Life Style Care plc

# Sovereign Lodge Care Centre

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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? | Requires Improvement |

# Summary of findings

## Overall summary

Sovereign Lodge Care Centre provides facilities and services for up to 64 older people who require personal or nursing care. The service is purpose built and provides accommodation and facilities over three floors. People live in single rooms with en-suite toilets and showers are also available in most rooms. The ground floor provides care for up to 26 people whose main nursing needs are related to physical health needs. This includes people who have had a stroke or live with a chronic health condition like Multiple Sclerosis, Diabetes or Chronic Obstructive Airways Disease. The first floor provides nursing care for up to 27 people with a dementia or mental health disorder. Both nursing units can also provide end of life care with the support of community specialist s. The second floor provides personal care for people with health and mobility problems related to older age. People on this floor can be independent requiring minimal support from care staff.

At the time of this inspection 25 people were living on the ground floor and 25 people were on the first floor with six people living on the second floor. This inspection took place on 30 March and 1 April 2016 and was unannounced.

The service had a registered manager in place. 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 quality monitoring systems needed further development to ensure they were used to ensure best practice and to identify shortfalls and demonstrate effective responses. This included the provision of suitable guidelines for medicine administration and accurate records for the application of topical creams in order to demonstrate staff delivered these in a consistent way. In addition some care documentation was not completed contemporaneously or consistently. This could lead to staff not having up to date information on people's needs and care provided.

People were looked after by staff who knew and understood their individual needs well. Staff were attentive, treated people with kindness and compassion and supported them to maintain their independence. They showed respect and maintained people's dignity. All feedback received from people and their representatives were very positive about the care, the atmosphere in the service and the approach and openness of the staff and registered manager. Comments included, "Everything is brilliant now. I have seen this home become an excellent place with caring staff and a manager who listens and changes things when they need to be changed."

All feedback from visiting professionals was positive. They told us staff work with them to improve outcomes for people and were keen to learn new approaches when working with people living with a dementia.

Staff had a good understanding of safeguarding procedures and knew what actions to take if they believed

people were at risk of abuse. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Senior staff had an understanding of DoLS and what may constitute a deprivation of liberty and followed correct procedures to protect people's rights.

Staff were provided with a full induction and training programme which supported them to meet the needs of people. Staffing arrangements ensured staff worked in such numbers, with the appropriate skills that people's needs could be met in a timely and safe fashion. The registered nurses attended additional training to update and ensure their nursing competency.

People were given information on how to make a complaint and said they were comfortable to raise a concern or give feedback. A complaints procedure and comment cards were readily available for people to use.

Staff monitored people's nutritional needs and responded to them. Preferences and specific diets were provided. People were supported to take part in a range of activities maintain their own friendships and relationships. Staff related to people as individuals and took an interest in what was important to them.

Feedback was regularly sought from people, relatives and staff. People were encouraged to share their views on a daily basis and satisfaction surveys had been completed. The management style fostered in the home was transparent listened and responded to people and staff's views.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Medicines were stored, administered and disposed of safely by staff who were suitably trained. There were enough staff on duty to meet the needs of people.

People told us they were happy living in the home and relatives felt people were safe. Staff had received training on how to safeguard people from abuse and were clear about how to respond to any allegation of abuse.

The environment and equipment was well maintained to ensure safety.

People had individual assessments of potential risks to their health and welfare. Staff responded to these risks to promote people's safety.

### Is the service effective?

Good

The service was effective.

Staff had an understanding of the Mental Capacity Act 2005 and DoLS and how to involve appropriate people, such as relatives and professionals, in the decision making process.

Staff were trained and supported to deliver care in a way that responded to people's changing needs.

Staff ensured people had access to external healthcare professionals, such as the GP and community mental health team as necessary.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

### Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff. Staff knew people well and had good relationships with them. Relatives were made to feel welcome in the service.

Everyone was very positive about the care provided by staff.

People were encouraged to make their own choices and had their privacy and dignity respected.

## Is the service responsive?

Good

The service was responsive.

People were able to make individual and everyday choices and we saw staff supporting people to do this.

People had the opportunity to engage in a variety of activity that staff supported them with either in groups or individually. More person centred activities were being progressed and people had their social arrangements assessed and responded to.

People were aware of how to make a complaint and people felt that they had their views listened to and responded to.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality monitoring systems were not well established to identify all areas for improvement and monitoring.

The registered manager and senior staff in the service were seen as approachable and supportive.

Staff and people spoke positively of the management team's leadership and approach.

# Sovereign Lodge Care Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 30 March and 1 April 2016 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor who was a training consultant with specialist knowledge of caring for people living with a dementia.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service this included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not ask the provider to complete 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.

During the inspection we spoke with four people who lived in the service who could share their views on their care, eight relatives who were visiting on the day of the inspection. We also spoke with two visiting health care professionals who were attending the service.

In addition we spoke with various staff including the registered manager, the deputy manager, the chef, the activities co-ordinator, two registered nurses, two members of the housekeeping team, the administrator and five care staff.  After the inspection we spoke with another health care professional from the community

health team.

Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the day on the first floor. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We observed care in communal areas to get a full view of care and support provided across all areas, and in individual rooms. We observed lunch and breakfast sitting with people in the dining room in both areas of the home. The inspection team spent time observing people in areas throughout the home and were able to see the interaction between people and staff. We attended a mid - morning management meeting that was held each day.

We reviewed a variety of documents which included six care plans and associated risk and individual need assessments. This included 'pathway tracked' people living at Sovereign Lodge Care Centre. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked at four staff recruitment files, and records of staff training and supervision. We read medicine records and looked at policies and procedures, record of complaints, accidents and incidents and quality assurance records.

Good

# Is the service safe?

## Our findings

People and their relatives were confident that people were safe living at Sovereign Lodge Care Centre. People said staff were available and responded to the call bells when they were rung. Other people knew that staff were around the home checking on people regularly to ensure their needs were attended to. One relative said, "I know when I leave my husband is safe warm and protected." Visiting health professionals were positive about the standard of care which ensured people were receiving safe care.

Staff arrangements include separate staffing on a daily basis for each of the floors. This was based on the skills and competency of staff and the individual needs of people. For example, each shift on the second floor required a senior carer with competency in medicines. People on this floor had also had a preference for female staff to provide their personal care and this was reflected within the staffing provided. The ground and first floor each had a registered nurse to oversee and monitor the clinical care provided. People told us there were enough staff to respond to their needs although they were often 'very busy.' Agency staff were used to cover known vacancies and was well managed with regular agency staff who knew the service being employed.

Systems to ensure the security of the service were in place with people entering a reception area signing a visitor's book before being escorted into the service. The service was clean and health and safety maintenance was in place, the system to report and deal with any maintenance or safety issue was effective. For example one inspector noted a broken soap dispenser in the staff toilet, this was repaired on the same day.

The provider had systems in place to deal with any foreseeable emergency. Contingency and emergency procedures were available to staff and a member of the management team were available at any time for advice. First aid equipment was available and staff had undertaken appropriate training Staff knew what to do in the event of a fire and appropriate checks and maintenance had been maintained. The registered manager told the inspection team of the fire arrangement when they arrived on the premises. The provider had taken steps to ensure the safety of people from unsafe premises and in response to any emergency situation.

All staff including domestic staff received training on safeguarding adults and understood clearly their individual responsibilities to safeguard people. Staff were able to talk about the steps they would take to respond to allegations or suspicions of abuse. Staff were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. They knew where the home's policies and procedures were and the contact number for the local authority to report abuse or to gain any advice. Records confirmed that systems were in place to ensure any suspicion of abuse was referred appropriately. Senior staff confirmed how they had worked with the safeguarding team and gave examples of how they had protected people against abuse.

Staff had a good understanding of people's risks and how to respond to them. During the management meeting staff discussed people's individual risks and how these were responded to in order to keep people

safe. For example, any accidents or incidents in the service from the previous day were discussed with the whole team to ensure a full review and agreed actions for safety. We found risk assessments were used appropriately to identify and reduce risks. For example, risks associated with nutrition, moving people and pressure areas were documented and responded to. When people were at risk of pressure damage to skin staff ensured appropriate equipment including pressure relieving mattresses when needed. Staff checked that these were working and set correctly to ensure people's safety. We also found people were moved safely and appropriately by staff when they needed assistance.

The service had a designated person to co-ordinated staff recruitment. There was a recruitment procedure in place. We found staff records included application forms, confirmation of identity and of the person's right to work. The recruitment process included a thorough interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring checks (DBS) completed by the provider. These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse. In addition separate files were kept on agency staff employed to ensure DBS checks had been completed along with right to work checks. Those who were employed as registered nurses also had a further check with the NMC to ensure they were registered.

There were robust systems in place to ensure the safe storage and administration of medicines. Medicines were stored, administered and disposed of safely. People and relatives told us people received their medicines when they needed them. However some records relating to topical creams were not fully accurate this was raised with the registered and deputy manager to review the systems for recording.

Storage facilities throughout the service were appropriate and well managed. For example, medicine rooms were locked and the drug trollies used on the floors were secured to the wall when not in use. We observed medicines being given in the morning and at lunchtime staff demonstrated that staff followed best practice guidelines. Medicines were administered by registered nurses or senior care staff who had undergone additional training and competency checks. Discussion with a registered nurse confirmed they were knowledgeable about the medicines prescribed to people and about possible medicine interactions. Observation confirmed staff administered medicines in a person centred way, with staff checking what medicines were required and answering any questions people had. A copy of the medicines policy and procedures was kept in the treatment rooms for easy reference.

Some people were on variable dose medicines and medicines that needed to be given at specific times, these were well managed. For example some people had health needs which required a change to the medicine dose related to specific test results. These were accurately reflected on the Medicine Administration Record (MAR) chart and within individual care plans.

Good

# Is the service effective?

## Our findings

People and relatives had confidence in the skills and abilities of the staff employed at Sovereign Lodge Care Centre. One person said "The staff are all very good, they all know exactly how to respond to X and get the best results for him." Feedback from visiting health care professionals was very positive about the skills and competence of the staff and their willingness to learn. People were complimentary about the food and how they were provided with choice and variety.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people. New staff received a comprehensive induction programme. This included working alongside senior staff in a shadowing role and the completion of competency assessments. Agency staff told they also undertook a thorough induction programme which was documented within their files.

Staff and training records confirmed that a programme of training had been established and staff had undertaken essential training throughout the year. This training included health and safety, infection control, food hygiene safe moving and handling, dementia awareness and safeguarding. Staff training was co-ordinated and reviewed by training co-ordinators within the staff team who were given additional training to organise and provide most of the essential training. For example the chef was trained to provide all staff with their essential health and safety, safeguarding, food hygiene and nutrition training. Additional skills training was also undertaken with staff and included communication, telephone skills, uniform expectations and management of personal relationships within staff group. We found the training programme was varied and reflected the needs of people living in the service. For example on the day of the inspection visit an outside professional was providing training to staff on the use of 'dolls' when supporting people with a dementia.

Systems were in place to support and develop staff. Staff told us that they felt very well supported and had the opportunity to develop their knowledge and skills. The provider was committed in developing staff at all levels throughout the work force. A senior staff member told us how the provider was developing one staff member who had a disability with additional resources through the college to enable this learning.

The registered nurses were supported to update their nursing skills, qualifications and competencies and told us they received regular supervision. For example, staff had recently attended end of life care provided by the local Hospice and told us they attended outside seminars. They had the opportunity to reflect on these and their own practice through a clinical supervision process. The registered nurses were also supported in maintaining their registration with the training they are required to undertake to maintain their registration with the UKCC, the registering authority. One registered nurse told us "The provider is giving us information about re-validation, getting someone from the RCN (Royal College of Nursing) to talk with the registered nurses." Discussion and observation of the registered nurses confirmed they were competent and delivered care in a person centred way.

Staff had completed training on the Mental Capacity Act (MCA) and DoLS. There were relevant guidelines in the office for staff to follow and all staff understood the principle of gaining consent before any care or

support was provided. The MCA 2005 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.

Staff were constantly asking people for their agreement and gave choices to people throughout the day. For example, staff showed people different meal choices at lunch time and in this way promoted individual preference and agreement to the meal provided.

Mental capacity assessments were completed on each person on admission as a baseline assessment. Senior staff confirmed that these would be completed again in relation to any individual decision. Records were also kept of who had been given rights to make decisions on behalf of people when they had capacity to do so. Staff were aware any decisions made for people who lacked capacity had to be in their best interests and would include appropriate representation for the person concerned and this was reflected within the care documentation.

We found that senior staff had applied to the local authority for DoLS when necessary. These safeguards ensure any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm. The registered manager confirmed that the restriction imposed by the locked doors in the home were being followed up with the local authority to ensure the least restrictive practice was used whilst keeping people safe in the service.

People were supported to have enough to eat and drink. People's nutritional needs had been assessed and regularly reviewed. Risk assessments were used to identify people who needed close monitoring or additional support to maintain nutritional intake. For example a nutritional risk assessment was used routinely for people and staff monitored people's weights regularly to inform this risk assessment. Staff asked for professional advice if people lost weight or showed signs of difficulty with eating. Drinks were thickened to ease swallowing when specialist advice indicated this treatment. For people who had difficulty in eating and swallowing suitable meals were provided that included soft and pureed meals. Where a need had been identified staff monitored how much people ate and drank each day to ensure they received appropriate nutrition. Associated records were completed and included fluid charts that recorded fluid offered and taken. Where concerns had been identified the GP had been informed for further advice.

Staff had a good knowledge of people's dietary choices and needs. The chef and catering staff were instrumental in responding to people's needs and preferences and were proactive on promoting good food experiences for people. The chef told us about enhancing the nutritional content of food for people who were at risk of malnutrition and how they were available to discuss people's individual needs with people and health professionals including the speech and language therapist and dietician. We heard how special events were used to engage people with good food experiences for example a recent cheese and wine activity had been held with the support of the activities co-ordinator. Specific dietary needs were responded to and recorded on diet sheets that were used to serve the meals from the servery on each floor. People were also shown examples of the food on offer so they could make choices at the time they wanted to eat.

We observed the midday meal and saw snacks and breakfast given to people who preferred to eat a late breakfast. People liked the food provided and relatives were complimentary about the food and the way staff worked with them to ensure people ate enough. One relative said "I organise a separate menu for X and the kitchen and care staff ensure he has meals that he likes." Another relative told us "The food is very good and there are always plenty of choices."

The mealtimes observed on the first and second floor were well organised with staff available to provide support in a relaxed way taking time to engage with people and provide a pleasurable experience. However when we observed lunch served to a small group of people on the ground floor we found this was a task led activity. Staff did not spend quality time with people to ensure their meal time was a positive experience. For example, people were not assisted and encouraged with eating their meals promptly and people were attended long after having been served their meal. This led to a disjointed mealtime where people may have received food that was cold. This was discussed with the registered manager and quality manager. Both confirmed this matter had been raised for review and improvement to ensure good outcomes for all people around mealtimes was being progressed along with consideration being given to re-scheduling some mealtimes. Quality action plans confirmed this matter was being reviewed.

People were supported to maintain good health and received on-going healthcare support. People said that they could see the GP when they wanted to and were supported in attending hospital appointments. One person was attending hospital each day for on-going treatment and staff were co-ordinating transport and associated support. Relatives confirmed health care support was sourced appropriately and they were kept informed of any health changes.

Records and discussion with staff confirmed that staff liaised effectively with a wide variety of health care professionals who were accessed regularly. The staff worked hard to communicate effectively and co-ordinate a multi-disciplinary approach to care. For example, specialist nurses were contacted and involved in planning and reviewing of care for people who had skin damage.
Specialist advice was also sought from mental health care specialists who supported staff in providing tailored support to people who could exhibit behaviour that challenged. One relative told us how specialist advice had been followed and a personalised music therapy provision had given some relief for her husband. Visiting health care professionals told us the working relationship with the staff was constructive and very positive. Staff demonstrated professionalism and a commitment to providing the best care possible working in conjunction with all additional health care professionals available.

Good

# Is the service caring?

## Our findings

People were treated with kindness and compassion in their every day care and contact. People who used the service, relatives and visiting professionals were positive about the caring attitude of the staff and said the staff were kind, and very caring. One relative said, "Staff are so kind they take time to sit with him, staff put their heart and soul into this work." They also told us how staff were matched to ensure people were supported by staff they enjoyed being with. Some staff were able to communicate in another language with one person who was now unable to communicate verbally in English. This was considered as part of staff allocation. A visitor told us "All the staff are brilliant."

Visiting professionals were also impressed by the care staff and the way they cared and communicated with people. "Staff have a pleasant patient and caring approach to people." One professional told us they had been impressed with the interactions they had witnessed. They felt staff knew people well and treated them as individuals and showed a real kindness.

During our observations we heard and saw staff interact with people in a caring, pleasant and patient way. All staff demonstrated their concern for people's well-being and safety and attended to them with genuine caring approach. When staff supported people they did so with patience and worked at the person's own pace. All staff had a good knowledge and understanding of the people they cared for. They were able to tell us about people's choices, personal histories and interests. People were called by their preferred name and were dressed according to individual preference.

People had information immediately outside their rooms which included details of their names. People's bedrooms varied in the personal items on display, with some rooms containing individual memorabilia. Most rooms had photographs of family and/or older photographers of themselves at a younger age. This gave staff a point of reference for conversation and gave people a sense of identity. People's bedrooms were seen as their own personal area and reflected individual interests. Staff did not enter rooms without knocking and permission to do so. One visiting professional told us how staff had supported one person who had moved from another care home to access their home and moved some possessions to Sovereign Lodge  Care Centre that were important to them.

The home encouraged people to maintain relationships with their friends and families. Visitors were attending the home regularly throughout the time of our visits they came for short and longer visits with some staying to eat with their relative. Staff engaged with them positively during these times. Relatives told us they could visit at any time and they were always made to feel welcome. Two relatives told us they had been included in staff training on dementia, which they found informative and appreciated being included and being able to share views and challenges with the staff. Some visitors chose to stay much of the day and this was facilitated by staff who ensured they had beverages and meals as appropriate.

People and relatives told us people's dignity and privacy was respected. People received consultations with professionals in private and visitors were supported to see people where they wanted to. Many people preferred to have quiet time in the privacy of their own rooms and staff responded to this. Staff responded

and supported people's privacy as part of their daily care. For example when staff moved a person with equipment in a communal area they took care to use mobile screening to ensure dignity and privacy was promoted.

Staff talked about the how they enjoyed their work and making a difference and enhancing people's lives with a pleasant and caring approach. Staff were enthusiastic about looking after people as individuals. One staff member said, "It's a privilege to work with people who need this sort of support." Another said, "I love this work I like being able to connect to people and make them smile." Staff understood the importance of an individual and caring approach and understood the key principles that underpinned dignity. Some allocated staff had undertaken additional training to provide dignity champions in the service. A dignity champion is someone who believes that being treated with dignity is a basic human right, not an optional extra. Further staff had been spoken to about undertaking further training to become dementia mentors. There were reminders in everyone's care plan that choice and ensuring people's dignity must be part of everyday care and a notice board displayed principle of supporting people's dignity. Staff gave us examples of how they promoted people's dignity and we saw these were transferred into practice. One staff member told us about training that had supported them in providing dignified care. "I do not treat people as a family member but as I would want my family treated. All people are or have been loved by someone and we all need to respect this."

Good

# Is the service responsive?

## Our findings

People and their representatives were involved in deciding how their care was provided and people received care that was personalised to their wishes and preferences. Staff responded to people's choice and accepted them. For example people had a later breakfast if they wanted and for people who got up early drinks and breakfast was available for them. This was important to people living with dementia who chose to eat at different times and needed to be supported when they wanted to eat. People and relatives told us there was a wide range of activities and entertainment that suited the varied needs of people.

Before people moved into the home the deputy manager carried out an assessment to make sure staff could provide them with the care and support they needed. Following this assessment the possible admission is discussed by the senior staff in the service including the registered manager to ensure a suitable placement and that the admission process is managed appropriately. For example ensuring all appropriate equipment and training is in place before admission.

Assessments included information about people's likes and dislikes and how they would like their care provided. This included people's beliefs and identified what was important to people. For example people were asked if they had preferences on the gender of care staff providing personal care. Where people were less able to express themselves verbally people's next of kin or representative were involved in the assessment process. Care plans were written following admission and reviewed on a monthly basis. A relative confirmed that they had seen the care documentation which they felt reflected their mother's likes and dislikes and care needs clearly. Relatives all told us they were kept fully informed of any changes in care and felt they were included and involved as their relatives would want.

Care plans were written following admission and were reviewed on a monthly basis. Care plans gave guidelines to staff on how to meet people's needs while promoting an individual approach. Care plans were mostly detailed and supported staff to view people as individuals and staff told us they used these documents. Some people had complex care needs in relation to their health and behaviours that needed specific support. We found staff had a good understanding of these people's specific care needs and responded to them appropriately. For example, staff told us how they provided care to people at risk from pressure damage. They were familiar with the equipment and care that people at risk required. This care was fully recorded and evaluated, daily checks on any equipment used ensured it was correctly set for optimum therapeutic effect. Care plans had specific guidelines to care for people who were at risk from falling with records confirming hourly checks to be undertaken.

During the management meeting staff discussed changing needs of people and updated the team on any planned or contact with GPs or other health care professionals. For example discussion took place around end of life care for one person with recent contact with GP and hospice team. Staff had ensured suitable medicines were available and staff had undertaken appropriate training so they could be administered appropriately if required.

A range of activities were provided throughout Sovereign Lodge Care Centre which was found to be active

and vibrant with communal areas being well used with regular interaction being promoted. The service employed specific staff to organise and facilitate activities and entertainment that met people's individual need. The activities co-ordinator was found to be very active and enthusiastic and planned a variety of activity and entertainment. She was also involved with regular individual contact with people living in the service and was well known by everyone. One relative referred to the activities co-ordinator and said, "She is full of energy and will do anything for you to help." A programme of activity was available and advertised within the home and included group activity with signing and entertainment and individual activity which included visiting small animals and dogs that can be stroked and interacted with.

The environment was being updated and decorated to reflect a more interesting environment, for people. This had included seating areas along the corridors and textured objects that people on the dementia floor could pick up and refer to. We found some activities were not always developed with reference to up to date available research. For example how people living with dementia may benefit from certain environments, particular activities and more person centred activities. This was discussed with the registered manager and quality manager who had identified this as an area for further development. An action plan to provide further training to staff on person centred activities was in place and the registered manager was able to demonstrate the booking of training had been confirmed. .

People and relatives told us they would raise a complaint if they needed to and would approach senior staff in the service. One person told us if they were worried about anything they would "speak to the nurse and my wife." Another person told us, "I can speak with the manager and know who the assistant manager is and can speak to her too." They felt they would be listened to and have any concern dealt with. Relatives and visitors felt confident any issue they raised would be dealt with in a professional way. Most told us they would speak directly with the registered manager who "always makes time for you and always deals with any concern."

The service had a clear complaints procedure that was available to people and their representatives to use if they needed to. Leaflets on making complaints were displayed in the front entrance. Records confirmed that complaints received were documented investigated and responded to in a positive way. For example one complaint led to staff ensuring further opportunities for activity were accessible to one person. This demonstrated that complaints were used to improve outcomes for people.

The registered manager confirmed along with relatives that he maintained regular contact with people and their relatives and often sought them out to gain individual feedback. Communication and systems for feedback were thought to be effective. Residents meetings and satisfaction surveys were also used to gain additional feedback.

Requires Improvement

# Is the service well-led?

## Our findings

People and relatives were consistent in their positive feedback about the management of the service. They were confident that the registered manager had an effective overview of the service and managed the service well. They had a high profile in the home being accessible to staff people and relatives. Relatives and visitors said they were listened to and the culture of the home was open and relaxed with a pleasant atmosphere. People's comments included, "The manager is approachable he listens he does not take things personally he is not defensive but responds immediately," and "The manager is very good he is always willing to listen to your ideas." Visiting professionals were also positive about the management of the service which they felt met people's needs well and promoted a friendly atmosphere.

Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas. We found management systems that included quality monitoring did not always ensure safe and best practice was followed in all areas. For example we found 'as required' (PRN) medicine guidelines for medicines were not in place for all people. PRN medicines are only taken if they are needed, for example if they were experiencing pain PRN guidelines provide staff with guidance about why the person may require the medicine and when it should be given. In addition records relating to topical creams were not always accurate. This meant that the provider could not demonstrate that medicines were always delivered in a consistent and safe way. We also found some care documentation was not completed in a consistent way. For example, daily charts that recorded when people were checked, moved offered and given drinks and food were not well completed. Records on the first floor had not been completed all day when checked at the end of lunch time. They were not used as a live reflection of how care was being provided and were not written contemporaneously. This could lead to incorrect or out of date information being used when planning and caring for people. These areas were identified as requiring improvement. The deputy manager told us the system for recording daily records had been changed recently to improve the standard and was under review. She and the registered manager recognised that record keeping needed further review and improvement.

During observation staff were seen to be attentive and interactions on the whole were very positive however we found some interaction did not demonstrate that all staff had an effective understanding of caring for people who were living with dementia. For example we observed one member of staff telling one person on a number of occasions to 'sit down' when he wanted to go for a walk. Another person was becoming increasingly distressed and appropriate distraction techniques were not used. A recent quality review undertaken by the quality manager had identified the need for further emphasis on improving people's experiences and an action plan had been drawn up. This identified the plan to improve training for staff specific to those living with dementia along with the allocation of more dementia and dignity champions to monitor and improve care in practice.

There were a number of other quality auditing systems in place these included a variety of audits and feedback mechanisms from people and relatives. These had been used to improve the service. For example, any comments and feedback are discussed at management meetings with actions followed and embedded into practice. This has included care staff monitoring more closely to ensure the television is being used in

line with people's preferences and choices. This was a direct response to feedback in a survey.

There was a clear management structure in place at Sovereign Lodge Care Centre that staff were familiar with. This included head of departments that supported the registered manager who had an overview of the service and as a registered nurse took an active role in monitoring the care within the service. Staff were aware of the line of accountability and who to contact in the event of any emergency. There was on call arrangements to ensure advice and guidance was available every day and night if required. All staff were aware of the whistleblowing procedure and said they would use it if they needed to.

Staff said they felt well supported within their roles and said they could talk to the registered manager and other senior staff within the service. The registered manager fostered an open, relaxed rapport at all levels, a positive approach in developing and improving the service in an open, honest and constructive way promoting a learning and inclusive atmosphere. Staff and people appeared very comfortable and relaxed with him and approached him freely. One staff member told us how she was welcomed as a new staff member and "It's an exciting time to work in this home they are revamping and improving the environment to improve care for people and they help you as a staff member to be the person you want to be." Others staff said "I feel totally supported," and "He (the registered manager) always takes us seriously, he is very supportive." There were systems to provide staff with regular supervision and appraisals and staff told us these were useful sessions which were used to develop staff. We were told that an interpreter was employed to facilitate supervision for one employee who was deaf. This demonstrated the provider's commitment to equal opportunities.

Systems for communication for management purposes were well established and included a daily meeting with the senior staff on each of the floors. These were used to update senior staff on all care issues any management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "What's good is the manager is open to suggestions, carers (give information to the nurses) who have a daily nurses meeting and during staff meetings issues are raised and acted on." Each floor also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them communicated with them and ensured advice and guidance was acted on by all staff.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. The registered manager confirmed a procedure was in place to respond appropriately to notifiable safety incidents that may occur in the service.