Care Quality Commission

Colourscape Investments Limited

The Lodge

Inspection report

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

Tel: 01904430781

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22 January 2018
23 January 2018

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 17, 22 and 23 January 2018. The inspection was unannounced on day one and we returned to complete a night time visit which was also unannounced. The registered manager was aware we were returning on the third day.

The last inspection took place on the 9 and 22 December 2016 and The Lodge was rated as requires improvement in all domains except caring which was rated good. The home was in continued breach of Regulation 17 Good Governance. Concerns related to poor record keeping. In addition to this a recommendation was made about staffing levels and activities.

The Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Lodge accommodates 28 people in one building. There are 22 bedrooms downstairs with a further six upstairs.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The cleanliness of the home and laundry systems were not meeting expected standards. People and their relatives expressed concerns about bedrooms not being kept clean and clothing had gone missing.

Risk assessments were in place. However, for some people with complex needs in respect of their dementia and behaviours which posed a risk of harm to themselves or others there was a need to provide more direction for staff about how to manage these risks.

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

You can see what action we told the provider to take at the back of the full version of the report.

There had been a number of incidents after 8pm whereby people had become distressed and caused harm to themselves or others. Concerns were raised about the complexity of people's needs and the impact this had on other people as staff were providing one to one care.

In the main, safeguarding referrals had been appropriately made. Staff understood how to recognise and protect people from avoidable harm or abuse and they felt confident that any concerns they raised would be investigated thoroughly. Despite this we found one safeguarding issue which had not been appropriately reported by the registered manager. We have made a recommendation about this.

Systems had been set up to assess the quality of care people received and where improvements were required there was a robust action plan to work through these.

Whilst it was evident a significant number of improvements had taken place under the leadership of the new registered manager and operations manager, further work was required to ensure people received care which was consistently good. We were assured the management team and staff team were committed to driving the required improvement but required further time to do this.

Despite the improvement still required, everyone we spoke with described the service as homely. Due to the relatively small size of the home staff had the opportunity to get to know people well. Staff were kind, compassionate and respected people's diversity.

Staff were provided with the support, training and supervision they needed to deliver effective care. More specialist training on how to support people with behaviours which posed a risk of harm to themselves or others was due to be provided to staff.

The service followed the principles of the Mental Capacity Act (2005). Detailed mental capacity assessments were completed and we saw evidence the service had taken all practical steps to support people to make their own decisions. Where people were unable to make an informed decision there were best interest decisions in place which took into account their previous known wishes.

People told us the food was excellent and everyone spoke positively about the chef. Snacks were accessible for people throughout the day and people helped themselves.

Care planning documentation had improved and we could see the focus was on what was important to the individual. There was a focus on people's strengths as well as a record of the support they needed. People's likes and dislikes were recorded and staff knew people well. There was room for further improvement in care planning to ensure people's changing needs were documented.

People had access to a range of meaningful activities which they told us they enjoyed.

Complaints had been appropriately responded to. The home had also received some compliments about the care people received.

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 consistently safe.

The home was not always clean and there had been significant issues with people's laundry. Risk management plans, in respect of behaviour, were not robust.

Medicines were safely managed.

Staff recruitment was safe. Staff knew how to safeguard people from avoidable harm.

Is the service effective?

Good

The service was effective.

People told us the food was excellent and we received consistently positive feedback about the chef.

Staff received the training and support they required to provide effective care. Staff referred people to the relevant health and social care professionals as needed.

The service was working in line with the principles of the Mental Capacity Act (2005). Staff sought consent from people appropriately.

Is the service caring?

Good

The service was caring.

People, staff and visitors all described the service as being 'homely'.

People had positive relationships with staff who knew them well. Staff were kind and treated people with respect.

Confidentiality was respected.

Is the service responsive?

The service was responsive.

Care planning records were improving and focused on people's strengths as well as the support they needed.

People had access to a range of activities which they enjoyed.

People knew how to make complaints. When complaints had been made these had been responded to in line with the provider's policy.

Is the service well-led?

The service was not consistently well-led.

There had been a significant change in the management team in the last six months and we could see a number of improvements had been made.

We received positive feedback from relatives about the registered manager. However, there was some mixed feedback from staff about how well they were supported.

There was room for further improvement and the regional manager had a clear action plan to ensure these improvements were made.

CareQuality Commission

The Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was a comprehensive inspection which took place on 17, 22 and 23 January 2018. The first day of the inspection was unannounced and we returned on the evening of 22 January 2018 which was also unannounced. We completed the inspection on 23 January 2018. The final day of the inspection was announced.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider was asked to submit a provider information return (PIR) before this inspection. 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. The PIR was submitted within the required timescale.

We contacted the local authority commissioning and contracts team prior to the inspection and sought their feedback. The home had been on an improvement plan with the commissioning and contracts team since June 2016. However, we were told improvements had been made since the new management team started at the service in June 2017. We also received feedback from a visiting health care professional.

Since the last inspection CQC had received six whistle blowing concerns. These related to staffing levels, particularly on a night time, behaviour management and support for staff, infection control, training and the heating system.

Day one of 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. The second day was carried out by two inspectors and the final day was completed by one

inspector.

We spoke with the registered manager, operations manager and 12 care workers and ancillary staff. We spoke with three people who lived at the home and five relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and induction records for four members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said, "They [staff] are decent people" and "There are lots of people around." Two people said there were enough staff, and one commented, "They will come and talk to you if you want them to."

At the last inspection we made a recommendation about staffing levels. Following this the staffing levels at night had been increased from two care workers to three. Prior to this inspection we received concerns about staffing levels within the home on a night time.

We saw sufficient number of staff available to meet people's needs during the day time. During our night time visit we observed staff were busy but there were sufficient staff available to meet people's needs at that time. However, there were some people living at the home who required a lot of support from staff and during our inspection there were two people who were provided with one to one support at variable times. In addition to this, since our last inspection, there had been 17 safeguarding referrals which related to incidents of distress between service users and eight of these had occurred after 8pm. We discussed this with the registered manager who had not noted the number of incidents after 8pm.

Care workers expressed concern about the complexity of the needs of some of the people living at the home. Particularly those whose behaviour posed a risk of harm to themselves and/or others. Comments included; "We do not have enough staff to look after people well, this is because of the complexity of needs of some people living at the home", "It's got worse since the last inspection staffing levels are no better as people's needs are more complex" and "Quieter residents are neglected as we have to spend more time with people who are aggressive."

The registered manager acknowledged there was still some work to do to ensure night staff felt supported. The registered manager had covered some night shifts, arranged night staff meetings, had completed some supervision sessions and had booked some more to help them understand the difficulties.

We saw areas of the home which were not clean. Handrails were sticky to touch in places and some toilets and equipment in bathrooms were stained. The registered manager explained that they previously had three cleaners however they currently only had one. The registered manager explained they were in the process of recruiting two more members of cleaning staff, this had proved a challenge due to the length of time recruitment checks were taking.

We saw the cleaner was working hard to maintain cleanliness at the home but they said it was difficult being just one person. Relatives told us the home was not always clean. Comments included, "They used to have three cleaners who were always busy, and it was excellent. They have one now. My [relative]'s commode is not always emptied and clean", "It was very clean when my [relative] first came here, but now it is rare the carpet is vacuumed. We have raised it at the relative meetings and we are told they are trying to employ another cleaner but nothing happens" and one person said, "I have to bring in wipes to clean the surfaces in my [relative]'s room."

One bedroom had a strong smell of urine. The registered manager explained they were looking at alternative flooring which should alleviate the problem.

All of the relatives we spoke with raised concerns about the laundry. One person said, "My [relative's] clothes are all labelled and often go missing. Once none of the clothes in the wardrobe belonged to her, so I took them all back to a member of staff and told them to find her clothes. She has always been proud of how she looked and this upsets me." The registered manager explained the laundry system to us. However, on checking this we found it was not being adhered to.
The registered manager and the operations manager were aware of the issues regarding the laundry and explained they had created a new position of laundry assistant. They had recruited to this post but the person had given back word due to the length of time it had taken for the recruitment checks to come through. The registered manager explained they would continue to try and recruit to these posts.

Following the inspection the registered manager told us a new laundry assistant and two new cleaners had started at the service. They also told us they had a new system to ensure the laundry operated effectively."

In the main risk assessments had been completed and provided care staff with guidance about how to reduce the risk of harm. Risks associated with weight loss, falls and skin integrity had been assessed and measures to minimise risk had been implemented.

However, we reviewed the care plan and risk assessments for one person whose dementia meant they displayed behaviour which posed a risk of harm to themselves and others. We looked at the daily notes for January 2018 and saw there was recorded evidence of the person being 'physically aggressive' towards care staff and other people living at the home on at least five occasions. The person had been referred to the specialist mental health team to review the support they needed. However, there was no risk assessment to provide staff with guidance about the risk of harm this person could pose to themselves and others and there was no clear guidance for staff about how these risks could be mitigated. There was evidence of care workers providing one to one support which meant they were not then able to support other people living at the home. Night time care workers we spoke with were concerned about the amount of support this person required and the impact it had on the care they could give to other people living at the home.

There was evidence they had been working closely with the GP and the community mental health team to review the support this person required. However, the registered manager was not aware of the number of recorded incidents of 'physical aggression' and agreed they would look into this further.

We were concerned people were not receiving consistently safe care and treatment because risk assessments were not always in place where people displayed behaviours which posed a risk to themselves or others. Infection control and prevention measures also required improvement.

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

During the day we saw staff spent time with people. They offered reassurance and chatted about each other's lives. There were sufficient staff available to meet people's needs. The registered manager explained that staffing levels were assessed using a dependency tool. They were confident there were enough staff to meet people's needs. Minimum staffing levels were one senior care worker and two care workers. During the daytime there were other ancillary staff available who also supported people.

All of the relatives we spoke with during our inspection told us there were enough staff to keep people safe.

Comments included, "They [staff] are diligent", "Mum was wary when she first came here but has settled and that is down to the staff" and "They [staff] chat with me about how Dad is doing and tell me to come to them if I have any concerns."

Staff had been recruited safely. Applicants had completed application forms, two references had been sought and a Disclosure and Barring service (DBS) check carried out. DBS checks provide information about any convictions, cautions, warnings or reprimands. These checks help employers make safer recruitment decisions and are designed to minimise the risk of unsuitable people working in health or social care settings.

The registered manager told us they had spent time supporting staff to recognise potential abuse. Staff demonstrated a good understanding of how to safeguard people who used the service, they were aware of the types of abuse and how to report concerns. Staff had received safeguarding training. They told us they would always share any concerns with the manager or a senior member of staff and they were confident their concerns would be taken seriously and action would be taken to keep people safe.

Since the last inspection the service had made a number of safeguarding alerts. We could see the registered manager had been open and transparent regarding any potential abuse and had worked with the local authority to ensure investigations were completed and lessons learned.

However, we saw one safeguarding incident which the registered manager had not referred to the local authority. We discussed this with them and they explained they had not referred this as they did not believe the person had come to harm.

We recommend the provider reviews the systems in place for referring safeguarding matters.

Accidents and incidents were recorded and reviewed by the registered manager and the operations manager. Any actions required to reduce the risk of harm had been taken.

There had been problems with the boilers at the home which meant electric heaters had to be used to ensure people were kept warm. Risk assessments were in place regarding these. On the first day of our inspection we noted the corridor (in the extension) and some of the communal bathrooms were cold. The registered manager arranged for the handy person to take the temperature, which in the corridors was recorded as 17 degrees. The registered manager arranged for electric heaters to be used as a temporary measure. A new boiler was installed during our inspection. The registered manager told us this was the second boiler which had been replaced (out of three) and anticipated this would resolve the matter.

Medicines were safely managed. The service used a monitored dosage system (MDS) which was prefilled by the local pharmacy. We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. Safe systems were in place to manage controlled drugs. Care workers who administered medicines received up to date training and medicines competency assessments had taken place. We saw staff sat with people whilst they took their medicine and offered encouragement where it was needed.

There was a fire risk assessment in place and the fire alarm system, emergency lighting and fire extinguishers had been serviced. Weekly and monthly fire safety checks were carried out by the home's handyperson. Personal Emergency Evacuation Plans (PEEPs) had been completed for each person who used the service and contained detailed information regarding the level of support people would need in an emergency situation. These were located centrally in an emergency file and this meant they were easily accessible.

Essential safety checks had taken place. There were gas safety and electrical installation certificates in place and the emergency call system, hoists and slings, and passenger lift had been serviced. Portable appliances had been tested.

Good

Is the service effective?

Our findings

The registered manager told us that new staff had an initial meeting with them where they discussed their expectations, "I expect high standards from the staff team and provide the training and support they need." They told us new care staff completed electronic learning and then an induction which included shadowing more experienced care workers. The registered manager also told us that new care workers completed the Care Certificate. This ensured care workers received a standardised induction in line with national standards.

One care worker told us, "I received excellent support when I started; I did some on-line training and then completed a full day of first aid training and medicines training (face to face), then I was assessed three times to make sure I was giving people their medicines safely." Overall staff told us they felt well supported by the registered manager. Although one staff member told us, "I think we would benefit from more in depth training around dementia."

Staff had received essential safety training which included; basic first aid, infection control, fire safety, medication and moving and handling training. However, the home supported people with complex needs in relation to their dementia. Some people displayed behaviour which posed a risk to themselves or others. The registered manager had arranged some specific training for staff to support people with challenging behaviour but at the time of our inspection only three staff had attended. They told us more training was booked.

Records showed that staff supervision meetings had taken place on a regular basis. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs.

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

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

The registered manager and staff team understood the principles of the MCA. We saw records which showed that staff completed assessments of people's capacity in line with the legislation. Where people lacked the capacity to be involved in specific decision making we saw that their representatives were involved in the decision making process. We observed staff consistently offer choices to people and seek their consent. One person had been supported by an Independent Mental Capacity Advocate (IMCA). IMCAs support and

represent people who lack capacity in respect of decision making.

One person had a best interest decision in place to receive their medicine covertly, for example this would be placed in food. All of the relevant people had been involved in this decision making and staff explained they administered medicines to the person covertly as a last resort and always tried to encourage the person to take their medicines first.

We received consistently positive feedback about the food. Comments included, "Great food," "Eating is an issue for [relative]. They lost a lot of weight before coming here. The staff are aware so they help if needed and [relative] has put weight on," and "The chef makes a birthday cake for people and makes a big thing of Christmas." Relatives and people we spoke with gave consistently positive feedback about the chef. One person said the chef was "A treasure" and another commented "He is more than a chef." We observed the chef and kitchen staff spend time in the dining area; they talked with people about the food on offer, gave choices and encouraged people to eat.

Snacks such as individually wrapped biscuits, chocolate and crisps were available in the main lounge area and we saw people helping themselves to these throughout the day.

People's nutritional needs were assessed and their weight was monitored. Where concerns had been identified about people losing weight the service had sought appropriate advice from relevant healthcare professionals. This was recorded within their care plan.

People were supported by GPs and community nurses, and other health professionals such as mental health nurses and support workers, physiotherapists and dieticians. All contacts were recorded, to include any advice offered by health care professionals. We saw details of a person's health conditions were included in their care plan. A health professional we spoke with said, "Sometimes the staff are a bit thin on the ground and are working beyond their capabilities." However, they went on to say, "Staff know people well, they follow our advice and refer people to us appropriately."

The environment was not purpose built and the corridor downstairs went around in a loop. Whilst this enabled people to walk around freely it meant there were spaces on corridors where people were out of sight. We observed a number of people walking around the corridor throughout the day. Some work had been undertaken to make the environment dementia friendly. The majority of people living downstairs had memory boxes on the walls outside their bedroom to help them identify their room. However, these were not in place upstairs. Redecoration was underway to ensure the home was accessible for people living with dementia. The operations manager told us this was work in progress.

Good

Is the service caring?

Our findings

All of the relatives we spoke with told us staff were kind and treated their relatives with respect. One relative said, "My [relative] often refuses to be washed and shaved and gets distressed. So they leave him for a while and go back, by which time he lets them attend to his hygiene. They allow me to help if I want to as I cared for him before he had to come into the home. I appreciate this."

We saw positive relationships between people who lived at the home and the staff team who supported them. One person chatted with a member of staff before they left for the night. They said, "We've had a real laugh today haven't we? The day has gone fast." Care workers spoke fondly to people and shared stories about their own lives. When people became distressed staff intervened and offered reassurance. For some people who were reassured by touch, staff held their hands. We saw care workers walking alongside people who were distressed. They displayed a calm approach and helped to reduce people's distress.

We were consistently told by relatives and staff that the service was "homely" and had a "calm atmosphere." Staff knew people well and understood their individual likes and dislikes. They were able to describe people's preferences and how they liked to be supported.

During our observations, including our SOFI observation, we noted staff respected people's individual choices and preferences in a compassionate and caring way. We could see that people dressed in their chosen style.

People were supported to keep in touch with family and friends. Relatives confirmed they were able to visit at any time and were always made welcome by staff. We saw relatives spent time with people over lunch and lunch was a sociable occasion.

We saw a number of relatives and friends visit during our inspection and one visitor brought in their pet dog. There was a lively atmosphere which people enjoyed.

A member of staff said, "Residents are happy. This is the feel I get from staff too. I think families see what a good job staff do, how caring they are and they respect what we do." Another said, "It's homely. People are happy and we're very caring, we have some fantastic staff." The registered manager said, "We have a loyal and dedicated staff team who want it to work for the residents."

We saw staff addressed people by their preferred names and knocked on people's bedroom doors before entering, which protected people's privacy. Staff closed people's bedroom and bathroom doors when they provided personal care which maintained people's dignity. People's confidentiality was respected and care records were stored securely.

Good

Is the service responsive?

Our findings

At the last inspection we made a recommendation about activities. At this inspection the registered manager told us they had done a lot of work to improve activities for people living at the home and to engage with the local community. During our inspection there was lots of activity for people to enjoy. When structured activities were not taking place we saw people chatted with staff and looked at books and magazines or listened to music or watched a DVD of their choice.

The registered manager explained they had recruited two activities co-ordinators who provided activities over a seven day period. The member of activity staff recruited to work at the weekend was undergoing recruitment checks. A range of activities were on offer to people; one to one sessions, reminiscing, movement activities and games.

Relatives provided positive feedback. Comments included; "[Activity co-ordinator] is great. My [relative] doesn't communicate and hasn't got involved in anything for years. I cried when [relative] gave me a Christmas card he had made with [activity co-ordinator]", "I haven't seen my [relative] do anything for years, but [activity co-ordinator] got her involved with a word search and colouring. She is really good with the residents."

Alongside this the registered manager had set up two sessions per week of armchair exercise. During the first day of our inspection we observed a chair exercise class. This was provided by an external facilitator who was supported by a care worker and we saw six people enjoyed this. After the group exercises other people were supported with one to one exercises. People were laughing and enjoyed it. A relative told us, "The exercise classes are great and the lounge really comes alive."

Over the Christmas period the registered manager had arranged for local school children to visit and sing Christmas Carols. They told us they had applied to the donkey sanctuary to have a donkey visit the home and had talked to people about a home pet; some people would like a cat so this was being considered.

Overall we found care plans were person centred and focused on people's strengths as well as the support they needed. They provided staff with clear guidance about how to support people. They contained information about what was important to people and their likes and dislikes. In addition to the detail within care plans we saw staff knew people well. People told us they were involved in planning the care their relatives needed. One person said, "I have good two way communication with the care staff, we talk all the time about what [relative] needs."

However, we also found some information within daily records which indicated people's needs had increased and whilst we saw care staff were aware of this and were providing the support people required or seeking support from appropriate health and social care professionals this was not consistently recorded within the care plan and risk management plans did not reflect this. The registered manager told us they had worked hard to improve care plans but acknowledged there was some further work to do.

We reviewed a pre admission assessment which did not refer to the information recorded about the person on the discharge summary from the hospital. The person displayed some behaviours which posed a risk to themselves or others and required a significant amount of support from staff. The assessment and care plan did not reflect the complexity of their needs. The registered manager and staff were providing as much one to one support as they could however this had not been commissioned. This meant staff were taken away from supporting others. We discussed this with the registered manager who explained they had not completed the pre admission assessment and said they would have asked more questions as the person had previously been on a specialist dementia ward in hospital for some time.

The registered manager explained they had set up a new information booklet for people and their families which had been designed to help people and their families settle into the home.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were recorded in care plans and all staff we spoke with knew the needs of each person well. We noted that individuality was valued and that people were seen as individuals rather than staff focusing on their diagnosis.

Whilst no one at the home was receiving end of life care at the time of our inspection the registered manager told us they would work closely with the relevant health professionals to ensure people received the support they needed.

The service had received three compliments since our last inspection. The registered manager had recently received positive feedback from a local authority care manager about the home. The email read, "I was impressed with the care file, it was well presented and easy to read. It was up to date and reviewed regularly and staff knew the service user well."

Relatives told us they knew how to make a complaint. However, on the first day of our inspection we noticed the complaints policy was not on display within the home. We spoke with the registered manager who agreed they would ensure the policy was available for people and their relatives or advocates. When we returned on the second day we saw information about how to make a complaint was available on the noticeboard in the entrance area. This demonstrated the registered manager acted on feedback.

The service had received 12 complaints since our last inspection (both formal and informal) these had been investigated and the complainant had been given feedback. This included an apology where appropriate.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in December 2016 we found the home continued to be in breach of Regulation 17 Good Governance. Concerns related to the accuracy of record keeping, in particular food and fluid charts and personal care records. During this inspection we observed record keeping had improved; food and fluids charts and personal care records were completed and there were generally clear and accurate records of daily activities and contacts with families and health and social care professionals.

The home had undergone significant changes with the management team in the last six months. The registered manager had started work at the service in July 2017. They were supported by an operations manager who had joined the organisation in June 2017.

The registered manager told us they had found a number of problems when they started work at the home and had worked closely with the operations manager and staff team to improve things. They said, "Staff work their socks off but they didn't have the leadership they needed. They were keeping the home running to the best of their abilities but were left to self-manage." They told us one of their biggest challenges had been staffing issues and they had started afresh with staff supervision and training as they were concerned the records kept previously were not accurate. Whilst a number of additional staff had been recruited there was an ongoing programme to recruit care and ancillary staff. A significant amount of work had been done to improve care planning records and to ensure they focused on the person. In addition to this the registered manager said they had worked hard to improve activities for people living at the home.

The operations manager explained some of the challenges they found when they took over, "There was no real leadership. The culture change which was needed has taken a long time. I think we're really getting there and staff can see we are working hard. We've focused on quality audits, reporting safeguarding concerns, relationship building and improving the reputation of the home."

Despite these improvements there remained some inconsistency in the feedback we received from staff about how supported they felt and the management teams understanding of the complexity of people's needs, particularly on a night time.

Whilst it was clear the management team had completed a significant amount of work and they were invested in improving the home, both the registered manager and the operations manager acknowledged there were further improvements to be made. They had a detailed action plan to ensure these improvements were made. This covered the key area where improvement was required, actions taken or required and who was responsible with a clear timescale. The issues we identified during our inspection were known to the management team and they had a plan in place to try to improve the situation. For example, care plans had been reviewed and the plan was that a new electronic system would be rolled out which the operations manager told us should improve consistency. The registered manager had recruited a laundry assistant on three separate occasions but they had not started for a range of reasons. This demonstrated there were plans in place to drive improvement but it would take longer than the six months they had had to date.

The operations manager said, "The team have worked remarkably hard, we have made improvements in a short period of time. We have developed good relationships with the local authority commissioning and contracts team, they have been a great support and have offered a critical eye."

The home had been under scrutiny from the local authority and had been on an improvement plan since June 2016. This meant commissioners were keeping close oversight of the home. The contracts officer told us the home was improving. They explained the registered manager and operations manager were open and transparent and they had been working with them and were committed to improving the home. They said, "The [registered] manager is open to feedback and has been proactive in inviting peers in to provide such feedback."

Effective systems had been developed to monitor the quality of the service delivered and there were robust systems in place which identified improvements required. These systems had been in place for six months and needed time to be embedded. We saw evidence of a range of quality assurance audits completed by the registered manager; care plans and documentation, pressure area care, weight management, infection control and health and safety. In addition to this the handy person completed a range of essential safety audits; for example fire alarms, emergency lighting and water temperatures.

An infection control audit completed by the registered manager in January 2018 had identified concerns with the cleanliness of the home. The audit had been scored as 84 per cent meaning actions were required for improvement. The registered manager had identified some bathrooms needed a 'deep clean'; some staff required infection control and prevention training and noted the bedroom which had an unpleasant odour. There was a list of actions required to improve this which demonstrated the registered manager was working to improve this.

These audits were signed off by the operations manager and they completed a 'monthly operations visit'. This included a review of care plans, incidents and accidents, weight management and safeguarding issues. This meant the provider had good systems in place to oversee the quality of care being delivered.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Policies and procedures were up to date and provided staff with good practice guidance. Staff understood their roles and responsibilities. One member of staff said, "I think we're making steady progress. The staff team are on board and working with the process and I think staff would, generally speaking, say they felt well supported."

Relatives told us when the registered manager started at the home they were sent an introductory letter so people knew who she was and they were advised relatives meetings would be started again. There was a sense of confidence in the registered manager. One relative told us, "The [registered] manager is honest and open about improving [The Lodge] and talks openly about the previous CQC findings. I am impressed with what she says she is going to do to improve things." All of the relatives we spoke with were positive about the registered manager and their leadership style. Comments included, "She is visible", "Very ambitious, knows what she is aiming for and has improved things", "She is very approachable", "She has really lifted the game" and "[Registered manager] interacts with the residents and relatives and is approachable."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risk of harm from the spread of infection due to a lack of consistent cleanliness and laundry systems. Risk management plans were not always robust for people whose behaviour posed a risk of harm to themselves or others. Regulation 12 (2) (a) (b) (h).