Joseph Rowntree Housing Trust

Red Lodge

Inspection report

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Date of inspection visit:
14 July 2016
15 July 2016

Date of publication:
22 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out over two days on 14 and 15 July 2016 and the inspection was unannounced.

Red Lodge is owned by the Joseph Rowntree Housing Trust (JRHT). The home is situated in New Earswick to the north of York city centre. Each person living at the home has their own flat, furnished with their own furniture, and access to a range of communal areas, which include a restaurant, communal lounges and quiet areas. The home has its own car parking and benefits from outside garden and seating areas.

Red Lodge provides a care home service without nursing care and incorporates a domiciliary care service, which assists people residing in the on-site sheltered accommodation. The home is registered to provide care and support for up to 42 older people, some of whom have a learning disability or autistic spectrum disorder. At the time of our inspection there were 35 people receiving a service.

The home had a manager in place and the registered provider had submitted an application to the Care Quality Commission (CQC), which was being processed to certify the individual as the registered manager. 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.

We saw people received care and support that was managed by a wide range of risk assessments for the individual, the home and the environment. However, we found that risk assessments were not always appropriate or person centred and where people's needs had been reviewed, resulting actions had not always been implemented.

We found that environmental risk assessments and reviews had been completed to help protect people and others from the risk of fire and waterborne diseases but at the time of our inspection, resulting actions were outstanding and remedial actions had not been implemented in a timely manner.

The registered provider showed us a health and safety file that contained reference to a policy and procedure for accident and incident reporting but the document was not available. We found that documented outcomes for and evaluations of accidents had not been completed to identify trends and reduce the risk of re-occurrence.

The registered provider undertook pre-employment checks for care workers they employed. These included checks with the Disclosure and Barring Service (DBS), details of pre-employment references, application forms and right to work in the UK documents. The provider undertook some additional checks when recruiting agency staff. However, these checks were inconsistent and failed to provide information to demonstrate care workers who worked in the service from employment agencies were always suitably trained and of appropriate character to work with vulnerable people.

People and care workers we spoke with voiced their concerns around the number of care workers available during the night shift. We were informed that staffing was reviewed and was adjusted dependent on the number of number of residents, their needs and any planned activities. People had access to a call system and care workers responded to people on an individual basis. We recommended the registered provider undertook a review of the effectiveness of night staffing.

People we spoke with told us they felt safe. Care workers we spoke with had received training in and understood how to recognise signs of abuse and discussed appropriate action they would take if they had concerns. We saw a safeguarding policy and procedure, however, the whistleblowing policy was in the process of being updated and a copy was not available in the file at the time of our inspection. Safeguarding concerns were managed appropriately with guidance sought from the relevant safeguarding authorities.

Safe systems and processes for the management of medicines were in place. Medicines were administered safely by care workers who had received appropriate up to date training. However, the policy statement for the management of medications required updating.

We found that the registered provider was implementing an induction programme for all new employees that reflected the care certificate. Despite a process in place to provide supervisions, one to ones and annual appraisals, these had not always been completed.

Training for employees was managed electronically ensuring care workers received appropriate training at the right time and included adaptions to meet people's individual care and support needs.

Staff had received training and understood the requirements of The Mental Capacity Act 2005. We looked at people's care plans and saw people or their representatives were involved in their care planning and where people had capacity, consent had been sought that confirmed they agreed with the care and support provided. There was evidence that for those people unable to make decisions about their care, decisions were made in their best interests using an appropriate process.

People were supported to maintain good health. Care plans contained detailed information to ensure people had access to relevant health professionals to support them with a holistic approach and enable them to remain healthy.

People's dietary requirements were noted in their care plans and the chef ensured that food provided met with people's individual requirements.

People and their families told us and we saw that care workers provided compassionate and person centred care that was centred on the individual. The manager told us people were assigned a key worker as their main point of contact. However, people were not always clear who this was.

People were treated respectfully and their dignity was maintained at all times. Care workers understood the importance of this and told us how they recognised and maintained people's confidentiality.

People had received an initial assessment of their needs as part of their application process to the home to receive either residential or community care in their own rooms. This enabled the registered provider to ensure they were able to meet the person's needs and to ensure the service was right for the individual.

We observed a number of activities took place at the home. People were supported to follow their interests and take part in social activities and were protected from social isolation.

People knew how to complain if they were unhappy about any aspect of the service. We saw that information from complaints and compliments was collated and fully investigated with a view to future learning and improvement.

People, staff and relatives we spoke with told us that they felt the manager was approachable and was working hard to improve the standards of care at the home. There was a clear management structure in place and staff had an understanding of their roles and responsibilities.

We found three breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the staffing, supervisions and risk management. You can see what action we told the provider to take at the back of the full version 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?

Requires Improvement

The service was not always safe.

Risk assessments for people the home and environment were evidenced but these were not always appropriate to people's individual needs and actions had not always been implemented.

Appropriate checks on employees and agency staff were not always completed.

Accidents and incidents were recorded. However outcomes for and evaluations of accidents had not been completed and the accident policy could not be evidenced.

People received their medication in a safe way. However, associated policies and procedures required updating.

Care workers had undertaken appropriate safeguarding training and were able to discuss signs of abuse and how to report their concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

A process was in place to support employees and to document probationary induction and reviews, one to one supervisions, observations, competency checks in medication, people handling, and an annual appraisal. However, the process was not followed and care workers had not always received supervision and appraisal.

The registered provider was working in line with the Mental Capacity Act 2005. People were supported to make informed decisions wherever possible and care plans were signed by people or their representatives.

Is the service caring?

Good

The service was caring

People received support and care from care workers who

understood the importance of treating people with dignity and respect.

Care workers understood how to respect people's confidentiality.

Care workers were kind, efficient and caring and showed they cared for the people they were supporting.

People were involved in planning their care and support and were given information about advocacy services.

Is the service responsive?

Good

The service was responsive.

Care plans gave staff detailed information on how to support people and keep them safe and plans were reviewed and updated regularly.

People were supported to undertake activities and to access the community if they requested.

People and their relatives knew how to complain if they needed to. Complaints were recorded and information was collated and fully investigated with a view to future learning and improvement.

Is the service well-led?

Requires Improvement

The service was not always well-led

Systems and processes that were in place to assess monitor and mitigate risk including policies and procedures, failed to reduce or remove the risks within an appropriate timescale.

People receiving a service were consulted on their experiences of the home and monthly residents meetings were held to keep people up to date with any changes.

There was a clear management structure in place and staff had an understanding of their roles and responsibilities.

Quality assurance processes monitored the service provided and had led to improvements in some areas of care for people.

Red Lodge

Detailed findings

Background to this inspection

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

This inspection was carried out over two days on the 14 and 15 of July 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, the provider completed a provider information return (PIR). The PIR 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, such as notifications about any incidents or accidents that we had received from the registered provider and information we had received from the local authorities that commission a service from the home.

On the day of the inspection, we spoke with five people who lived in the home including two people receiving community care and three people who received residential care. We also spoke with the chef, a cook, and three members of staff, the registered manager, and the head of quality compliance for the service.

As part of the inspection, we reviewed the care records for four people including their medicine records and risk assessments. We also looked at seven staff files and other records used in running a care home that included quality assurance systems, policies and procedures and health and safety records. We observed the care and support being provided to people and observed a medication round and the lunchtime meal in the dining room.

Requires Improvement

Is the service safe?

Our findings

We saw people's care plans contained information about their care and support including associated risk assessments and action plans. Where people were at risk, files included a 'High Risk' label on the front page to assist care workers to identify areas of high risk and to provide people with care and support in a safe way. Risk assessments were in place for people and the environment. These included but were not limited to, identified risks to people from falls, mobility, infection, nutrition and medication. However, we saw that where people chose to smoke in their own rooms, risk assessments were not in place to mitigate the associated risks to care workers and visitors. We saw one person had a risk assessment for the use of bed rails. A review highlighted there were problems with the bed rails but we did not see where this was actioned or documented. We spoke with the manager about our concerns. They showed us a risk assessment template for smoking in the Health and Safety file and they completed this for people who smoked during our inspection. They told us the bed rails had been set up the wrong way round but this had not been recorded. The manager said, "We are changing the process to address risks, we have a significant amount of risk assessments in place but these are not as robust as we would like them to be."

The manager showed us maintenance certificates for the premises, which included the electrical wiring certificate, gas safety certificate and portable appliance checks. These were up to date and helped to ensure the safety of the premises. The manager told us all hot water taps were fitted with thermostatic valves to ensure a maximum temperature of 43 degrees centigrade. However, this was not monitored. The manager showed us a file containing checks on hot and cold water systems for legionella control. This included a logbook detailing 'Faults and Non Conformities'. We saw that remedial actions were required in October 2015 that included the disinfecting of showerheads and that these had not been actioned. This meant the registered provider had failed to address actions highlighted to prevent the spread of waterborne infections. We spoke with the manager about this and they commenced action during our inspection to address the concerns.

A Health and Safety file we looked at included annual assessments undertaken to assess fire-associated risks. Because of these assessments, we noted actions that included the removal of storage items in an electrical cupboard, repairs that were required to secure access to the main electrical room and a deep clean of the kitchen. We saw these actions were recorded in 2015 and again in 2016. We discussed this with the manager who showed us the areas of concern in the building and we noted that remedial action had not been taken to rectify all of the actions highlighted in the annual assessment for 2015 or 2016. We saw storage items remained in an electric cupboard and the main electrical room was not secured. However, evidence was provided after the inspection that the kitchen had been deep cleaned in March 2016. Other checks that had been completed included weekly fire alarm test records, monthly emergency lighting, fire incident recording, an evacuation procedure and a fire safety logbook that included information on training by employees in the event of a fire.

We looked at the recording of accidents and incidents. We saw there were documented incidents but outcomes for and evaluations of accidents had not been completed to identify trends and reduce the risk of re-occurrence. The Health and Safety file contained reference to a policy and procedure for accident and

incident reporting but the document was not available. We asked the manager about these omissions and they told us, "The accident policy has been reviewed centrally and we are awaiting a copy," they continued, "The reporting forms have been updated as part of a corporate quality assurance reporting process, the forms in the file are no longer in use."

The above concerns meant despite some policies and procedures in place to manage and mitigate risk, care was not always provided in a safe way. Appropriate risk assessments were not always in place and actions had not been implemented which meant people were not always kept safe from harm.
This was a breach of the Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager for the recruitment records for seven members of staff. Information available did not contain pre-employment checks as the manager told us this information was held centrally. We asked the manager to provide us with details of the checks they had undertaken after our inspection. We were provided with employee start dates and information to confirm that checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. Other information provided included details of pre-employment references, application forms and right to work in the UK documents. We saw from the information provided that all staff had completed an application form and references had been obtained.

The provider undertook some additional checks when recruiting agency staff that helped to ensure those employed were of suitable character to work with vulnerable people. We looked at the agency file and saw that one agency staff on duty did not have the checks in place. Minutes from a recent staff meeting stated, 'We need to lead the agency staff, please communicate if a certain person is not capable or qualified." This meant the registered provider did not always carry out and document checks on agency staff to help ensure they were suitably trained and of appropriate character to work with vulnerable people. The manager told us they would contact the agency to obtain this information.

People and care workers we spoke with voiced their concerns around the number of care workers available during the night shift. We looked at staff rotas and at the time of our inspection, the home had two 'awake' care workers on duty during the night and no 'sleeping' support staff. One person said, "We have a fob that we wear and we can press it to summon assistance if we need it." They went on to say, "Sometimes staff come quickly but other times you can wait fifteen minutes or more if they are busy with somebody else." Care workers we spoke with said, "During the day we have adequate staffing that changes dependant on need and activities but night time can be a problem especially if we both have to attend to a fall and someone else calls for us," and "Staffing has improved but night times can be a struggle." We spoke with the manager about this. They told "We use a staff dependency tool which was last updated in January [2016]." They said, "We manage staffing based on the number of residents, their needs and any planned activities and numbers are changed accordingly." The manager told us, "People have access to a call system and we respond to everybody on an individual basis." In light of feedback received, we recommended that the provider updated the staffing dependency tool and monitored the effectiveness of night staffing.

People had been assessed to indicate the support they required in an emergency and a Personal Emergency Evacuation Plan (PEEP) completed. A PEEP is a document, which advises of the support people need to leave the home in the event of an evacuation taking place.

People we spoke with told us they felt safe. One person said, "I don't have any concerns about my safety and the staff are great." Another person told us, "I do feel safe, I don't know all the staff as we have some that are temporary but they are all good people." Care workers we spoke with understood how to recognise signs of

abuse and discussed appropriate action they would take if they had concerns. A care worker said, "We have a duty to keep people safe from harm and abuse and I wouldn't hesitate in whistleblowing any concerns to senior management, local authority or the CQC."

The manager showed us a safeguarding policy and procedure, which provided care workers with additional guidance. However, the whistleblowing policy was in the process of being updated and a copy was not available in the file at the time of our inspection. We saw from training records that care workers had undertaken appropriate safeguarding training that included annual refresher electronic learning to ensure their knowledge was up to date. The manager had submitted safeguarding concerns to the local authority and the CQC to ensure these were appropriately investigated. A care worker said, "As a result of a safeguarding concern where a person had missed their medication, we were provided with additional training and the process was changed." This meant the registered provider had measures in place to learn from events and help prevent re-occurrence.

Safe systems and processes for the management of medicine were in place. Medicines were administered safely by care workers who had received appropriate up to date training and we observed care workers signed the medicine administration records (MAR) to show they had administered the medicine. The registered provider did not maintain an up to date documented list of care worker signatures for those who signed the MAR sheet as during audits they told us they recognised these. A care worker said, "We need to update the signature list as we have recently had a change of staff." MAR charts were all completed correctly and any errors or omissions had been documented. Medicines were stored, received and disposed of securely. The temperature of the medicine fridge and storage room was regularly checked to ensure that medicines were being kept at the appropriate temperature.

The registered provider had a policy statement for the management of medications. We saw this had a review date of June 2012. We spoke with the manager about this and they told us all policies and procedures were updated centrally and they would request the latest version for the file.

Protocols for medicines to be administered when required gave staff guidance on the circumstances when the medicine was to be administered. This meant people had their pain relief in a consistent manner.

Requires Improvement

Is the service effective?

Our findings

People who lived in the home provided a mixed response when asked if they thought care workers knew how to support them and had an understanding of their needs. One person told us, "Staff are generally very good and they do understand my care needs." Another said, "The agency staff aren't always introduced to us and don't understand my needs but they seem competent in what they are doing," and "I have to tell agency staff what I need doing but they learn fast." The manager told us, "We do not put agency staff through an induction process to the service and they are not formally introduced to people before they start work at the home." This meant the registered provider did not provide agency staff with any formal induction and there was no evidence to demonstrate how they were supported, and assessed as competent before independently carrying out their roles.

We looked at how care workers were supported with professional development, appraisals and development to carry out their roles by the registered provider. We saw that care workers had a supervision programme in the files that we looked at. We saw this included a provision to document probationary induction and reviews, one to one supervisions, observations, competency checks in medication, people handling, and an annual appraisal. However, we saw that these documents lacked consistency and had not always been completed. We spoke with the manager who told us, "We have a process in place to deliver supervisions and annual appraisals however this has not been followed and staff files are not up to date." They told us they had taken over responsibility for this and were in the process of updating this information. Care workers we spoke with told us they did not always receive documented supervisions. One care worker said, "No, I haven't had a one to one or supervision since Christmas." Another said, "The new manager has a lot to do, we have been told one to ones and supervisions will be scheduled which should hopefully lead to our annual appraisals." This meant care workers did not receive periodic supervisions and appraisals to ensure their competency to undertake the role was maintained and their performance appraised.

The above concerns were a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider told us they were implementing a new induction process that incorporated the Care Certificate and we saw three people had completed this. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. We saw the induction covered eight principles of care that included, duty of care, person centred approaches, positive behavioural support, equality and diversity, privacy and dignity, health and safety and infection prevention and control.

The registered provider told us in their PIR, 'Staff are trained and supported to provide person centred care and support from induction.' Training was managed electronically ensuring care workers received appropriate training at the right time. Care workers we spoke with told us and employment records confirmed that they had completed mandatory training, which included safeguarding, moving and handling, dementia awareness and fire safety.

A care worker told us, "The training is fantastic and well managed so we are just told what we need to attend

and when," they continued, "It's a real mix of classroom and on-line learning and we can complete some using the computers in the library." Another care worker said, "Training is adapted to meet people's individual needs, which means we can acquire a range of skills so we can meet people's individual care and support needs and provide them with the best quality of life." We looked at files for staff and saw that training was adapted and provided to meet people's individual needs. This included personal needs, assisting with eating and drinking, and challenging behaviour. We saw from care worker files that they received certified training in dementia awareness that included a 'Virtual Dementia Tour' that provided them with an understanding of what it is like for people to live with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty 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 whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received training and understood the requirements of the MCA. Where people had been deprived of their liberty, applications had been submitted to the local authority for a DoLS authorisation. The manager was aware of changes in the case law around DoLS and that additional DoLS authorisations may need to be submitted as a result.

We looked at people's care plans and saw people or their representatives were involved in their care planning and where people had capacity, consent had been sought that confirmed they agreed with the care and support provided. There was evidence that for those people unable to make decisions about their care, decisions were made in their best interests.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST') was completed in peoples care records. A care worker said, "We use MUST to monitor people's diets, if we have concerns we call the GP who can refer the person to a dietician." We saw peoples dietary requirements noted in their care plans. A cook told us, "We receive information on people's individual dietary needs (with regards to eating) from care workers and these are noted in the Dietary Summary Sheet." We observed notes on the summary sheet included information on people who were diabetic, lactose intolerant, and one person who preferred a light diet without spicy food. The cook told us, "We make sure we cater for people as individuals so that everybody is happy and healthy."

People were encouraged to eat healthily. The home had a dining room and people could choose to eat where they preferred, which included in their own rooms. Feedback on the food was positive from people who told us, "The food has improved considerably, we have a new chef and they cook everything fresh, even the soup is made with fresh vegetables," and, "The food here used to be dreadful but the new chef has really turned things around, we have a healthy choice too."

The kitchen had an environmental health officer food hygiene rating [FHRS] award of 5. Ratings are based on how hygienic and well-managed food preparation areas are on the premises. A food preparation facility is given FHRS ratings from 0 to 5, 0 being the worst and 5 being the best. An FHRS rating of 3 is acceptable. The cook told us they were working hard to maintain the rating which included a deep cleaning of the kitchen and the ordering of a new refrigerator to replace the one out of action.

The assisted dining room was spacious and furniture had been set out to facilitate people in wheel chairs. Tables were colourful and there was a choice of juice and water available throughout the mealtime. We observed the lunchtime meal and saw sufficient staff were on hand to support people with eating and drinking if they required it. We observed a calm unrushed atmosphere with people clearly enjoying their food. The menu was varied and people's additional dietary requirements were catered for.

People were supported and their health care needs were monitored. The registered provider told us in the PIR, 'Staff facilitate doctor and hospital appointments and support people to engage with medical professionals if needed.' Any changes in people's health or well-being prompted a referral to their GP or other health care professionals such as a district nurse or opticians. One person we spoke with confirmed that they were able to access their GP when needed. They said, "I will ring them myself or ask the staff to arrange it." Another said, "They come whenever I ask to see them."

Records in people's care files indicated they had been supported to access health care professionals, such as GP's, practice nurses, hospital consultants, district nurses, chiropodists, occupational therapists and physiotherapists. Any advice or guidance from healthcare professionals was incorporated into people's care plans.

Good

Is the service caring?

Our findings

A relative of a person receiving a service at the home told us, "They [care workers] really do provide great residential care and care workers are so considerate to [Person's] needs." They said, "We looked at lots of homes and had a good feeling about this one from the start, and we have been proven right, [Person] settled in so quickly, we are very pleased." Another relative told us, "They [care workers] are very committed and really support people to remain independent, [Person] receives a care and support package in sheltered accommodation and they have the option to pay for meals and utilise the residential homes restaurant so they are familiar with the whole environment."

We asked staff how they knew people in the home. They told us "We get to know people by spending time with them and also by speaking with their families and other people involved in their care and support," and, "We can look at the care plans, they are personalised and have a section called 'What's important to me' this contains background information on the individual." We saw this information helped to develop a personalised service for people and included information on things people liked to do, being in control of their life, relationships, daily living and leisure time activities. We saw documented plans to provide care and support for people with their end of life wishes and preferences and that these were signed to demonstrate the person had been involved and agreed to the information.

The atmosphere in the home was calm, friendly and busy with people in different areas of the home. Relatives visited their family members and sat with them in communal areas as well as their own rooms. It was clear that regular care workers and other staff knew people. We observed staff chatting to people in communal areas and people responding positively to this. For example, one person was wandering without purpose in the corridor and staff approached them to see if they wanted to go into the lounge, they smiled and held their hand out then followed the staff member to the lounge for afternoon tea.

The manager told us people were assigned a key worker. The registered provider told us in the PIR, 'The key worker system supports and encourages good relationships with residents and family." We found it was not always clear in care plans who a person's key worker was. One person said, "I don't think I have a regular carer but they are all nice." Other people we spoke with told us, "The regular care workers are great, they understand my needs but we have some temporary staff, I think from agencies but they don't always know my needs." We spoke with the manager about this and they told us that people had a key worker and they discussed the possibility of introducing name badges so they could be easily identified by people receiving a service.

We observed care workers supporting people with daily tasks and encouraging people to maintain their independence, such as mobilising around the home, taking part in activities and eating their meals. When speaking with people who were seated, we observed care workers lowering themselves down to the person's level, calling them by name and speaking softly with them. We saw care workers promoted people's privacy and dignity. Staff knocked on people's doors and waited to be asked in.

Any personal care and support was conducted behind closed doors. Care workers told us when supporting

people with any personal care they would always ensure this was done with the person's door and curtains closed as appropriate for the task and would always ensure that people were covered when supporting them with bathing. A care worker said, "I always explain what is happening and encourage the person to do as much as they can."

Care workers understood the need to maintain people's confidentiality. A care worker told us, "We are in a very privileged position and people confide in us like a family member, it is important that we don't share or discuss anything with anybody who doesn't need to know or who is not involved with the persons care, unless of course they are at risk of harm."

The registered provider had information available on the provision of advocacy services. We saw that where people did not have full capacity or were unable to express their views or opinions they were provided with information and assisted to make a referral to an advocacy service. Advocacy is a process of supporting and enabling people to express their views and concerns and enables people to access information and services to promote their rights and responsibilities.

Discussions with care workers revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within the service and by peoples own family and spiritual circles. We saw one person's care plan included, 'Church visits to provide Holy Communion' in response to any religious preferences. During our inspection, we observed the vicar having lunch with the individual in the communal dining room. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

People had received an initial assessment of their needs as part of their application process to the home to receive either residential or community care in their own rooms. This enabled the registered provider to ensure they were able to meet the person's needs and to ensure the service was right for the individual. A care worker told us, "People usually move in and receive community care and support and many remain with the service and transfer to receive full residential care," they went on to say, "This often involves a seamless transition as they are familiar with how the home functions." A person receiving residential care told us they were in receipt of residential care and that they were very happy with the assessment process.

We reviewed four people's care plans, which were centred on the individual. Each file contained personal information about what the person liked to be called, a photograph of the person, next of kin details and their health and medical condition. The registered provider told us in the PIR, 'Care plans contain a section, 'what is important to me' where we record personal history, personal preferences, interests and inspirations.' We saw this provided a basis for person centred care.

The care plans we looked at included risk assessments and associated support plans, which helped care workers to provide support and care that was responsive to their individual needs. For example, we saw that one person had leisure time activities recorded that included attending coffee mornings, visiting relatives and watching television. We saw a note for care workers to 'keep the TV remote accessible to the individual'.

Dependency assessments were in place for people for daily activities that included eating, transferring, moving, dressing, incontinence and mental health. We saw these were scored against the person's ability to be, 'fully independent, requires assistance or requires full support' and appropriate support plans were in place to meet the outcomes.

Care plans were reviewed and where people had capacity they were involved or close family members and other health professionals were consulted to ensure the information was up to date with the person's current needs. However, despite this we saw that information was not always up to date and was sometimes misleading. For example, we saw one person had a support plan in place to provide a healthy diet due to an assessed high body mass index (BMI). Minimum monthly reviews stated 'No change' and reflected that the person 'will choose what to eat', which was not reflective of their identified care needs. We saw a care plan summary detailed a person's health needs but there was no mention that the person had Type 2 diabetes in the summary although this was clearly documented further on in the file. One person was in receipt of a medicine, however this was not detailed in their support plan. We spoke with the manager about these concerns. They told us that the care plans were reviewed and updated and the files we looked at would be reviewed to ensure they were in line with people's current needs. We saw that the support plan for the medication had been updated during our inspection.

We observed some people at the home showed signs of dementia. A care worker told us, "We undertake dementia awareness training so we can understand what it is like for people at the different stages." They said, "We work closely with the persons family, GP and at the later stages we work with other health

professionals to ensure the service remains suitable for their needs or to help them move on to receive a service more appropriate to meet their needs." This meant the registered provider had plans in place to respond to people's changing needs and to provide effective care suitable for their needs that included support for people to transition between services when required.

We saw people were supported to follow their interests and take part in social activities and people were protected from social isolation. We observed a number of activities during our inspection. People were involved in a softball exercise class and other people were competing in some bowling. The activities were full of laughter and we saw people were happy to engage. A care worker told us, "We encourage people to be active and involved as much or as little as they wish."
Care plans included information on activities people enjoyed and the manager told us these were catered for wherever possible. People told us, "I have not been restricted in undertaking anything I want to do, there is knit and natter, art, singalongs and we go out on day trips," "I use the library at the other home and I like to go and sit out in the garden when the weather is warm" and, "There always seem to be some activities to take part in and we can join in with those that are put on for those receiving residential care."

We asked people if they knew how to complain if they were unhappy about any aspect of the service. One person told us, "I would speak to the care workers or the manager" And another person told us, "I don't have much cause to complain now the meals have improved but I would not hesitate to complain to management if I was unhappy, it has to be right, doesn't it?" We looked at how complaints were managed. The registered provider told us in the PIR, 'Complaints are fully investigated with a view to future learning and improvement.' The manager demonstrated the process for dealing with complaints that included a summary of actions, outcomes and a written response to the complainant within defined timescales. We saw that information from complaints and compliments was collated and fully investigated with a view to future learning and improvement.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in place and the registered provider had submitted an application to the CQC, which was in process to certify the individual as the registered manager. The manager was on duty and supported us during the inspection.

The registered provider had a statement of purpose. We saw that this included the visions and values of the service. Monthly audits were undertaken that lead to a quarterly evaluation of the service. We saw that despite some areas of improvement because of, for example medication audits, we found other audits resulted in actions that had not been implemented. For example health and safety audits including those for Fire and Water safety were documented but where actions were identified and recorded, measures in place had failed to reduce or remove the risks within an appropriate timescale where they were associated with a regulated activity. This meant procedures in place were ineffective in monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity. This was a breach of the Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People, staff and relatives we spoke with told us that they felt the manager was approachable and was working hard to improve the standards of care at the home. A care worker told us, "Staff morale in the home has really improved since [Manager] came into post, we have reduced medication errors to almost zero and people living here seem happier too." A relative told us, "[Manager] is approachable and seems to know what is going on around the home." One person receiving a service told us, "The manager has a lot to do but they still take the time to chat."

The manager knew about their registration requirements with the CQC and was able to discuss notifications they had submitted. This meant they were meeting the conditions of registration.

There was a clear management structure in place and staff had an understanding of their roles and responsibilities. The registered provider told us in the PIR, 'The registered manager is supported by a deputy manager and senior care officer plus senior care staff located on site." The manager told us, "I have access to a range of ancillary staff that includes maintenance teams and administration who work for part of the wider group of Joseph Rowntree Housing Trust, I only have to pick up the phone and support is available." During our inspection, we saw the manager speaking with ancillary staff to address some of the concerns we had raised.

Care workers told us they were not always made aware of changes within the organisation but that they were aware of changes in people's needs that were discussed at daily shift handover sessions. A care worker said, "If anything could be improved I would say it would be to have regular supervisions and one to ones as we use these as an opportunity to quiz management on changes and discuss personal concerns." We spoke with the manager about this and further information can be seen as part of our key line of enquiry for Effective.

The manager told us information on the organisation and the home was shared with care workers at monthly staff meetings. The manager provided us with a copy of minutes from the last meeting held in June 2016. Discussions documented in the minutes included, DBS checks, handovers, a watercooler in the community area, agency staff, care plan entries and laundry.

People using the service were encouraged to have their say through service user meetings, which were held for people to have the opportunity to discuss any issues and raise any concerns. Information was shared with people residing at the home regarding approval of a major planning application for the future redevelopment of Red Lodge. The plans approved will result in the erection of 44 residential care suites plus two respite care suites and 105 extra care apartments following demolition of Red Lodge. People we spoke with raised their concerns about the development with us during our inspection. We discussed this with the manager who showed us minutes of a recent residents meeting. We saw the redevelopment had been discussed and a question and answer session had been undertaken to help reassure residents and keep them informed throughout the process.

We saw the registered provider had undertaken an annual survey with people in the home. The survey reflected the themes that incorporate a CQC inspection and summarised questions and responses. For example, they included a section for residents with respect to how caring they felt the service was. The results showed that 70% of respondents agreed staff were caring and supportive, 5% did not respond and 25% strongly agreed. Responses to people knowing their care worker included 20% strongly agreed, 45% agreed and 20% disagreed with 5% not responding. This meant the registered provider had taken steps to make sure that people were involved in making decisions and planning their own care, that they felt listened to, respected, and had their views and wishes respected.

People, staff and others told us and we saw from care plans that people received multi-agency support and care from other health professionals. The registered provider told us in the PIR, 'Red Lodge staff have a good relationship with local GP practices, there is also involvement where needed with District Nurses, CPN's, Consultant Psychiatrists, Speech & Language Therapists, Social Workers and Pharmacists.' This meant people received holistic care that met with their changing needs and preferences.

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not assessed the risks to the health and safety of service users receiving care and treatment and had not done all that was reasonably practical to mitigate such risks. The registered person had not ensured that the premises or equipment used was safe or used in a safe way. Regulation 12 (1)(2)(a)(b)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 17 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider had not received appropriate support, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform.

Regulation 18 (2) (a)