Sovereign Guest Services Limited

Sovereign Lodge

Inspection report

Newbiggin Lane
Westerhope
Newcastle upon Tyne
NE5 1NA
Tel: 01912714029

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Ratings

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

Overall summary

The inspection took place on 3 and 9 December 2014 and was unannounced. This means the provider did not know we were coming. We last inspected Sovereign Lodge in November 2013. At that inspection we found the service was meeting all the regulations we inspected.

Sovereign Lodge provides personal care for up to 44 older people and people with dementia. Nursing care is not provided. At the time of our inspection there were 41 people living at the home.

The home 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.

We found that people were provided with care that promoted their safety and welfare. Risks to personal safety were assessed and managed to reduce the potential of people being harmed. Staff had a good

Summary of findings

understanding of their responsibilities to protect people against the risks of abuse and unsafe care. The environment was safe and clean and equipped for people's safety and comfort.

People were supported to maintain their health and access a range of health care services. There were appropriate arrangements for making sure people were given their prescribed medicines safely. A varied diet was offered and staff assisted people who were unable to eat and drink independently. Nutritional needs were closely monitored and dietetic advice was obtained when necessary.

Suitable recruitment checks had been undertaken before new staff started working at the home. Sufficient numbers of staff were employed to safely meet people's needs and provide continuity of care. Staff were trained in safe working practices and were given training specific to meeting people's needs, including specialist dementia training. All staff were supervised and had their work performance appraised to ensure they were supported and competent in their roles.

People and their representatives were consulted about and involved in reviewing their care and treatment. Formal processes were followed to uphold people's rights when they did not have the capacity to make important decisions about their care.

Staff were caring and considerate in their approach and treated people with respect. They were aware of people's individual needs and preferences and knew how to support them. Each person had individualised care plans for meeting their needs. These care plans were regularly evaluated to check they remained effective. Activities, events and outings were provided for stimulation and to help people meet their social needs. There were flexible routines in the home and people made choices in their daily living.

People living at the home and most of the families we spoke with were satisfied with the care and had good relationships with the staff. There were systems in place for making complaints and to give feedback about the service. Any concerns or complaints were taken seriously and promptly investigated and acted on.

The registered manager was committed to developing the service and communicated openly with people and their families, and with staff, about the running of the home. The home's standards were continuously checked to assure and improve the quality of the service that people received.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

Measures were taken to manage risks and keep people safe during their care delivery.

Staff understood how to prevent people from being harmed and reported any concerns about their safety.

New staff were checked and vetted to make sure they were suitable to work with vulnerable people. There were enough skilled and experienced staff to provide safe and consistent care.

People were supported to take their prescribed medicines safely.

Is the service effective?
The service was effective.

Good

People were cared for by staff who were knowledgeable and appropriately trained in meeting their needs.

The registered manager was aware of her responsibilities towards people who were unable to consent to their care and who might need to be deprived of their liberty.

Appropriate support was provided to meet people's nutrition and hydration needs.

People were supported to maintain good health and received input from a range of health care professionals.

Is the service caring?
The service was caring.

Good

People told us the staff were kind and friendly. Our observations confirmed that staff were caring and respected people's privacy and dignity.

Staff understood people's individual needs and how they preferred to be supported.

People and their families were encouraged to make decisions about the care they received and express their views about the service.

Is the service responsive?
The service was responsive.

Good

Staff attended promptly to people's needs and requests.

People's care needs were fully assessed and documented in personalised care plans which were adapted as their needs changed.

Activities and outings were provided to support people in meeting their social needs and to be involved in the community.

Thorough investigations were carried out in response to any complaints about the service.

Summary of findings

Is the service well-led?

Good

The service was well led.

The registered manager provided leadership and was open and transparent in her communication about the way the service was managed.

Staff felt they were well supported in their roles and personal development.

The quality of the service was systematically monitored and took account of people's feedback and care experiences.

Sovereign 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.

The inspection took place on 3 and 9 December 2014 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 10 people living at the home and with six relatives. We spoke with the registered manager and nine care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at five people's care records, 12 people's medicine records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People living at the home told us they felt safe. Their comments included, “They (staff) treat us all very well”; “I know the staff are here day and night if I need them”; and, “The staff are good, they would never hurt anyone.” A relative told us their mother’s care plans took account of her personal safety and said she was kept safe and comfortable at the home.

The service had policies and procedures on safeguarding vulnerable adults from abuse and on whistleblowing (exposing poor practice). Staff were given copies of the procedures and they were available in the staff room and on the company’s intranet for them to refer to. The staff we talked with understood their roles in preventing people from being abused and were confident about reporting any concerns. One staff member said, “I’d report anything I was worried about to the senior or the manager.” Another staff member told us they had provided a written statement as part of a whistleblowing investigation that had resulted in disciplinary action.

The registered manager said she aimed to employ staff with the right values who would not tolerate people being harmed or treated unfairly. She told us scenarios were given at interviews to check whether applicants were able to recognise abuse and how they would respond. She said all new staff were trained during their induction to instil the principles of protecting people from abuse and, thereafter, annual safeguarding training was provided.

The registered manager was aware of her responsibilities to act on any allegations of abuse. She kept a safeguarding log of all referrals made to the local safeguarding authority and notified to the Care Quality Commission. We saw that most referrals related to incidents of potentially harmful behaviour between people with dementia. The safeguarding records showed the nature of each incident, progress notes on the actions taken, and outcomes. The majority of staff were trained in supporting people with behaviour that may become challenging and the manager had undertaken advanced training enabling her to give support and advice to staff. Where necessary, a specialist behaviour team provided input and staffing had been increased to ensure people’s safety. We were told some people had also moved onto nursing care when their needs could no longer be safely met.

Appropriate steps were taken to ensure the safekeeping of people’s money. No-one within the service acted as an appointee (a representative appointed on behalf of a person) for people who needed help managing their finances, to avoid any conflict of interest. People were encouraged to manage their own finances, or to be supported in doing so by their families. Lockable drawers were provided in bedrooms to store personal items and cash could be held securely in the home’s safe. Suitable records were maintained of money deposited, spent and repaid to people. All entries were witnessed and countersigned and receipts were kept for purchases. Monthly checks of records and cash balances were conducted to assure people their money was being handled safely.

We reviewed recruitment records and found all necessary checks and vetting had been carried out before new staff started work. However, we noted that although two references were obtained, including one from the last employer, the second reference was usually a character reference. This was the case even where applicants had other previous employers from whom references could have been sought. We raised this issue with the registered manager to take forward within the company.

The registered manager told us that staffing levels were based on the numbers of people living at the home and their care needs. A trial of a new dependency assessment tool was planned to be carried out to more accurately assess the required staffing resources. The rotas showed that the current levels were seven to eight care staff during the day and five care staff at night, including senior staff on each shift. The home used existing staff and bank staff to cover absence and rarely needed to use external agency staff to maintain the staffing levels. This meant there was good continuity of care. An on-call system was operated in the event of an emergency or if staff needed advice and support outside of office hours.

The staff we spoke with felt there was enough staff on duty to safely meet people’s needs. A staff member who worked on the memory unit told us they understood the importance of closely supervising people for their own and others’ safety. She told us staff worked flexibly to ensure there was always a staff presence in the lounge and keep checks on people in other areas.

Care records showed that risks to people’s safety were assessed and managed. For example, people’s care plans

Good

Is the service safe?

addressed how to reduce risks associated with moving and handling, falls, nutrition, taking medicines, and behaviour that could be harmful. Equipment, such as airflow mattresses to prevent skin damage, was provided to ensure people were cared for safely.

Care was provided in a clean and safe environment. We saw all areas of the home were clean and that domestic staff followed cleaning schedules for daily, weekly and monthly household tasks. Servicing agreements were in place and health and safety checks were carried out to make sure facilities in the building and equipment were safe and fit for purpose.

There were clear systems for reporting and analysing accidents and other safety-related incidents. Thorough monthly audits were done to check any required follow up actions had been taken and to identify any trends. The audits were then sent to head office for senior management to review the findings and keep checks on people's safety and welfare.

People were suitably supported in taking their prescribed medicines. Senior staff administered all medicines and they were trained and assessed as competent in the safe handling of medicines. People had care plans which guided staff on their individual medicines routine. These included, for instance, instructions for giving anti-coagulant medicines and where a person's medicines had been authorised to be given covertly. Medicine administration records were completed appropriately. They verified that medicines had been given as directed and codes were used to explain any occasion when medicines had not been taken. Monthly audits of the management of medicines were conducted to make sure people had received their medicines correctly.

Good

Is the service effective?

Our findings

Staff told us they were provided with good opportunities for training that helped them understand and meet the needs of people living at the home. Their comments included, "We definitely get good training here, not just the mandatory courses but in broader aspects too", and, "I worked a three month probation and did full induction training. I get plenty of training and am doing an 'end of life' care course." Staff commented positively on the training they received in caring for people with dementia and behaviour that challenged the service, including advanced and facilitator training. They also told us that they were encouraged to study for National Vocational Qualifications (NVQ) in care. This was confirmed in the training matrix which showed the majority of care staff had either achieved or were in the process of studying for these qualifications.

Individual records and certificates of staff training were kept. A training matrix, giving an overview of all courses completed by the staff team, was also maintained. This indicated that staff had completed core training in safe working practices such as moving and handling and first aid, and other training relevant to the people they cared for. A training schedule was also in place that showed staff were planned to undertake courses in topics including health and safety, infection control, equality and diversity, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff were given an appraisal and six individual supervision sessions annually. The staff we spoke with confirmed this and said they were well supported in their personal development by the registered manager and senior staff. One staff member said, "I get plenty of support", and another described supervisions as being "a two-way process" where they felt able to discuss their performance and training needs.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. These are safeguards under the MCA which protect people from having their liberty restricted without lawful reason. We found that mental capacity assessments were carried out to determine if people were able to make the decision to live at the home. The registered manager was working with the local authority to ensure applications for safeguards were put in place for those people who lacked capacity to make this decision.

People were supported to have adequate nutrition and hydration. Staff were trained in nutrition and food hygiene. Nutritional assessments were updated every month and people were weighed monthly. Where risks were established, such as unexplained weight loss or poor appetite, GP's were informed and people were referred to dietitians. Care plans were developed which gave staff guidance on meeting people's dietary needs. Where applicable, the plans included dietetic advice, details of special diets and nutritional supplements, and how staff should assist people with eating and drinking.

There was a four week menu with choices at each meal. The menus had been changed earlier in the year as a result of people voting to have a lighter meal at lunch and the main meal at teatime. People were asked to choose their meals for the day each morning. Choice and quality of food was also discussed at 'resident and relative' meetings.

Catering staff had access to information on nutritional risks and provision of special diets. They told us they were informed about and catered for specific dietary needs, and currently provided soft texture diets for some people. Food was also routinely fortified and creamy milkshakes were made to provide extra calories and nourishment.

People were supported to maintain good health. Information about people's medical history and their current physical and mental health needs was recorded in their care records. The records showed that people accessed a range of NHS and community health services including doctors, district nurses, community psychiatric nurses, opticians and dentists. All visits and appointments were documented and, where necessary, advice regarding care and treatment was built into care plans for staff to follow.

Good

Is the service caring?

Our findings

People living at the home told us they had good relationships with the staff. They said the staff were "friendly and helpful" and "lovely, kind girls" and expressed no concerns about the way their care was given. People told us they made choices in their daily living such as when they wanted to have a bath or shower and the times they got up and went to bed. Our observations confirmed there were flexible routines, such as people choosing to get up throughout the morning and being given a late breakfast.

Most of the relatives we talked with were very complimentary about the care of their family members. They told us, "I'm happy with her care and have no complaints"; "My mother is very settled. The care is fabulous and the care staff are all lovely"; and, "She's safe and well cared for, we're very happy and don't have to worry about her." These relatives also said that staff kept them well informed about their family members care and well-being.

Relatives of two people who lived on the residential unit told us they had recently discussed issues about care and communication with the newly appointed residential lead. One relative said they believed progress was being made. The registered manager told us she had implemented a number of measures to attempt to resolve the relatives' issues. These included assigning the new deputy manager and residential lead as keyworkers to their family members and reintroducing records of communication between relatives and staff. Good care practices and communication with relatives had also been reinforced with staff at meetings and during individual supervision.

The registered manager said people and their families were encouraged to be involved in making decisions about their care and treatment. This was confirmed by a number of relatives who said they had recently attended care review meetings and discussed their family member's care plans. Arrangements could be made to involve advocacy services if people did not have representatives who could act in their best interests.

Feedback about the care provided and different aspects of the service was sought at 'resident and relative' meetings. All relatives had been invited to attend a meeting with the company's chief executive and regional director. The minutes of the meeting showed open discussion had taken place about changes in the company ownership; staffing updates; forthcoming social and fundraising events; and proposals for upgrading areas of the building and grounds.

The staff we spoke with had a good understanding of the needs and wishes of the people they cared for. We observed that they were caring in their approach and treated people as individuals. For instance, we saw staff on the memory unit talking with people about their families and interests to good effect. One person's family told us staff on this unit had a sound knowledge of the best ways to care for people with dementia. One of the relative's commented, "X (senior care) is absolutely wonderful, first class." They also told us about how staff tailored their mother's care to her needs. For example, they said staff understood she would not sleep in her bed so made sure she was comfortable and covered her up to protect her dignity when she fell asleep in the lounge.

During our observations of care practices we saw that staff spoke politely, offered people choices and gave them time to respond. They asked people's permission before supporting them and explained what they were doing or were about to do. At mealtimes we saw people were given help to cut up food and that staff provided one to one support to people who were unable to eat independently. One person had a lamp beside them at the table and staff told us this was at the person's request so they could see their food better. Serviettes were provided and some people used disposable aprons to protect their clothing from food spillage. People said they were able to choose what they wanted from the menu each day and generally enjoyed their meals.

Records showed that people and their families had been consulted about how they wished to be cared for at the end of their lives. Some staff had undertaken training in end of life care and more staff were planned to receive training. The registered manager told us the service worked closely with doctors and district nurses in managing pain and ensuring people's comfort during this time. She said staff treated people with compassion, were allocated to sit with them when family were not present, and did their utmost to provide families with extra support.

Good

Is the service responsive?

Our findings

People we talked with said they were happy their care needs were met and they had no complaints about the home. Their comments included, "I'm well looked after here"; "I always get all the help I need"; and, "If I was ever unhappy about anything I'd just speak to X (staff member) or Y (the manager)."

We observed that staff were attentive and responded to people's needs in a timely way. However, on the first day of our inspection staff were busier than usual as they were caring for a number of people in their bedrooms who were affected by a virus. On the residential unit we saw that staff spent little time in the lounge which impacted on those people who needed help, for instance with drinks given during the morning. Two of the relatives we spoke with said they felt that staff did not usually spend much time with people in the lounge. This was fed back to the registered manager who discussed the matter with staff. On the second day of our inspection we saw that care staff were more visible and spent time engaging with and supporting people in the lounge area.

People living at the home had care plans which described how to meet their social needs and inclusion in the community. The people we talked with told us they enjoyed the social activities and events which took place and confirmed they had opportunities to go out of the home. A new activities co-ordinator was due to take up post soon. The registered manager said in the meantime staff had been doing activities with people, such as games, crafts and reminiscence. Regular social and fundraising events and visiting entertainment had also been arranged.

Secure outdoor areas were provided and new garden furniture had been bought for people to sit outside in good weather. The home had been given a share in a minibus and people were being asked to choose where they would like to go on outings. Two people had gone on holiday with people from another care home in the company. Another short break was being planned using money raised at the home's summer fayre.

We looked at a sample of care records to see how people's care was planned. A range of assessments were completed and routinely updated to identify people's current needs and dependency levels. Each person had corresponding care plans which set out their independent abilities and the support they required in meeting their needs. The care plans were personalised and addressed each area of personal care, physical and mental health, social needs, and the person's preferred routines in daily living. All care plans were evaluated monthly and there was evidence that plans were amended or rewritten in response to people's changing needs.

A staff member told us that, when they first started working at the home, they had found care records informative in getting to know people who lived on the memory unit. Life histories were recorded and one-page profiles were being developed, with relatives being asked to contribute information where necessary. These profiles were intended to give staff a better understanding of the person as a unique individual; what was important to them; and how they liked to be supported.

People and their relatives were aware of their rights to complain about the service. We viewed the complaints file and saw that all complaints logged had been acknowledged and responded to. The registered manager or the company's regional director took responsibility for investigating complaints. We saw that people had been given thorough responses, either in writing or by telephone, including explanations and apologies, where applicable. A theme had emerged in some complaints about damage to the built-in wardrobes in people's bedrooms. The registered manager told us the wardrobe doors were planned to be replaced. Complaints about care were also discussed during supervision to ensure staff were clear about good practice and lessons learned.

Good

Is the service well-led?

Our findings

The home had an experienced registered manager who had been in post for over three years. Her working hours were in addition to the staffing levels, enabling her to focus on providing leadership to the staff team and fulfil her management responsibilities. The registered manager told us she was well supported in her role by her peers, the regional director and the company's central compliance team. The internal management team had also recently been strengthened by the appointments of a deputy manager and a residential lead who each supervised the running of one unit.

The registered manager attended the company's home managers meetings and managers meetings with the Local Authority commissioning team. She said this helped keep the home up to date with company and local policy and provided valuable information for her to share with the staff team. The registered manager was enthusiastic about further developing the quality of the service provided. For instance, the home was currently using 'Progress for Providers', an initiative that helps providers of care services assess their progress in delivering personalised services to people.

The staff we talked with described an open culture within the home and said they had good communication with the manager and senior management. They told us there were regular staff meetings where they discussed practice issues and the running of the home. Care staff commented positively on the support they received from the registered manager and senior staff and their opportunities to progress their personal development. Their comments included, "I'm always happy to approach the manager"; "X (the registered manager) is very fair and she supports me in furthering my career"; "The deputy and residential lead work with us. They're good at leading staff during their shifts"; and, "Y (senior care worker on memory unit) is a very good senior. Y and the new deputy are brilliant, very good at working with us on the floor".

People's relatives said the registered manager was visible and accessible if they wanted to talk with her. Most relatives told us they visited the home regularly and took part in 'resident and relative' meetings where they felt able to openly air their views about the service.

An annual survey was conducted to gauge people's satisfaction with different aspects of the service. The registered manager told us she had taken action on negative comments about food and communication from the last survey. These included changing the menus, discussing options for communicating with relatives, and arranging care reviews and more relatives meetings. A member of the provider's compliance team had also undertaken an audit specific to people's dining experience.

A range of audits were carried out into the quality of the service that people received. These looked at areas including the management of medicines, health and safety, catering, infection control, and reviewing a percentage of care records each month. The registered manager also gathered information such as people's weight loss, falls, and any safeguarding alerts and complaints, which she sent to the compliance team for analysis. This meant the team could monitor and take follow up action on significant issues affecting people's safety and welfare.

A regional director visited the home each month to check on standards and the company's compliance team carried out an extensive quality audit each year. These audits were linked to the standards set by the Care Quality Commission and all results were fed into a live action plan. We saw that the action plan was routinely reviewed and updated as remedial actions had been completed to improve the service.