager told us, "Ensuring the home is clean and tidy is extremely important." Dedicated cleaning staff were employed and observed cleaning the service during our inspection. An infection control champion was in post who had attended specific training which was cascaded to the staff team. Cleaning tasks were signed off and the provider conducted regular audits of infection control. People's linen was regularly cleaned and systems were followed that reduced the risk of cross-contamination. Staff were observed washing their hands before and after supporting people. Staff were also observed using personal protective equipment (PPE), such as aprons and gloves, before providing care to people. Hand sanitizer was available throughout the home and we observed staff and visitors making use of it.

People were protected from being supported by unsuitable staff. The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, work histories, proof of right to work in the UK and health checks. The provider also routinely carried out checks with the Disclosure Barring Service (DBS). DBS is the disclosure barring service. This is used to identify potential staff who would not be appropriate to work within social care.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. A fire risk assessment had been completed and regular fire alarm checks had been recorded. Staff received training and knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP). Equipment was also available around the home to aid evacuation if required.

Health and safety checks had been undertaken to ensure safe management of utilities, these included amongst others water and legionella checks, electrical appliance testing, regular checks and maintenance of moving and handling equipment, and the lift. During the inspection, we noted one stair lift which had not a recent service and failed to advise that it was not in service. The provider advised that it was not in use and took immediate action during the inspection to decommission the stair lift. There was an emergency plan which informed staff what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

There were sufficient numbers of staff deployed to meet the needs of people. Staff had time to interact and support people in an unhurried and calm way. The staff rotas demonstrated that there were consistent numbers of care and nursing staff deployed each day and night. The registered manager told us, "We have a dependency tool in place to determine staffing levels but we also determine staffing levels from a practical basis by knowing the needs of our residents. It's not about numbers of residents but about their care needs." Staff, people and their relatives felt staffing numbers were safe and people confirmed that staff responded to their care needs in a timely manner. A relative told us, "There always seems to be enough staff. I come in two or three times a week and there's always plenty around. They always make me feel so welcome.

There's plenty of good, friendly, banter." Another person told us, "For me there are enough staff. When I'm asleep I'm dead to the world so I wouldn't hear bells going off but I've certainly not got any problem with the number of staff and I haven't heard anyone complaining either."

The management of medicines was safe. The registered nurses were responsible for ordering, administering and recording of medicines. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. There were protocols for their use to ensure they were given consistently. When people had their PRN medicines this was recorded on the Medicine Administration Record (MAR) to show the medicine had been given. The provider had recently changed the medicine management system and the way medicines were stored within the service. Medicines were now stored safely in locked cabinets in people's own rooms. The registered manager told us, "We changed the system based on best practice guidelines and also due to size and style of the building. It was difficult to push a medicines trolley around the service." The change in system had consequently led to a large number of medicine errors. The registered manager told us, "Following the changeover, we noticed a large number of medicine errors occurring, primarily concerns noted with the carrying forward of medicines. As a result we have changed the way we audit medicines and the number of errors are reducing.

A monthly medicine audit was completed and the audit dated February 2018 found only nine errors. These were in relation to miscalculation of stock levels when carrying stock forward and a couple of missing signatures on Medication Administration Records (MAR charts). The registered manager told us, "We are heading in the right direction; however we are not there yet. Therefore we will now be considering completing a medicine stock check after each medicines round." Medicine error forms were in place to learn from errors and near misses and the provider as part of their management governance framework was regularly reviewing the actions to drive improvement around the administration of medicines.

People confirmed they received their medicines on time and when they needed them. One person told us, "They are strict about the medicines and come round like clockwork. I know I wouldn't remember to take my medicine if I had to do it myself." A visiting relative told us, "I know my loved one gets her medication regularly and that they ensure she takes it. She couldn't remember to do it herself. That's not an option." We observed the registered manager supporting people with their lunchtime medicines. They clearly explained the purpose of the medicine, ensured they had a drink to hand and only signed the MAR chart once the person had been supported to take their medicine safely.

Requires Improvement

Is the service effective?

Our findings

People were supported to live healthier lives. Staff received the required training and skills to enable them to deliver effective care. People and their relatives were complimentary of the staff team and confirmed staff had the necessary skills to provide person centred care which promoted their well-being. One person told us, "We're all important people here and all treated the same. The staff are all wonderful and extremely good at their jobs. That's everyone, including the laundry. I can put something in in the morning and it's back the same day. Simply marvellous." However, despite the positive feedback we received, we identified areas of practice that require improvement.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Robust systems were not in place to identify when a person may be subject to an unlawful deprivation of liberty. In March 2014, changes were made to the Deprivation Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. A number of restrictive practices were in place at Carlisle Lodge, including the use of bed rails. A key pad was in place to enter and exit the home. Some people were living with advanced dementia and required the use of a tilt space chair (chairs which promote safety but restrict movement). A DoL checklist was completed each month for people but failed to adequately assess whether people might be subject to an unlawful deprivation of liberty. For example, one person's checklist noted that a DoLS application was not required as due to the person's physical condition they would be unable to leave the service. The DoLS checklist failed to consider whether the person was able to consent to their living arrangements or whether they could consent to the restrictive practices used within their care delivery. The registered manager advised that for this individual, a DoLS application was also not required because the individual was not subject to continuous control and supervision and due to their physical condition; they would be unable to leave the service. We queried with staff and the registered manager whether staff would know at all times where the individual would be. They confirmed they would and that the person was subject to regular checks to ensure their safety. The use of bed rails and a tilt space chair also meant the person's movement and freedom was restricted. The DoLS checklist failed to follow the principles of the Supreme Court Ruling (2014) and sufficiently assess whether people living with advanced dementia, unable to consent to their care routine and living arrangements were deprived of their liberty. We reviewed the care planning documentation for four people living with advanced dementia whom staff felt lacked capacity to decide about their living arrangements. We found this was a consistent theme across their care planning documentation. The registered manger also confirmed this was an area of practice that they needed to explore. Subsequent to the inspection, we were informed that the provider would be submitting DoLS applications for authorisation.

Guidance on what constituted a deprivation of liberty safeguard was also not available as a stand-alone policy document for staff to access. Failure to adequately assess if people are unlawfully deprived of their liberty contravenes Article 5 of the Human Rights Act 1998.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Training schedules confirmed staff had received training on the MCA. Staff had some knowledge of the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. Staff told us they explained the care they were to provide to a person before they gave it and sought to gain their consent. We saw this in practice. One staff member told us, "We will spend time with people, put ourselves in their shoes and explain every step."

However, the principles of MCA were not embedded into every day practice and the care planning process did not consistently reflect the principles of the MCA. For example, mental capacity assessments were completed on a monthly basis but were not decision or time specific. The registered manager told us, "The monthly assessments are a guide as to whether the person is able to make their own decisions." Guidance stipulated by the MCA 2005 Code of Practice states that 'mental capacity assessments should be time and decision specific and completed when the need arises.' A number of people had bed rails in situ. Under the MCA code of practice, bed rails can be seen as a form of restraint. Staff and the registered manager were able to explain the rationale for the use of bed rails and a bed rails risk assessment had been completed. People's capacity to consent to the use of bed rails had not been assessed and a time and decision specific capacity assessment had not been completed.

Failure to work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were motivated and supported through a program of training which promoted their individual learning, development and their involvement in the service. Upon starting employment with the service, staff were encouraged to develop their skill set through the Care Certificate and external qualifications. The Care Certificate is an identified set of standards that care staff adheres to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The registered manager told us, "We also enrol staff onto the level two health and social care diploma with the local college."

The importance of continuous learning was recognised by the manager to ensure that people received effective care. The provider's PIR noted that more support was being provided to people living with dementia. In response to this, the registered manager advised that recent training had been provided to staff on 'positive behaviour support for people with dementia.' Staff spoke highly of the training provided.

The programme of training had recently been changed following new ownership of the service. The provider told us, "Since taking over, I have changed the delivery of training from on-line to face to face. I firmly believe that face to face training promotes better outcomes for people and staff prefer face to face training. I also believe in sharing knowledge, keeping staff motivated and providing staff with self-worth." Staff spoke highly of the recent face to face training and confirmed how the training made them feel valued and supported. One staff member told us, "We have good training opportunities, all face to face. There's a good focus on quality and we strive to be as good as we can be."

Staff confirmed they felt supported within their role and received regular supervision. The registered manager also advised that supervisions were utilised as a forum to reflect on the training provided. They commented, "A staff member had supervision the day after we received training on dementia care. It was discussed whether they felt the training was helpful, whether it will help in practice and what other training could be helpful." Registered nurses were supported to develop skills and ensure they were up to date with practice to meet the requirements of their registration with the Nursing and Midwifery Council (NMC). For example, registered nurses had received recent clinical training on diabetes and tissue viability. People and their relatives confirmed they were confident in the skills and abilities of care and nursing staff. One person told us, "Oh, yes, the staff are very experienced. I have to be hoisted into my wheelchair. I feel comfortable because they know what they are doing. They adjust the hoist to me, not me to the hoist and I can't tell you how important that is, when you know you're going to be dangling up there you want to feel you're in good hands."

People were effectively supported to eat and drink enough to meet their needs. Each person had a detailed eating and drinking support plan based on their requirements and preferences. Staff were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet but also the need to balance this with people's rights to decide for themselves what they wished to eat. The cook worked closely with people and staff to identify and support people's nutritional needs.

We observed lunch being served during the inspection. Tables were neatly decorated and people chose where they preferred to have their lunch. Staff greeted people in a warm and friendly way and people were offered a range of alcoholic and non-alcoholic drinks. Meals were well presented and people were encouraged to eat independently. Where support was required, staff provided assistance in a calm and unhurried manner whilst engaging about the day ahead. People spoke highly about the food provided. One person told us, "The food is excellent. I have no complaints. Proper home cooked food." Another person told us, "It's very good food. I can eat as much as I want. I love the porridge. It's my favourite meal." A third person told us, "Every meal we choose the day before. If I did ask for something particular they would do it for me, as long as they had notice. The food is very, very good. Always hot when served. There's always plenty to drink too. We can have wine with our meal if we want it. I do."

Systems were in place to ensure that people's nutritional needs relating to culture, religion and individualised preferences were met and monitored. The registered manager advised how support was provided on an ongoing basis. They told us, "We continually assess people's nutritional needs and take into account their cultural and religious beliefs as part of the ongoing care process. Recently it was Ash Wednesday and we ensured that we had meat free alternative meals. We have also supported residents whose faith is Muslim and we have provided halal meat. My cook has no budget as food is the highlight of people's day and it is important that they enjoy it."

Staff worked well with other organisations to ensure that they delivered effective care and support. Care plans contained information about people's individual needs and preferences. Staff knew the people they cared for well and liaised with other organisations such as GP's, dieticians, social workers and chiropodists. The registered manager told us, "We have very strong links with the local GPs and local hospice. I must admit, I do stick up for my residents and I will fight to get the best care for them. I've had debates with psychiatrists before and I will always stick up for the residents. I always think, if that was my Mother, would I want that for them?"

People had access to healthcare services and received on-going healthcare support. People told us they received the healthcare that they needed in a timely way. One person told us, "If needed, the doctor would

be called but I'd go and see the doctor at the surgery if it was only routine. The chiropodist comes here, she's very good." The dentist and optician I'd go out for." Another person told us, "The doctor will visit if called. The same for the optician or dentist I believe. Though if I wanted to go to a surgery I could." A visiting relative told us, "I'm content my wife is very safe here. There have been one or two occasions she's not been well and they've whipped her off straight away to the doctor. They don't mess around, I can't fault that."

The premises were suitably adapted. People had access to all parts of the accommodation and people and their relatives were involved in the design and decoration of the service. The registered manager told us, "We refurbished the lounge and conservatory recently and put the dining room table in the conservatory for our Christmas party. People were really receptive to the dining room table there and at our recent resident and relative meeting it was agreed for it to stay there and to transform the dining room into a relaxation area." People had access to various seating areas alongside access to outside space which enabled them to spend time alone or with others if they preferred.

Good

Is the service caring?

Our findings

Staff treated people with kindness and compassion in everything they did. Throughout our inspection staff were smiling and respectful in their manner. They greeted people on their first encounter with affection and by their preferred name and people responded positively. People and their relatives spoke highly of the service, commenting on the kind and caring nature of the staff and the registered manager.

We saw many examples of positive interactions between staff and people during the inspection. Staff were warm and friendly, frequently enquiring if people were comfortable and had all they needed. They were genuinely concerned for people's well-being. One staff member knelt down next to a person whilst they were sitting in their chair enquiring how they were. They noticed the person was rather quiet and not themselves and asked if they would like to sing. They proceeded to sing to the person who in returned smiled and began to sing as-well.

Staff clearly enjoyed their work and were motivated to provide as good a service as possible for people. Comments from staff included, "This is a caring and happy home and staff morale is brilliant." Another staff member told us, "There's a very good atmosphere. I would feel very happy to have family members cared for here. The management is good, staff are happy. It is everything I could wish for. It is calm and relaxed, a lovely environment. Compared to other homes, this is heaven."

People were treated with kindness and compassion by staff who knew them really well. Staff had a good knowledge of people as individuals, their needs, likes and choices and what was important to each person. Staff were committed to providing good, compassionate care. From talking with people and staff, it was clear staff knew people well and had a good understanding of how best to support them. They told us about the people they cared for, their personal histories, and interest's cultural and religious needs. They spoke about people's individual care needs and preferences for example what time they liked to get up, what they liked to do during the day and food and drink preferences. Staff told us about the importance of knowing each person as an individual. During the inspection, one staff member was observed interacting with a person and spent time reminiscing with them. They enquired, 'you use to be tennis player didn't you?' They then proceeded to spend time with the person talking about the Royal Family.

The service presented with a friendly warm atmosphere and people were encouraged to bring items in from home to make their room feel 'homely'. One person told us. "It's a very homely atmosphere here and I can just ring my bell when I'm ready for bed, I can make my own decisions. I like to get up early, usually between 06.00am to 06.30am. When they come into my room to help me undress or whatever, they always close the curtains and make sure the door is closed. Even when I ring the bell, they always knock before the come in." Another person told us, "They are great. They come in and chat, they know me well. My room has been made to feel very homely. The curtains and bedding match. One day it didn't and when the manager saw it, she made them change it. She's a very good person. She's caring and will sit and listen."

Staff told us how they treated people with respect, this included respecting people's meal choices and wish to participate in social activities. During our inspection we saw staff knocking on people's doors before

going in; they would wait until asked to come in. In most cases where the door was already open, the staff members still knocked and paused or spoke to the person before entering. People confirmed that their privacy was respected and felt staff understood the principles of providing good dignified care. One person told us, "Nobody asks us to do anything we don't want to do. I get up when I want. Go to bed when I want. Stay in my room if I want. It's my choice. I shower twice a week, I could do more if I wanted. My bedding is changed for me. They are always polite and knock before they come into my room." Another person told us, "They always knock before the come into the room and always draw the curtains before any personal care. If I want to stay in my room, that's fine. If I want to go down, they'll take me. I sometimes like to eat in my room and they bring it to me. I can make my own choices. I get up and go to bed when it suits me. They just ask me what I want to do."

Peoples' equality and diversity was respected. They were supported by staff to maintain their personal relationships. This was based on people's choices and staff understanding of who was important to the person, their life history and where appropriate their spiritual and cultural background and sexual orientation. People were supported to meet their spiritual needs and there were regular visits to the service from local churches. One person told us how they looked forward to their Holy Communion every week and the registered manager confirmed that support was in place for people to be supported to access their place of worship.

Staff encouraged people with shared interests to spend time together which helped people forge friendships. For example, two people were observed spending time in the conservatory enjoying the sunshine. Laughter and banter was observed throughout their interactions. One person commented, 'shall we get our bikinis out?'

We saw visitors arriving at different times of the day and they received a warm welcome from the staff. People and their relatives confirmed there were no restrictions around visiting. One person told us, "My daughter comes in whenever she wants. There are no set times. It's always lovely to see her and the staff make her very welcome too." Another person told us, "We can have visitors whenever we like. There are no set times. Just turn up and come in." Staff were observed making visitors hot drinks and enquiring with people if they enjoyed their visit from their loved ones. One staff member was observed to joke with one person around their family members eating their sweets.

Guidance produced by Age UK advises on the importance pets bring to older people. Carlisle Lodge recognised the importance pets bring to older people living in a care home. The registered manager told us how they brought their dog into work and people spoke highly of having a dog around the service. One person told us, "I like to leave the door open so that the dog can get into my room for a cuddle if he manages to escape."

Good

Is the service responsive?

Our findings

People and their relatives told us that they received care which was centred around their individual needs and preferences. One person told us, "They always have time for you here. We all get along very well and have a good laugh." Another person told us, "They are very kind to me. I like it. The talk to me and hold my hand." A third person told us, "Life is good, I like living here. They're kind and helpful and always have time for you."

Before moving into the service, the registered manager completed a pre-admission assessment to ensure the person's needs could me met at the service. Information from the pre-assessment was then used to develop care plans and risk assessments when people moved into the home. Care plans contained information about each person, their family history, individual personality, preferences and interests. This information had been developed by the person, their family and staff. The care plans were relevant to each person and included information about their mobility, nutrition, continence and personal care. In addition to people's care needs there was information about their lifestyle, social, religious and cultural needs and beliefs. Information was recorded regarding people's healthcare needs and the support required to meet those needs. Care plans contained guidance for staff on how best to support each individual. People were given the opportunity to observe their faith and any religious or cultural requirements were recorded in their care plan. Reviews took place regularly with people, and where appropriate their representatives, were involved with these.

People told us they were involved in the design and formation of their care plan and felt that their view was taken into consideration. One person told us, "I was involved in my care plan, it just jogs along but if things change the care plan will probably change with it. I'm happy with the way things are running." Another person told us, "Yes, there is a plan and every so often we get together, my daughter comes too, and we have a talk."

Systems and processes were in place to identify and meet the communication needs of people living with a sensory loss. The registered manager told us, "I'm very hot on communication needs and our pre-admission assessment considers any communication support and whether the individual requires information in large print, braille, sign language or lip reading. We currently support some people who are registered blind and we have made links with the blind society to ensure their communication needs are met." People had individual communication needs care plans in place which provided guidance on how to meet their individual needs whilst also ensuring that the risk of social isolation was mitigated.

Some people required end of life care and staff supported them to maintain a comfortable, dignified and pain free death. Staff were aware of any changes to people's health and comfort. Appropriate support and treatment was sought in a timely way when needed. People's pain medication was regularly reviewed to ensure each person was comfortable. Advanced care plans were in place which considered what the person's wishes were and where they would like to be cared for. The registered manager told us, "We work closely with the local hospice who have delivered end of life training and advanced care planning." Advanced end of life care plans were completed as far as possible and considered people's wishes and

preferences. However, staff were also mindful of people's wishes not to discuss this.

People told us that that they could take part in various social activities which they enjoyed. One person told us, "I like it here very much and often go to the lounge. It's a very homely atmosphere, but don't always feel like socialising. I have a daughter close by and she comes in. I like to watch my television and because this is my home, that's respected. This is the best life I could wish for, although I never envisaged living in a home this is wonderful, as good as it can be. They listen. It's the little things that matter." Another person told us, "I like it when we play a game called 'Say What You See', it's hilarious. Literally you have to say what you see and what some people come out with is so funny. Nobody takes themselves too seriously. We all have a good laugh." A third person told us, "I used to do more with the activities but can't get out of my chair now. Nearly every day we do something. Bingo, YMCA, where a group of people bring quoits, bean bags and the like and you have to throw them into a ring, and other exercises. There's also softball every week. I like going to the knit and natter with another lady. We're knitting baby clothes. I like watching sport on telly. I certainly don't have time to be bored."

The provider's PIR demonstrated that improvements could be made to the provision of activities and on the day of the inspection, the registered manager demonstrated that action was being taken to drive improvement. The registered manager told us, "We've recognised that we need activities to be available seven days a week and more activities are required to support people living with dementia. We are therefore recruiting a second activity coordinator and we have signed up to Dementia care." Whilst the provider had recognised that improvements could be made, people told us they were happy with the current provision of activities. An activity programme was on display and activities included bingo, ball games, quizzes and card games. One to one activities were also provided. On the day of the inspection, we observed a variety of quizzes which people and staff were engaging with. With pride, the activity coordinator was able to explain how through listening to people and providing activities based on their hobbies and interests, people's quality of life had improved. They told us how one person who spent most of their time in their room. Staff ascertained that they liked to knit and through setting up a knit and natter group, they started to come out of their bedroom and they are now knitting baby clothes with other people.

The use of technology was utilised throughout the service to support people to receive timely care and support. Call bells were readily available for people to access and summon support. Wifi was also available throughout the service and people had access to laptops and tablets. Staff recognised the importance of technology in supporting people to maintain relationships with their loved ones. One person told us, "I use an Ipad which is simply wonderful. One of my daughter's lives abroad and I Facetime her and it's as though she is in the room with me. It's been very useful."

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. For people living with a sensory loss, the complaints procedure was verbally explained to them and reiterated throughout care plan reviews. On the day of the inspection, the provider had not received any formal or informal complaints in over a year. People and their relatives confirmed that they would have no hesitation in raising concerns. One person told us, "I have no worries and no complaints. If something was bothering me I wouldn't hesitate to speak out."

People and their relatives were regularly asked for their feedback about the service through quality assurance questionnaires, feedback surveys and regular meetings. A 'resident and relative meeting' was held a couple of days before our inspection and people provided positive feedback about the meeting. People confirmed that their views were listened too and that any feedback was acted upon. The registered manager told us, "This is people's home and we will act on any feedback." Where people had made suggestions through quality assurances questionnaires or 'resident meetings' these were acted upon. For

example, one person had requested bacon pudding which was added to the menu. One person feedback in a recent survey that they felt the food was monotonous. Action was taken to address their concerns the chef met with the individual and planned a menu based on their likes and preferences.

Requires Improvement

Is the service well-led?

Our findings

Staff, people and relatives spoke highly of the service and its vision to deliver high quality care. One person told us, "It's a really content, homely atmosphere. I'm very happy because we're treated so well." Another person told us, "Everything is good here. They can't do a lot to improve it because it's top notch as it is." A visiting relative told us, "It's a very calm but happy atmosphere here. The fact that my wife is always clean, her clothes are clean and she's dressed properly I think shows they care and I'm sure that makes her happy too."

Although we received positive feedback we identified some areas that needed to be improved.

There was a range of audits and quality monitoring in place. However, these systems had not identified all the areas for improvement we found. For example, the manager's monthly audits failed to identify that the principles of the Mental Capacity Act 2005 were not consistently being adhered to or that people may be unlawfully deprived of their liberty. A recent legionella risk assessment had been completed in January 2018; however the report from the contractor stated that some of the water tanks were not compliant with Health and Safety Executive (HSE) recommendations. Remedial works were requested. The registered manager told us that they were aware of the work needing to be completed but hadn't devised an action plan to demonstrate timelines of when the work would be undertaken. We recommend that the provider reviews and monitors all audits to ensure they demonstrate improvements required and timelines for improvements.

A System was in place to ensure that registered nurses NMC (Nursing and Midwifery Council) registration was renewed and up to date. The registered manager conducted regular checks to ensure all nurses were safe to work at the service. However, this system failed the registered manager who was also the nurse on duty on the day of the inspection. During the inspection, it was found that their registration had lapsed. Nurses are only able to work with a valid NMC registration. The registered manager's was therefore required to complete a re-registration process. The registered manager told us that the checks they complete on nurses also included themselves but the registration must have lapsed in-between checks and was open about the error. They provided an immediate action plan to ensure all shifts they were due to work in a nursing capacity were covered until their registration had been renewed. Whilst the registered manager was open about the shortfall, they were dependent upon Inspectors to bring it to their attention.

Failure to have fit and proper persons employed is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management, including any issues in relation to equality, diversity and human rights. Management was visible within the service and the registered manager told, "We lead by example and very visible." Staff spoke highly of the leadership style of the registered manager. Comments included, "We can always talk to the manager. She is very open and friendly." Another staff member told us, "I have always admired the way that

the manager cares. She's fair and very supportive and there's an open and honest atmosphere."

The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team.

The provider who was also the registered manager and took over ownership of the service in 2016. They described with pride the opportunity they were given of becoming provider whilst reflecting on working within the service for over 20 years. They told us, "The home is my baby and I embed a culture of our home is your home. I also want to create a homely atmosphere." The values and vision of the service were embedded into practice and staff described the key strength of the service as its homely atmosphere. One staff member told us, "There is a warm, friendly and homely atmosphere. A lot of thought is given to each individual resident. It is very person centred." One person told us, "Since the manager took over she's made a difference outside and in. On Monday we had a meeting with the residents and other relatives. She is a formidable woman and runs a tight ship. She's caring and has her eye on the ball and makes sure things are right. The staff all seem to like her."

Staff were actively involved in the design and development of the service. They were encouraged to be involved in considering and proposing new ways of working. For example, one member of the management staff was supported to obtain their level five health and social care leadership diploma. Through achieving that diploma they suggested how improvements could be made to the management of medicines. Their suggestions were listened too and acted upon. Following any changes in the service, staff were asked on their feedback on how they felt the change was handled and were asked to provide any feedback for improvement. The provider valued their staff team and actively encouraged them to be involved in the running of the service.

Links with the local community had been established. Students from a local school visited every week during term time to engage with people and support with activities. Links had also been established with the blind society who provided support to people living at Carlisle Lodge. The service also worked in partnership with key organisations such as the CCG (clinical commission group) to support care provision.

The registered manager was committed to improving and developing the service. An annual development plan for 2018 was in place which highlighted the provider's plans for the forthcoming year. Planned actions included continued refurbishment of the service, increasing the frequency of 'resident meetings', implementing champion roles for staff and the implementation of a call bell audit. The registered manager told us, "I want to motivate staff and the roles of champions and other roles for staff who have acquired a level three diploma I feel will provide them with self-worth and motivation to develop."

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 had informed the CQC of significant events appropriately. The registered manager was aware of their responsibilities under the Duty of Candour. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong. The Duty of Candour is a regulation that all providers must adhere to.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant persons. The registered person had failed to act in accordance with the 2005 Act. Regulation 11 (1) (2) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Persons employed for the purpose of carrying on a regulated activity did not have the qualifications necessary for the work to be performed. Regulation 19 (1) (b) (4) (a).