Bliss Family Care Limited

The Lodge Residential Home

Inspection report

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Date of inspection visit:
21 August 2017

Date of publication:
07 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Lodge Residential Home provides accommodation and personal care for up to 32 older people. There were 29 people living at the home care at the time of the inspection.

At the last inspection in July 2016, the service was rated Good; at this inspection we found the service to require improvement in four areas and inadequate in the management of the home. We carried out this inspection following information of concern from members of staff and the public.

People's experience in the home differed according to their ability to speak for themselves and their dependency on staff to help them to mobilise and receive personal care. The majority of people were happy at The Lodge Residential Home as they were mobile and could choose how to spend their day; they had built positive relationships with staff and received care that met their needs. However, there were not always enough staff to meet everyone's needs and this had led to situations where staff were not always kind to a minority of people using the home. People's dignity was not always maintained and people were not always treated with respect.

The registered manager had not followed the provider's safeguarding policy as they did not always report issues of concern to the safeguarding authority or CQC. Staff had reported their concerns directly to the local safeguarding authority and CQC to safeguard people from potential harm, as the registered manager did not always respond to their concerns.

People could not be confident that their verbal and written complaints would be responded to in line with the provider's policy, or that they could make a complaint without fear of reprisal. People had provided feedback about the lack of staff, reduced activities and the negative behaviour of staff but the registered manager had not taken any action to resolve these issues.

The provider had not recognised that the registered manager required support and supervision. Staff had not had all the training, supervision or support they required to carry out their roles. The registered manager had not developed good working relationships with staff or got to know people living at the home.

The provider and the registered manager failed to ensure there were enough systems and processes in place to monitor the quality of the service. They had not identified that people's risk assessments and care plans did not reflect people's current needs or that staff had enough information to provide people's care.

People received food and drink that met their needs. However, there was not a reliable system in place to ensure that staff understood people's dietary needs.

People's health needs were monitored and responded to appropriately. People received their medicines as prescribed, but the systems required updating to ensure staff were competent to administer medicines.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and people's consent was recorded. People were protected from the risk of unsuitable staff through safe recruitment procedures. People lived in an environment that was safe.

There were eight breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one Regulation of Care Quality Commission (Registration) Regulations 2009. The action we have taken can be seen at the end of the full 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.

People were at risk of unsafe care as the systems to safeguard people were not always followed.

Staffing levels were not consistent to ensure that people's care and support needs were always safely met.

Risk assessments were in place however these did not always reflect people's current needs.

People received their medicines as prescribed, but the systems required updating to ensure staff were competent to administer medicines.

People were protected from the risk of unsuitable staff through safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by staff that did not always have the training, supervision or support they required to carry out their roles.

People received food and drink that met their needs.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and people's consent was recorded.

People's health needs were monitored and responded to appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always have good relationships with staff.

People's dignity was not always maintained and people were not

always treated with respect.

People were not always listened to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's complaints had not always been addressed appropriately, the registered manager did not always follow the complaints procedure.

People's needs were not always met in line with their individual care plans and assessed needs.

People's needs were assessed prior to admission.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of systems to identify and monitor the quality and effectiveness of the care that people received.

The manager did not always take action where they had identified issues that affected people's care.

People did not have their feedback about staffing levels responded to.

The provider had not recognised that the registered manager required support and supervision.

The Lodge Residential Home

Detailed findings

Background to this inspection

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

This unannounced comprehensive inspection took place on 21 August 2017 by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We carried out this inspection following information of concern from members of staff and the public.

Before the inspection we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted and met the health and social care commissioners who monitor the care and support of people living at The Lodge Residential Home.

During this inspection we spoke with 13 people using the service and three visiting relatives. We spent time in the communal areas and observed the interactions and care for 18 people. We also spoke with six members of staff including the provider, the registered manager, a team leader, two care workers and the cook.

We reviewed the care records of people that used the service including medicines records, daily records and charts and three care plans. We looked at the recruitment, supervision and training records for four members of staff. We also reviewed records relating to the management of complaints, staffing and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm as the registered manager did not always take the appropriate action. Staff understood their responsibilities to safeguard people from the risk of harm; they reported their concerns to the registered manager. However, during the last two months staff had raised their concerns directly with Care Quality Commission (CQC) as they did not feel confident that their concerns had been acted upon. We found not all concerns raised by staff had been reported to the local safeguarding authority. For example we found a photograph of a person who had trapped their legs in their bed rails. Staff had reported this to CQC as the registered manager had failed to record this event or report this to the local authority safeguarding team. We had raised the incidents directly with the safeguarding authority. Staff had acted appropriately in accordance with the safeguarding and whistleblower policy. This was brought to the attention of the registered manager who could not account for why these incidents had not been reported but they told us they thought that they did not need to report the concerns as CQC had been informed by the whistleblower.

People had not been protected from the risk of abuse or improper treatment and there were no systems in place to report or investigate allegations of abuse. This is a breach of Regulation 13 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

There were not always enough experienced staff deployed to keep people safe and to meet their needs.

People told us they had to wait for care. One person said "They [staff] have a lot to do, you do have to wait, you just wait." Another person told us "I think we could do with a couple or three more staff as I have two staff [when I have personal care] and I am left to wait sometimes." One relative told us they felt there was not enough staff; they said it had an impact on their relative: "Recently he was left on the toilet for 20 minutes." Staff told us "We are short of staff a lot, there is supposed to be four staff, but more often we have three, which means that people don't get their baths." Another member of staff told us "We have never had agency (agency staff) before now, we are constantly rushing around, there is not enough staff anymore." We observed people waiting for help and there were extended periods of time when there were no staff in the communal areas; people who were at risk of falling were at risk of falls due to the lack of supervision by staff.

Although the registered manager assessed the dependency of each person they told us they did not use this information to calculate how many staff were required to meet people's needs. The registered manager told us "The number of people requiring two care staff has increased in the last year, there were now eight people requiring two care staff. We ideally require four care staff to be on duty at all times during the day to meet people's needs." The rotas showed that between 31 July and 20 August there were 12 shifts that had only three care staff allocated. The rota also showed that where there were no staff allocated for laundry, domestic and kitchen duties and care staff were allocated to these duties instead of providing personal care. This meant that there were not always the required four care staff deployed to meet people's needs during the day.

The registered manager had advertised for permanent and bank care staff and was in the process of recruiting more staff. Agency staff were used until new staff were employed. The provider and the registered manager advised they would start to use people's dependency to calculate staffing levels. They also had plans to employ an administrator to free senior care staff to provide care.

The registered manager did not have a system in place to ensure there were enough staff deployed to meet people's needs. The provider failed to ensure there were enough staff employed to meet people's needs. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

People's risks assessments were not consistently reviewed as their needs changed. For example records showed one person had fallen four times in 18 days; their risk assessments and care plans had not been updated which meant staff did not have a clear plan of care to help prevent them from falling. Staff had placed a sensor mat in the person's room to alert staff to the person mobilising when they were in their room. However, we saw the person sitting in a chair in their room; the sensor mat was placed under the bed and would not alert staff to them getting up out of their chair. This person continued to be at risk of injury due to falls. We brought this to the attention of the registered manager who updated the risk assessments and referred the person to the GP for a falls risk assessment.

People's risk assessments were not always calculated correctly. People's risk assessments did not take into account all of the information required to make an assessment. For example one person had discoloured fragile skin, this information had not been indicated on their skin or nutritional assessments; staff had indicated they had healthy skin. As a result, this person's risk assessment showed they were at low risk of damage to their skin, whereas they were at high risk and required specific care to protect them from skin damage.

The registered manager told us that "The risk assessments is an area which I accept needs to improve and will happen immediately, this has already been cascaded to the relevant person to ensure they rectify this."

There was no reliable system to prevent people from multiple falls. The registered manager did not have a reliable system in place to record the numbers and types of incidents occurring in the home. People's daily records showed that people had incurred falls; however, the registered manager did not have this information. This meant the registered manager did not have all the information they needed to prevent future falls or refer people to the GP or falls prevention team. The registered manager told us "We will be purchasing accident books in place of the forms; this will ensure that information is in one place." They also told us that they planned to put a staff communication book in place to improve their system.

The registered manager failed to assess people's risks accurately or update risks as their needs changed. People did not always have clear plans of care to mitigate the assessed risks This is a breach of Regulation 12 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People received their medicines as prescribed. Staff had received training in the safe administration, storage and disposal of medicines and they demonstrated how to safely administer medicines to people. However, the registered manager did not have a reliable system of checking staff competency; staff completed a medicines competency test but these had not been assessed for their accuracy. Although records showed that people received their medicines at the prescribed times, where medicines were given' as-required', the

times they were given were not recorded. There was a risk that people could receive 'as-required' medicines too close together. We brought this to the attention of the registered manager, they implemented a system of recording the times these medicines were given; we have not been able to assess this system for its' effectiveness. The registered manager carried out regular audits of the medicines administration records and followed up on any issues identified, for example, where staff had not recorded all the medicines which had been administered.

We recommend that the registered manager implements a system to check the written staff medicines competencies.

People could be assured that prior to commencing employment in the home, all staff applied for and were interviewed through a recruitment process; records confirmed that this included checks for criminal convictions and relevant references.

Requires Improvement

Is the service effective?

Our findings

People received care from staff that did not always have the skills and knowledge to meet their needs. New staff had an induction and training in areas such as safeguarding, first aid and moving and handling to prepare them for their role. However, where staff had carried out a competency test to demonstrate their knowledge from the training, these had not been reviewed. The registered manager did not have a system in place to ensure that staff understood their training.

Staff did not always receive their training updates in a timely way. The registered manager had recognised that not all training had been updated; the rota and records showed that staff had been booked to receive training in the near future in key areas such as falls management, food safety, health and safety and infection control. Staff required the updated training due to the increasing dependency of people in the home. The registered manager had been made aware that staff may not have all the training they required. For example during the resident's meeting in April 2017, one resident was concerned; they had asked "Are all the staff trained?" Not all staff had received training in the care of people living with dementia; this had an impact on people living at the home with dementia as there were no clear plans of care for their specific needs.

Staff were not always supported to carry out their roles. Staff had received supervision but this had not been carried out regularly. The provider's policy stated that staff should receive supervision four times a year; records showed most staff had not received supervision since March and April 2017. Staff told us "We don't get much time to meet up, we are short of staff." Staff had not received their annual appraisal. The registered manager told us that this had yet to be arranged.

Staff did not receive appropriate support to carry out their roles in the form of competency checks, regular supervision or annual appraisal. This is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . Staffing

People received food and drink that met their individual needs. People had been assessed for their risks of not eating or drinking enough to maintain their health and well-being. Staff monitored people's weight regularly. People were provided with equipment such as plate guards where necessary to help maintain their independence with eating. At the time of our inspection no one required assistance to eat.

People had a choice of meals and people told us there was always enough food. One person told us "We choose our main course for lunch the day before, they will come round and ask what we want for tea, cold, hot or sandwiches and then we choose tomorrow's lunch. Today it's strawberry tart, Bakewell tart, or apricot crumble. The cook today, her crumble is to die for."

However, the kitchen staff did not have all of the information about people's dietary needs such as a diabetic diet. Although permanent care staff were aware of people's dietary needs, due to the use of agency staff, there was a risk that people could get a meal that did not meet their needs. We brought this to the

attention of the registered manager who took immediate action following our inspection. They told us "A form is now in place to inform kitchen staff of any special nutritional needs and any diabetics."

We recommend that a system is put in place to ensure that the information about people's dietary needs is maintained to reflect their current 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There were no people in the home who were subject to a DoLS.

The registered manager and staff understood their roles in ensuring people's capacity to make decisions. They were in the process of updating the care plans to include people's written consent to care.

People's healthcare needs were met. Staff maintained records of when healthcare appointments were due and carried out, such as GP review of medicines, eye tests, dentist and the chiropodist. One person told us "If anyone has a fall they quickly get medical staff or paramedics. I've had several falls and ended up in the infirmary." Staff reported changes to people's needs to the registered manager. For example one person's chair no longer met their needs. The registered manager had referred them for an assessment for a new chair.

Requires Improvement

Is the service caring?

Our findings

People did not always experience relationships with staff that were caring. Although the majority of people (23 people) who were independent told us they received care from staff that were kind, some people who required staff to meet their mobility and personal care needs told us that some staff were not. This related to six people.

Some staff did not treat people with respect. For example one person had become confused over the time of day and had come down stairs early. Their relative told us that this had led to a discussion with staff which ended with staff calling him a liar. This had continued the person asking them all to 'smile it off' with another member of staff who calmly said to the resident 'I don't smile at liars'. We saw that staff had recorded the incident in a derogatory way where staff referred to the person as 'a fibber'. We brought this to the attention of the registered manager. They agreed the staff action did not demonstrate respect and they would speak with the staff involved and reiterate that staff should treat people with dignity and respect at all times.

There were some staff that people did not like. People told us that although most of the staff were nice to them, some staff were not always patient. For example one person told us that most of the staff were kind but "There are two or three [staff] that can be a bit nasty but you just have to ignore that". We informed the manager of the staff that people referred to ensure this issue was addressed with staff.

Staff did not always ensure that people received care that maintained their dignity. One person did not always get help to shave every day; he told us this upset him. Their relative told us "Yesterday was the garden party, [name] wanted to be a bit smarter and asked for a shave but they [staff] didn't do it until this morning." This person was not helped to maintain their appearance at a time when the home had many visitors or at a time the person requested it for a special occasion.

Staff did not always maintain people's dignity or their confidentiality. We observed people waiting for personal care after lunch. One person expressed their concern at waiting too long for their care. The member of staff replied that they had not been available due to 'other people having had accidents needing their care first.' This referred to people who had been incontinent.

People were not always listened to. For example we observed one person being moved in their wheelchair to the breakfast table. They said "I don't like sitting in a draft, I'm cold." They were wearing warm clothes, except their legs were bare. The staff moved the chair out of the doorway, but they did not respond to their complaint of being cold, or cover their bare legs.

Staff did not always communicate effectively. On two occasions staff helped people to move from their wheelchair to an armchair. On both occasions staff failed to explain what they were doing in a timely way and people became anxious. One person shouted out "What am I doing? Where am I going?" Staff had not ensured that people understood they were going to be hoisted and did not provide information or reassurance until they were prompted by people's anxiety.

People had signage on their doors that did not maintain their dignity. The A4 size signs read '[Name] this is not a toilet.' and '[Name] this is not your room, do not enter'. People did have their names on their bedroom doors but these were in such small writing it was difficult to read whose room it was until you were very close. There were many signs around the home of a negative nature, stating what could not be done which made the home appear more like a work place than a home. We brought this to the attention of the registered manager who said they would remove the signage and put more appropriate pictures and signs, for example to demonstrate where the toilet was.

People were not consistently treated with dignity and respect. This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

People's experience in the home differed according to their ability to speak for themselves and their dependency on staff to help them to mobilise and receive personal care. Most people (23 people) experienced good relationships with staff, one person told us "All the care staff are lovely, they are very helpful." Another person told us "Staff are excellent, I can't fault them." People who were independent enjoyed living at the home, we observed one person putting some music of their choice on in the communal area.

We observed care for people who were able to express themselves clearly that was considerate and kind. One person told us "We are well looked after, they are very good the carers here, they keep the place clean and keep us clean." Another person told us "I like living here, the staff are lovely." They told us their visitors were always made to feel welcome.

People's rooms reflected their personalities and contained items such as photographs that helped create an environment that was familiar and homely. However, not all the rooms had the facility to provide for people's belongings. One person told us "The laundry is good, but I don't have much room for my clothes." We observed that their wardrobe space was very small and their clothes were hanging in the room.

Requires Improvement

Is the service responsive?

Our findings

People had made verbal complaints to staff which had not been recorded and there was no evidence that these complaints had been acted upon. For example people complained about the reducing amount of activities and one person was complaining about their jewellery being missing. People could not always be confident their written complaint would be managed appropriately. The record of complaints revealed that where people or their relatives had made complaints their concerns had on two occasions resulted in conflict with the registered manager. One relative told us when they complained they had been unhappy with the way they had been treated during the complaint and it was not resolved to their satisfaction. Another person had experienced hostility from staff and was accused of being a liar. This had left two people and their families not feeling confident that they could raise concerns without fear of further conflict. The registered manager had not used the complaints they had received as a learning opportunity to drive improvements in the home; the information had not been shared with staff to help prevent future complaints. The information about the detail of the complaints and their outcomes had not been shared with the provider to ensure the provider had oversight of the concerns being raised in the home.

The lack of recording and appropriately responding to complaints constitutes a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . Receiving and acting on complaints.

Staff could not rely on the information about people's care needs from the care plans. For example staff had recorded that one person had a pressure sore forming in April 2017 and continued to require treatment in August 2017. Although this persons' risk assessment and care plans had been reviewed monthly, they had been assessed as low risk of skin damage and the care plan updates indicated no changes to their plan of care since December 2015. This person had broken skin that had developed into a pressure sore, they were at high risk. People were at risk of receiving care that did not meet their needs as staff did not have a care plans that reflected people's current needs.

Staff were not always reliably informed of changes in people's care needs. There was a system in place to provide staff with updated information whereby staff signed to say they had read and understood the changes to people's care; some staff had signed the forms on the day of the changes, but staff on subsequent shifts had not signed the forms. There was no reliable system to ensure staff had been made aware of changes and understood people's current care needs. For example one person's care needs had changed to require care staff to help provide their personal care. Another person required creams to their skin. This information had been passed to three staff on the next shift, but had not been passed onto staff on the subsequent shifts. People were at risk of not receiving care that reflected their current needs as there was not a reliable system in place to ensure all staff were aware of people's changing needs.

We brought this to the attention of the registered manager who told us they planned to implement a system to improve communication between staff and management to ensure that when people's needs changed that senior staff could update the risk assessments immediately.

People who were living with dementia could not be confident that staff understood how to meet their needs. Not all people living with dementia in the home had plans of care for staff to follow that explained how their dementia influenced their daily life. Staff did not have information on what triggered people's anxieties or how to manage these. We observed that some people living with dementia became anxious and staff did not know how to allay their anxieties.

There were no reliable systems in place to ensure that all people's needs were assessed and plans of care were in place. This is a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People received most of their care as planned. People who were at risk of falls at night had plans of care that included regular monitoring and sensor mats by their beds to alert night staff of them getting out of bed. Once the sensor mat had alerted night staff they could supervise people to mobilise in a safe way. We saw that people had sensor mats in their bedrooms and one person told us "Since my fall, staff come and check on me every two hours."

People did not always have the opportunity to receive their personal care when they chose. Each person had allocated bath days; and at times people did not receive their bath as planned due to the lack of staff. One person told us "I can only have a bath on set days; it's too much hassle on any other days so I make do with a good wash down." Staff told us that people were not always able to have their baths due to the lack of staff. We brought this to the attention of the registered manager who told us they were in the process of recruiting more staff so these issues could be addressed.

People did not always have the opportunity to take part in all the advertised activities. There was a large wall mounted calendar for the month of August showing there was a walking club and a gardening club on set days. People told us these clubs did not take place. One person told us "The walking and gardening clubs are not happening." Other people told us they were not aware of these clubs being available, one person said, "I'd like to go walking outside, I just walk around the home to get my exercise." One member of staff also told us "These clubs used to be popular, but we do not have enough staff to do them anymore, I don't know why they are still on the calendar."

Some activities continued to take place. Arrangements had been made for representatives from the church and the local community to come to the home to provide activities. One person said "We have entertainment most Wednesday afternoons and this morning there will be a lady come and give us movement to music or chair aerobics". We observed that people enjoyed the armchair aerobics. There had been a garden party with a band the day before the inspection. People told us they enjoyed this.

One member of staff was allocated for two hours a day for two days of the week to provide activities. One person told us "We've been on a couple of trips, a barge trip with a picnic lunch and to the Rose and Crown and had afternoon tea." However, staff told us "They [activities staff] are leaving at the end of the month and I don't know who will be doing the crafts and activities after then." The registered manager told us of their plans for new staff; this did not include a person dedicated to providing activities.

We recommend that the provider and registered manager include the provision resources to include meaningful activities to maintain people's interests.

Inadequate

Is the service well-led?

Our findings

There was a registered manager who had managed the home since January 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager failed to notify Care Quality Commission without delay of all incidents of suspected abuse or allegation of abuse. Incidents had been reported by staff to the safeguarding authority but these had not been reported to CQC as required. This is a breach of Regulation 18 (2)(e)(f).

The provider failed to have adequate oversight of the management of the home. The registered manager did not always understand their responsibilities to report all safeguarding concerns and incidents. There was no reliable system in place to ensure that all incidents were recorded and reported to the relevant agencies. Staff had not felt confident in approaching the manager with their increasing concerns and had chosen to contact outside agencies. Once the registered manager had been made aware that staff had raised alerts directly to agencies, they held a staff meeting and had written to staff to discourage them from contacting agencies until they had had an opportunity to manage the concerns. Staff had acted in the best interest of people using the service and had followed the guidance they had been given in training and in accordance with the provider's policy and procedures.

The registered manager did not have a close working relationship with all staff or people living at the home. They relied on two senior staff who managed the day to day running of the home with staff referring to these managers directly. There had been recorded incidents of disharmony between staff. The registered manager had tried to address this in team meetings and in writing; however, these had not successfully addressed the issues and did not take into account any of the concerns raised by staff about staffing levels.

Staff told us that their workload had increased due to the increase in people's dependency and lack of staff. People who required two staff to provide their care had to wait for care, and when their care was provided it was not always delivered in a kind way. The provider had not addressed the staffing issues. The provider did not have sufficient oversight of the management of the home to recognise that resources such as staffing needed to be reassessed due to the increased dependency. The registered manager did not use the information they had about people's dependency to calculate adequate staffing levels.

The experience of people living at The Lodge Residential Home depended upon their ability to speak for themselves and their independence. Although most people (23 people) experienced care that met their needs, where people had an impairment such as dementia or required two people to provide their care (6 people), the registered manager did not ensure that they received their care without prejudice.

There was no system in place to ensure people's dignity was maintained. The registered manager failed to recognise when staff had been disrespectful to people either verbally, by their actions or in their records.

There was a lack of insight into the impact of negative signage used around the home where people's bedrooms were labelled as 'not a toilet'.

There were no suitable systems in place to ensure that complaints were managed according to the provider's policy. The registered manager did not promote a culture of learning from complaints. The registered manager had not made themselves well known in the home. One person who had lived at the home for over four years told us "There is a new manager, but she never sees us."

The registered manager had not always responded to people's feedback. For example during a resident's meeting in April 2017 where 21 people attended the meeting, one resident had expressed their concern about their relationship with staff, the registered manager had recorded they had said "Staff can be a little short." There had been no action as a result of this comment. At this inspection we found further evidence that staff were not always respectful or maintained positive relationships with people living at the home.

Although people were asked for feedback during resident and relative's meetings, their comments had not been acted upon. For example during the resident's meeting in April 2017 people had complained of a reduction in activities. This inspection showed that there were going to be fewer resources in the provision of activities when the member of staff allocated to these had left. People expressed their concern in April 2017 about too few staff and the home's dependency on agency staff. One person told us "The home advertises that they do not use agency, but they do." The registered manager had not taken action to address the concerns by people living at the home.

Staff did not have the opportunity to learn from accidents, incidents or complaints as these were not discussed in team meetings. The registered manager did not ensure they had effective communication with staff to help drive improvement and provide safe care.

The registered manager carried out quality monitoring audits in areas such as medicines records, care plans and nutrition. These had failed to identify that staff had not completed their medicines competencies, that care plans did not reflect every person's needs or that kitchen staff did not have access to people's dietary information. The quality monitoring of the service did not identify that there were not always enough staff to meet people's needs or that staff did not always treat people with dignity.

The registered manager had not ensured that staff had received all of the training and competencies meet people's needs. There had been an increase in the number of people living with dementia and there was no system in place to check the competencies of staff in areas such as health and safety, management of medicines or safeguarding of vulnerable adults. There was no system in place to ensure staff received support in the form of supervision or appraisals. Where the registered manager had carried out spot checks at night they had seen the same two staff on both occasions.

The register manager had not implemented a system of monitoring infection control. The local authority had identified that there was no infection control lead in July 2017 and staff training was out of date. Although the registered manager told us that staff were due to receive training in infection control at the end of October 2017, no system had been put in place in the meantime to check that staff were providing care in line with the provider's infection control policy. There was no allocated person to lead the service in preventing infection.

The provider and registered manager failed to ensure that there were sufficient systems and processes in place to assess, monitor, mitigate risk and improve the health, safety and welfare of people using the service. This constitutes a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. Good Governance.

The provider is required to display a poster of the ratings form the previous CQC inspection. This is required by us to ensure the provider is open and transparent with people who use the services, their relatives and visitors to the home. During our inspection we saw that there was no poster displayed, however, a copy of the whole report was available in the reception. We brought this to the attention of the registered manager who took immediate action and arranged for the required poster to be displayed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to notify Care Quality Commission without delay of all incidents of suspected abuse or allegation of abuse. Regulation 18 (2)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There were no reliable systems in place to ensure that all people's needs were assessed and plans of care were in place. Regulation 9 (1)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks had not always been assessed accurately or updated as their needs changed. People did not always have clear plans of care to mitigate the assessed risks. Regulation 12 (2a and b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse as the registered manager did not always follow the systems and processes in place to safeguard them. Regulation 13 (2 and 3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People's complaints had not been recorded or responded to in line with the provider's policy. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes in place to assess, monitor and improve the quality of the service or the health and safety of people using the service. Regulation 17 (2a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to meet people's needs. Regulation 18 (1) Staff did not receive the training, supervision and support they required to carry out their roles. Regulation 18 (2a)