Belmont Sandbanks Limited

Madeira Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 7 February 2018.

Madeira Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Madeira Lodge is registered to accommodate care and support for up to 28 older people. At the time of the inspection there were 25 people living at the service.

There was a registered manager in post. 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 last inspected the service on 8 and 9 January 2017, the service was rated as requires improvement. There were three breaches of regulations at this inspection. These were the lack of information written in the care plans which did not always reflect people's assessed needs and preferences. Risks had been assessed but not always mitigated to keep people as safe as possible and the systems in place to monitor the care being provided were not effective.

At this inspection new personalised care plans had been implemented with additional information; however these had not always been updated to reflect the care being provided. Detailed risk assessments were in place but lacked information about how to manage the risk and what further action should be taken to keep people safe.

Checks and audits were being carried out regularly by the registered manager and staff but these audits had not identified the shortfalls found at this inspection. Therefore, the breaches identified at the last inspection had only been partially met.

The registered manager worked in partnership with other professionals, such as people's care managers and the mental health team. However they had not informed the local authority safeguarding team of an incident which occurred at the service. We have made a recommendation about consulting the local authority safeguarding protocols.

Medicines were not always managed safely. Accidents and incidents were recorded and analysed by the registered manager. However further analysis was required to show that previous falls and incidents were taken into account to reduce the risk of them happening again.

People's needs had not always been assessed when they came into the service for a short period of time (known as respite care) and detailed care plans were not in place for these individuals. People were

supported to eat and drink, however. records of people's fluid charts were not clear to confirm that people were receiving enough fluids to keep them hydrated.

People's preferences of how they wished to be cared for at the end of their life were not consistently recorded. We have made a recommendation about seeking advice and guidance from a reputable source about end of life care planning in line with current guidance.

All staff had completed 'on line' training courses, however there was no practical face to face training for topics such as moving and handling, challenging behaviour and first aid, to show the practical element and assess staff competency. There was a lack of detail in the complaint records to confirm what action the provider had taken and whether complaints were resolved in a satisfactory manner.

Checks on the premises had been made to ensure it was safe and the provider had ensured that the environment was suitable for people living with dementia.

The registered manager had not always notified the Care Quality Commission, as required by law of events that happened in the service such as safeguarding and when serious incidents occurred.

Staffing levels were sufficient at the time of the inspection and rotas showed that the staffing levels were consistent. New staff had been recruited safely and the necessary checks carried out to make sure they were safe to work at the service. The service was clean and tidy and systems were in place to reduce the risk of infection. Staff were observed wearing protective clothing such as gloves and aprons.

Health care professionals were contacted when people needed additional support, such as the mental health team and district nurses. People were supported to see the optician and the chiropodists regularly visited the service.

People were not always supported to have choice and control of their lives. Staff did not have the full guidance to support them in the least restrictive way possible; the policies and systems in the service were not always clear to support this practice.

People were treated with kindness and respect. Their privacy and dignity was maintained. Staff promoted people's independence and encouraged them to do things for themselves.

There was a varied programme of activities for people to enjoy and the service was being supported by an outside agency to promote engagement and social activities. There was a dementia cinema, a family support group and wellbeing exercise programme.

The provider had a clear vision of how to provide the service however the culture of the service was not always inclusive. There was no evidence to show how people had been involved in menu planning or easy read information provided to support people living with dementia to complain.

People and relatives told us they were satisfied with the service and the quality of care being provided. They told us that communication with the registered manager was 'good' and 'excellent'. The registered manager knew the people well and they worked alongside staff to assess the quality of care being provided.

Staff told us they felt supported by the registered manager who was always available for support and guidance. The latest rating of the service was on display in the entrance hall and on the provider's website.

We found two continued breaches and two further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report. This is the second time the service has been rated Requires Improvement.

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.

Risks relating to people's care and support had been assessed but there was a lack of information to guide staff about how to keep people safe.

Staff had not consistently reported incidents to the local safeguarding team.

Medicines were not always managed safely.

Accidents and incidents had been recorded but there was not always detailed information to confirm what action had been taken.

There were enough staff to meet people's needs and they were recruited safely.

Systems were in place to reduce the risks of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People who were receiving respite care at the service had not had their care needs assessed before they were admitted to the service.

Staff had received on line training but there was a lack of face to face practical training to ensure staff had the skills and competencies to complete their role effectively.

Staff had regular supervision and an annual appraisal to discuss their learning and development needs.

Staff ensured that appropriate referrals were made to health professionals for specialist support. People were supported to eat and drink safely.

People were supported to make decisions about their care and support. Applications had been made to the local authority in

line with the Deprivation of Liberty Safeguards.

The service was continuing to make changes to the environment to support people living with dementia to help them orientate themselves.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect. Staff were patient and were attentive when people became anxious.

People were given choices of what they wanted to do or where they wanted to go. Staff listened to people and treated them with dignity and respect.

Staff encouraged people to become more independent by supporting them to do things for themselves.

Staff smiled and chatted with people

Is the service responsive?

Requires Improvement

The service was not always responsive.

In some cases people's care plans were detailed with personal information about their care whilst others did not always reflect the care being provided

Records of complaints did not always show what action the provider had taken to resolve complaints.

The provider was currently introducing person centred activities and working with outside agencies to achieve this.

People were observed enjoying the varied activities being provided at the time of the inspection.

The service provided end of life care but was not providing end of life care at the time of the inspection

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had worked hard to introduce new systems to ensure the service was compliant however there remained continued breaches of the regulations.

The provider had implemented systems to check the quality of care being provided however the outcome of the audits had not identified the shortfalls found at this inspection.

In some cases, further analysis was required in the accident and reporting system to show clearly what action had been taken to continuously drive improvements.

Staff understood the visions and values of the service, however the service was not always inclusive such as involving people in menu planning, or providing easy read information to support people about how to complain.

The registered manager had not always submitted notifications in line with guidance.

The registered manager worked alongside the staff to monitor the quality of care being provided.

Madeira Lodge Care 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 inspection took place on 7 February 2018 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of caring for family members.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury.

During our inspection we spoke with ten people living at the service, the registered manager, and deputy manager and three care staff. Some people were unable to tell us about their experience of care at the service so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked around all areas of the service; we reviewed care plans and associated risk assessments for four people. We looked at staff duty rosters, training records, three recruitment files, health and safety checks for the building, and quality assurance. We observed the care and support people received. We spoke with seven relatives visiting the service.

We contacted four health care professionals but no responses had been received at the time of this report.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. They said, "I feel safe living here'. Relatives commented, "It wasn't safe to keep my relative at home, they are much safer here. It was such a worry". "I know my relative is safe here."

At the last inspection, risks associated with people's care and support had been identified but there was not always sufficient guidance in place to reduce these risks as far as possible and ensure people remained safe. These areas included supporting people with their mobility and managing their behaviour.

At this inspection the provider had implemented a new format of care planning and risk assessments. The registered manager and staff told us they had worked really hard to improve the plans and whilst some improvements had been made there remained shortfalls in the behavioural and moving and handling risk assessments.

Risks associated with people's care had been assessed and in some cases there was detailed guidance for staff regarding how to manage the risks. However some risk assessments and care plans did not explain to staff how to support people positively to reduce the risks to keep people safe. For example, on occasions, one person would exhibit behaviour that might upset others in the communal lounge. This had been recorded on an accident/incident form and staff were aware of this behaviour. However, there was no risk assessment in place to guide staff how to manage the risk to the person and others or reduce the risk of this happening again.

Some people displayed behaviours that may be challenging. There was information for staff about the behaviours that people may display, but, there was no detailed guidance for staff to manage these behaviours. For example, a behavioural risk assessment stated there was no trigger factors or signs as to why a person became aggressive. In December staff had recorded on the risk assessment that the person had eight incidents of negative behaviour. There were no changes to the risk assessment with any updates or strategies to reduce the risks. There was no information to confirm what, if any action had been taken, such as contacting professionals for advice or changing the person's support.

Some people required staff to support them with their mobility needs and required a hoist to support them to stand. One person's mobility needs had changed and it was noted they now needed a hoist to support them with their mobility, however there was no information about the size of sling to use or how staff should position the sling. Slings should be individual to each person's weight and height so clear individual guidance should be in place for staff to refer to.

Some people's mobility needs had been assessed by the registered manager who was not trained to complete this type of assessment. The guidance given to staff did not follow current moving and handling guidelines as the risk assessments did not contain the full details or step by step guidance of how to move this person safely. One person had restricted mobility and was only able to balance using one leg. They needed support to stand with two members of staff and records stated they needed to use a zimmer frame

and wheelchair for support.

These instructions relied on the person understanding what they needed to do to mobilise safely. The person was living with dementia and was not always able to follow the instructions. Staff told us that two members of staff moved the person from the chair onto the bed without the use of any aids, for example a handling belt or other equipment. Staff described to us how they moved the person and understood that this was not safe but no further action had been taken to ensure this person was moved safely.

The registered and deputy manager were aware of how staff were moving this person as the deputy manager moved them with another member of staff regularly. It had not been recognised by the management team that the practice was unsafe and did not follow moving and handling guidelines.

The registered manager told us that one person chose what position they preferred to attach the loops for the hoist sling on the main frame, and would then tell staff when they were in the right position. Staff told us that this varied depending on the decision the person made each time they were being moved. This information was detailed in the risk assessment; however staff had not recognised that not attaching the sling loops in the right place was unsafe. There had been no referral made to a health or social care professional or suitably trained moving and handling assessor for advice and support. There was no step by step guidance to show staff how to consistently move this person safely. The registered manager told us that the person had fluctuating capacity but this had not been taken into account when they made decisions about their mobility and using the sling.

The registered manager told us that they would contact an occupational therapist for a professional assessment so that staff would have the guidance they needed to ensure the person would be moved safely.

Accidents and incidents were recorded and analysed by the registered manager, however, further analysis was required to identify patterns and trends. For example one person had fallen in the lounge and it was recorded there were no injuries. The action and possible reason of the fall stated there had been a 'dementia dinner and dance' that evening and all of the people were, 'over happy.' No investigation had been carried out into any other reason why the person fell or what action had been taken to reduce the risks of this person falling again.

When people had head injuries, staff attended to their wounds but did not always contact health care professionals for further advice. For example one person fell in the lounge, records stated that the cause was unknown, their injuries included a cut eyebrow, a small lump to middle of forehead and two small lumps on the back of their head. The action staff took was to apply a cold compress, clean the cut and observe closely for 24 hours. Staff had recorded the incident in the person's daily notes, but there were no further evidence to confirm these checks had taken place or continued to reduce the risk of re- occurrence.

Risks to people's safety had not been consistently assessed and action had not always been taken to mitigate the risks. In an upstairs shower room, there was a heated towel rail against the wall with no protective cover. The towel rail was very hot to the touch. People who were confused and living with dementia had access to the bathroom, there was a risk that people would touch the towel rail and burn themselves. The registered manager turned the temperature of the towel rail down but had not recognised the risk to people.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. This was an ongoing breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always administered to people as prescribed. Some people were prescribed warfarin, to thin their blood to prevent clots from forming. There was not an accurate record of how many tablets had been given. There had been 40 tablets on 22 January and 10 tablets had been signed as administered. However, only 9 tablets had been removed from the packet. The person had not received their dose of warfarin on one day.
Some people were prescribed inhalers to help their breathing. Each inhaler has a limited number of 'puffs'. One person was prescribed two puffs twice a day; the inhaler should have lasted 30 days. However, the inhaler was dated as being started on 23 December, 39 days previously. The person had not received their prescribed amount of medicine.

Some directions for medicines had been handwritten. These directions should be signed by two members of staff to confirm that it is correct. Two handwritten directions had not been double signed as checked and correct.
The provider had failed to ensure that medicines were managed safely. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they needed them, they said, "I have cream on my legs which I sometimes keep in my room. If my leg hurts they give me an extra pain killer."

There were effective systems in place to order, store and dispose of medicines safely. The temperatures where medicines were stored, including those needing to be stored in a fridge, were recorded daily and were within the recommended range to ensure medicines remained effective. Some people were prescribed medicines on an as required basis, such as pain relief and medicines for anxiety. There was guidance in place for staff about when to give the medicine, the minimum gap between doses and the maximum dose in a day.

Staff described how to protect people from abuse and told us they would not hesitate to report any concerns to the registered manager. Staff told us that they were confident that the registered manager would take the appropriate action. However, events that had happened were not always recognised by staff as needing to be reported to the safeguarding team for evaluation. An incident of inappropriate behaviour which could have left people of risk of harm occurred in the communal lounge. Although the registered manager told us that staff reacted quickly and this did not affect other people, in order to protect the person and other people this should have been discussed with the local safeguarding team to assess if an alert should be raised. The registered manager told us they would contact the local authority safeguarding team to discuss this incident.

We recommend that the registered manager consult the local authority safeguarding protocols with regard to pre consultation and referral of safeguarding issues. □

People's finances were protected as there were systems in place to record any transactions. These records were checked to ensure that they were accurate.

People were protected by the prevention and control of infection. The service was clean and tidy. Relatives commented, "The standard of cleaning was excellent". "Cleaning is very good". The registered manager carried out checks on the infection control procedures in the service and cleaning schedules were in place to ensure the premises were clean and tidy. There were sufficient domestic staff to keep the service clean. Staff were observed using personal protective clothing such as gloves and aprons.

The registered manager checked that the equipment in the service was working. This included regular

servicing of the hoists, the boiler, fire equipment, emergency lighting and the electrical system. Fire call bell checks were checked weekly and evacuation procedures were in place
There were enough staff on duty to meet people's needs. Staff told us that they were able to support people when they needed it. The registered manager used a dependency tool to assess how many staff were needed to support people. Staffing levels changed according to what people were doing and the support they needed. Annual leave and sickness was covered by the staff team. The registered manager worked with staff if extra support was needed.

Staff were recruited safely. The required recruitment checks including references, photo identification, full employment history and Disclosure and Barring Service (DBS) criminal records checks were completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

Requires Improvement

Is the service effective?

Our findings

People told us they received the care they needed and they were supported to see the doctor when they needed to. They said, "I am very well looked after by the excellent staff". "If you feel a bit funny the staff will advise if you need a doctor then they call one".

Relatives commented, "The staff always call a doctor when my relative needs one". "My relative been here for several weeks and we have seen a remarkable improvement." "My relative loves living here".

People's needs were assessed using recognised tools as recommended by the National Institute for Clinical Excellence (NICE), including the risk of malnutrition and skin damage. Each person should have a detailed assessment of their needs carried out to ensure that the service can provide the care they need. When people came to live at the service on a permanent basis a full care needs assessment was completed with information from the person, relatives and the placing authority or hospital. This information was then used to develop the care plan.

However, the registered manager told us that when people came into the service for a short period of time (known as respite care) they did not had carry out a care needs assessment and no detailed care plan was put into place. The registered manager was also responsible for the management of the day centre (attached to the service at the end of the drive) and told us that most of the people on respite care usually attended the day care service so they had some knowledge of the person's needs. They told us this would be addressed straight away and in the future everyone using the service would be fully assessed with detailed care plans put into place. This was an area for improvement.

Staff had received training appropriate to their role. However, the training had been limited to online training so limited opportunity to discuss and debate issues and ask questions and practice hands on. Staff completed workbooks and these were sent to the training provider to be marked. A certificate was issued when staff passed the workbook. There had been no face to face training for topics such as moving and handling, challenging behaviour and first aid, to show the practical element and assess staff competency. The registered manager observed staff move people and signed them off as competent to use the hoist and other equipment. The registered manager was not a trained moving and handling assessor and therefore, not qualified to assess staff competency. Current moving and handling guidance specifies that staff should be trained in the specific equipment and techniques so that they have the skills and competency to carry out the handling plan and understand the risks and measures to control them. The registered manager told us that staff would be receiving practical moving and handling soon but there was no date booked.

The provider had failed to ensure that training was provided to enable staff to have the skills and competencies to perform their roles. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff received an induction when they started working at the service. This included shadow shifts, to work with more experienced staff and learn people's choices and preferences. Staff completed the care

certificate; this is an identified set of standards that social care workers adhere to in their working lives. Staff met with the registered manager during their probation period to discuss their progress and any additional support they may need.

Staff told us that they felt supported by the registered manager and they were able to discuss any concerns they may have. Staff received regular one to one supervision and appraisals with the registered manager. Staff discussed their development and training needs.

Staff sat and chatted to people, giving them reassurance and encouragement to eat at lunchtime. They gave people enough time to eat and enjoy their meal. There was a choice of meal at lunch time but each person received their vegetables already plated so they did not have the opportunity to say what they preferred. People's likes and dislikes were recorded in their care plan and in the kitchen; however there was no evidence to show how people were involved in the menu planning. Many people were living with dementia and there were no pictures of food to support them to make their choices. The deputy manager told us that people were given a choice of meal at lunch time by the staff holding up two different meals so that they could choose. This was not observed during the inspection.

Some people had small appetites and needed to be encouraged to eat and drink. During the lunchtime meal some people did not eat the meal they were offered. Staff offered them an alternative; however, some people did not eat this meal either. Staff tried to encourage people but were unsuccessful. Staff completed food charts for people who needed encouragement, to monitor how much people were eating. However, the charts had not been analysed to see if there were any patterns to what people ate and when. For example, one person had not eaten the main meals at lunchtime for two weeks, but they had eaten finger food such as sandwiches and crisps at tea time. Staff had not offered the person finger foods at lunch to see if the person would prefer them.

Staff monitored people's fluid intake when they were not drinking enough. However, there was no guidance for staff to show how much people should be drinking to keep them healthy. Fluid charts had not been totalled each day and reviewed to monitor how much people had drunk. There was no guidance for staff about what action they should take when people had not drunk enough fluids. Some people were living with diabetes and the care plan recorded they were to have a diabetic diet but there was no further details of what this entailed.

People told us they enjoyed the food, they said, "I like the food". "Food is good and you get a choice. You can have a cooked breakfast if you want one. They serve regular drinks but if you want an extra one you can ask for one". Relatives commented "The food is good, there is a choice but I don't think there are enough drinks". "There is a jug in her room so she gets plenty to drink". "If you want a cup of tea you just ask".

Staff worked with health care professionals to ensure people's needs were met. Staff monitored people's health and referred people to healthcare professionals such as the mental health team when needed. However, when people fell, there was not always evidence to show what, if any medical advice had been sought.

People's weight was monitored. When people lost weight they were referred to the dietician for additional support. Staff referred people to the district nurses when they had wounds or a catheter, for treatment and guidance. Staff followed the guidance from specialist healthcare professionals for example, people were supported to have dietary supplements to help them gain weight.

People were supported to lead as healthy lives as possible. People regularly saw the optician, dentist, and

chiropodist and to attend outpatient clinics at the hospital. One relative commented, "The staff always accompany my relative to hospital appointments". Staff had taken action when people's negative behaviour continued and had contacted the doctor and made referrals to the mental health team for support and guidance.

The service was continuing to make changes to the environment to support people living with dementia, such as using yellow signs with pictures to show people where to use the bathroom or to identify their bedroom. Bedroom and toilet doors were different colours and the hand rails were emphasised by using different wall colours above and below so that people would see them clearly.

People were able to move around the premises as they wanted without unnecessary restriction. The provider had plans in place to make further adaptions to the premises to continue to meet people's needs. A relative commented, "Madeira Lodge is a warm, light and bright environment. We see continuous improvement and decoration going on to keep it to a very high standard".

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's capacity to make decisions had been assessed. Where people had been assessed as not having capacity to make complex decisions DoLS had been applied where relevant. However, there were no MCA assessments for less complex decisions such as how people decided what they would like to eat and drink. After the inspection the provider sent us information to show that some individual decisions had been made but this information had not been signed by the assessor or by the people involved in the decision making process. This was an area for improvement.

Staff supported people to make day to day decisions such as how to spend their time. Staff sought people's consent before giving care and support. Staff respected people's decisions, if they refused support, for example, if people did not want to take part in an activity.

Good

Is the service caring?

Our findings

People and their relatives told us they were happy with the service and staff were kind and caring. They said, "I like living here, I like the company". "The staff are kind". "It's like living at home". "I like it they are good to me".

Relatives commented, "The carers are all very good". "I like the staff and my wife gets on well with them". "The staff are all excellent". "The team make me smile. There is genuine care and affection and I cannot praise them high enough". "The love, laughter and care provided made the situation easier". "It was good to see my loved one happy and relaxed when I visited and looking smart and well dressed".

A relative sent a compliments letter to the service in February 2018. They commented, "The staff are friendly, warm and accommodating". "They are knowledgeable and understanding, smart in appearance and always greet us with a smile".

Staff spoke with people discreetly when offering them support. Staff ensured that they were at eye level with people and spoke quietly, so only the person could hear them. Care plans had guidance for staff to support people with their communication, such as listening to people, giving them time to continue the conversation and reminding staff to stand in front of them and ask them to repeat the request if necessary. Staff were observed listening to people and waiting for people to respond during the inspection.

Staff knew people well and understood how much support each person needed. People were supported in the way they preferred, staff offered people reassurance when needed. When people became anxious staff sat and chatted with them until they were calm. Staff understood what people liked to talk about to relax them, for example, one person liked to talk about their family. The person appeared happier and was smiling at staff while chatting about their children.

Staff had recognised one person was not their usual self, so additional monitoring was in place and staff gently spoke with the person asking them how they felt, were they in pain or if they needed anything. The person responded smiling and saying they were aright.

People were supported to be as independent as possible. One person said, "I try to be as independent as I can. I have a bath or shower two or three times a week". Staff encouraged people to do as much as they could for themselves. Some people walked using a frame. Staff prompted them to use the frame safely, reminding them how they should hold the frame. People were able to move around the service and spend time where they wanted. Some people decided to spend time in their rooms, staff spent time chatting to them and looking at books.

People said they were able to make choices about their care. They said, "The staff give me warning about what time I'm getting up; they put their head round the door and say they'll be there in five minutes to get me up. If I want to stay in bed I can. I go to bed 10 pm or 11 pm I can choose".

One person told us that they chose who supported them with their personal care, they said, "I'd rather have a female carer than a man for my personal care but it is quite nice to chat to a man sometimes".

People spoke about how they enjoyed having their hair and nails done. They said, "I sometimes colour my own hair, I also occasionally do my own nails but it is nice to be pampered". "I have my nails and hair done".

People told us they liked their rooms. They said, "My room has been personalised, I chose the colour I wanted it painted and I have added some photographs to make it more personal".

People walked freely around the service and went back to their bedrooms when they wanted. Staff greeted people as they went about their duties, making sure people had everything they needed.

Staff watched people discreetly as they went back to their bedrooms to make sure they were safe. We observed staff knock on people's doors and waiting to be invited in. Staff described to us how they promoted people's privacy by closing the curtains when they supported with personal care.

People's privacy and dignity was respected. People were relaxed and comfortable with staff who spoke with them in a respectful manner.

Relatives told us that they were able to meet with their loved ones in private. They said, "When I visit we usually go to my relative's room so we can have some privacy and have a good laugh and a chat".

People were supported to make decisions about their care and advocacy services were available if needed. (An advocate helps people to make informed choices.) Visitors were made welcome in the service and offered refreshments.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff responded promptly when they needed support. They said, "The staff come quite quickly if I ring the bell". A relative commented, "The staff come like bullets in response to a bell".

At our last inspection, the information in people's care plans did not reflect their assessed needs and preferences. There was a lack of step by step guidance regarding people's preferred daily routines and information within this about their wishes and preferences.

At this inspection the provider had implemented a new format of care planning which had improved the content of the plans and they were more person centred, however their remained some shortfalls in the details of the care plans to give staff the guidance they needed.

People and their relatives were involved in planning their care and relatives had signed to agree the care plan if people needed support to make decisions about their care. One relative commented. "They review my relative's care plan regularly".

Each person had a care plan that gave details of the personalised care and support they needed. Staff had completed a 'My Life Book' for each person which detailed people's life histories, who was important to them, their likes and dislikes. The care plans also gave details about people's choices and preferences. However, when people's needs changed the care plans were not updated to reflect their new support needs.

One person's care plan contained detailed guidance for staff about how to support the person. The care plan stated the person was independent in many areas of their lives. When the care plan was reviewed in January 2018 it was added that the person now required a standing hoist, as their overall physical condition had deteriorated. Staff described to us the support they now gave the person, as they had become dependent on staff for all their needs. The support the staff were now giving had not been reflected in the review of the care plan, the care plan had not been updated.

Some people's care plans contained details of their behaviours that may challenge. One person's care plan stated that they should be given plastic cups, plates and cutlery because they threw them and smashed them. During the inspection, the person was given china plates and cutlery; staff were not following the care plan. The person did not display any of the behaviours described in the care plan during the meals we observed. The care plan also gave details about the person's behaviour; staff told us that the person did not always co-operate with staff and may shout and hit staff. However, staff had not completed behaviour charts or written in the daily notes if the person had displayed any of these behaviours. Care plan reviews had not identified if the care plan was still relevant to the person. Staff should have up to date records and guidance to refer to give people consistent support.

One person had information in their care plan that they would ask for the TV remote but staff were to give them a spare as they will turn the volume right up at night and disturb other people. There was no further information as to how this decision had been made and if the person had agreed. We discussed this with the

registered manager who said they would review the situation.

The provider had failed to ensure that accurate records were in place for each person to ensure the care plan reflected people's assessed needs and preferences. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they enjoyed the social activities, they said, "I like joining in with the activities". "I prefer my own company so I mostly stay in my room but I use the garden if it's nice". "I watch the TV, read, knit and staff call in for a chat". "The girls get me my magazines, I have four a week". "Take me up the shop occasionally" A relative commented, "The singing on a Tuesday afternoon is brilliant".

The provider was seeking ways to improve activities for people living at Madeira Lodge. They had sourced outside organisations to support them to introduce person centred activities to improve people's engagement and social lives. A session was in progress at the time of the inspection and people were happy and enjoying taking part.

The service had their own transport to take people to the local zoo, cafes and for days out. Staff told us how people enjoyed fish and chips out and went to Hastings or Bexhill during the summer.

The registered manager told us the plans for the service which included every day domestic appliances to encourage people to be more involved in their daily routines. They intended to have a yellow paved area where people could walk in a circular route and have raised beds in the garden for people to enjoy planting for each season. Parties were arranged celebrating each special occasion and people were involved in raising monies for local charities. Staff talked about the dementia training and were enthusiastic in bringing ideas into the service to improve people's lives.

Each person had a folder that showed what people had made and photos of them making cakes or taking part in singing. Staff spent time with people in their rooms on a one to one basis, playing board games or reading to them. People told us that they looked forward to going out in the good weather they enjoyed going outside. They said, "I like to go out in the garden in the summer". A relative also commented, "I love it here in the summer when we can go in the garden."

People told us that they would not hesitate to complain and had complained in the past. They said the registered manager listened to their concerns and took action. Relatives commented, "I don't have any complaints but I would be happy to approach management face to face if I did."

The provider had a complaints policy; this was available in the front hall of the service. There had been three written complaints since the last inspection. The registered manager recorded these in a book and attached the letters. Complaints had not always been investigated following the provider's policy. The registered manager had received a complaint in May 2017. They had taken immediate action to address some concerns and forwarded the complaint to the provider for further action. The registered manager had not recorded that the complaint had been sent to the provider. There was no record of the action that the provider had taken or whether there had been a satisfactory resolution to the concerns raised.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. The complaints policy was not available in an easy read format to support people living with dementia to understand how to make a complaint. This was an area for

improvement. Blank quality assurance surveys were located in the hallway so that anyone visiting had the opportunity to provide feedback about the service.

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The service was not providing end of life care at the time of the inspection. The service had made some progress in gathering information about how people wished to be cared for at this time. In some care plans there was a lack of information to show people's preferences about how they wished to be cared for at the end of their life, such as if they wished to be resuscitated should the need arise. After the inspection the provider told us that attempts to record this information was evidenced within various care plans where the families had been involved and given a response to their relative's end of life care wishes. However, the end of life care plan provided was not dated or signed to confirm who had been involved in the plan and how these decisions had been made. The plan also stated that that the family would talk about having a 'Do Not Attempt Resuscitation' (DNAR) consent form in place. This information had not been updated and at the time of the inspection the person had a DNAR in place dated 6 October 2017.

We recommend that the service seeks advice and guidance from a reputable source about end of life care planning in line with current guidance.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoke positively about the registered manager and the way the service was being managed. They knew the registered manager as they helped to support them each week, they said, "The manager calls in and has a chat".

Relatives said that communication with the registered manager was 'very good" and "excellent". They also felt their loved ones were being looked after well, they said, "It's a great weight off my shoulders. I know my relative is being looked after well. I can't fault the place". "There are no problems at all with this place, my relative is very content".

A recent compliments letter had been received from a relative, which noted, "Thank you for being so wonderful with us all when we visited. The way you are with all the residents is amazing". "Thank you and your staff so much, for the care and understanding you have shown my relative, the registered manager and staff are very dedicated to their profession".

The registered manager was supported by the deputy manager. The registered manager worked alongside staff to assess the quality of care being provided. Staff told us they felt supported by the registered manager who was always available for advice and guidance. Staff told us, "The manager works with us and always knows what is happening." The registered manager told us that they were on call to support staff if they need additional support.

At the last inspection there were shortfalls in the systems and processes to effectively monitor the service to ensure compliance with requirements. The provider sent an action plan to CQC advising they would be compliant with the regulations by 30 April 2017.

At this inspection it was clear that the provider had implemented changes to improve the service. They had engaged a consultant to support the service to improve and become compliant with the regulations. They had introduced a new format of care plans and risk assessments. The care plans were personalised but risk assessments for moving and handling and behaviour lacked information to show how risks were being managed. Audits and checks had been introduced and these had been completed regularly by the registered manager. However, the shortfalls found at this inspection had not been identified; therefore there were two continued breaches and two new breaches of the regulations.

The registered manager had carried out regular audits of the service; however the action taken to evaluate the care being provided was not always followed through to show the continuous improvement of the service. For example, during December 2017 there were a total of seventeen accidents/incidents; the registered manager noted this in the monthly audit and some action had been taken, such as a family had been requested to purchase an adjustable bed to reduce the risk of a person falling out of bed. The registered manager also told us that the night staff had been increased when people's dependency had changed to ensure they were safe.

The registered manager's rationale for the high amount of falls was that people were unwell and due to the many social events during December they were over excited because of the Christmas period. There was no in depth analysis to look for patterns or trends to reduce the risks of people falling. For example on 12 December 2017 there were two un-witnessed accidents when people had been found on the floor and one incident when a person suffered a skin tear. There was no information to say if the registered manager had investigated staffing levels to ensure they were sufficient to keep people safe.

When people fell the registered manager completed the details on an accident incident form which included a description of the fall and action and possible reason for the fall. These details were not always sufficient to show what further action had been taken for example, it was noted a person lost their footing which caused them to fall forwards and hit their face resulting in a nose bleed. The action taken was that staff stemmed the bleeding and there were no further injuries. There was no record if the staff had needed to seek medical advice or what further monitoring was put in place to prevent this from happening again.

The audit also showed that another person had a minor injury after 'lashing out' at staff and the action noted was that the person was known to be aggressive at times and staff to be aware of this. There was no information if a behavioural risk assessment had been updated or what other action was taken to support the person with their anxiety to reduce the risk of this happening again for example to implement closer monitoring or a referral to a healthcare professional for support.

The audits covered checks on areas of the service and detailed any action required and who was responsible for carrying out the work. For example, the action required after completing the audit of the care plans in December 2017 identified that some plans needed to be changed including implementing food and fluid charts. However, the time scale was 'ongoing' and the information did not identify whose care plan needed updating to keep an audit trail of what had been achieved and to make sure the plans had been updated. This was noted in December and at the time of the inspection there remained care plans that had not been updated.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This was a continuing breach of regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their roles and were supported though supervision and regular staff meetings to give them the opportunity to voice their opinions about the service. Managers also met with the provider regularly to discuss the continuous improvement of the service. Minutes of the meetings were held so that all staff had the opportunity to keep up to date with current issues.

In a recent quality assurance survey two relatives had rated the service as 'excellent' and commented "Very friendly staff, very helpful and never had to complain". A professional visiting the service had also rated the service as 'excellent'.

The service listened and acted on comments made to improve the service. When a relative commented that the activities were 'basic' the provider took action and had sourced an outside activity organisation to improve the activities and this was in progress at the time of the inspection. The registered manager told us that further improvements were being made planned for April 2018 to gather feedback from everyone involved in the service, we will follow this up at the next inspection. They told us that they were updating the surveys, not only the content but also how the information was gathered either by filling in a form by hand or on line. There were also plans to publish the results of the surveys on the provider's website.

Since the last inspection the registered manager had contacted relatives and a 'family committee' had been formed, records showed they were involved in organising a summer fare, designing leaflets and acquiring raffle prices for a raffle. The meeting was held in July 2017 and the event happened in September last year. This event helped raise money to improve the garden.

The provider's visions and values about the service were ' We believe that each individual person is a unique social being who has dignity and worth, and although requiring acts of assistance due to their frailty, or ill health, should do so only in a climate which enables them to retain their self-respect and independence'. Staff said they always treated people with dignity and respect and as individuals. We observed this practice throughout the inspection as staff were attentive to people's individual needs promoting their independence and valuing their opinions.

The service had links with the community and had been involved in setting up a dementia choir where one person was supported to sing accompanied by their relatives. The local school academy visited the service and had chatted with people on a regular basis. The service was also involved in supporting students from the local college with the work experience scheme which helped them to understand the needs of people living with dementia.

The registered manager was passionate about supporting people living with dementia and upholding their rights. They had attended local care forums to increase their knowledge and keep up with good practice. They told us that a newsletter was being produced for people which should be available from next month about the news and further events in the service. The registered manager had set up a dementia information/communication board to give relatives a better understanding how dementia affects people and their family.

The provider was a member of the Federation of Small Business, Kent Integrated Care Alliance and national and regional care associations and the Kent Invicta Chamber of Commerce. This membership and attending regular managers meetings were used to, keep managers up to date with changing guidance and legislation.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had not always submitted notifications in an appropriate and timely manner and in line with guidance.

The provider had not notified CQC of other incidents such as any abuse or allegation and serious injuries which require a statutory notification to be made to CQC. This is a breach of Regulation 18, of the Health and Social Care Act 2008 (Registration) Regulations 2009

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the entrance hall of the service and on their website.

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 provider had not notified CQC of other incidents such as any abuse or allegation which is a required statutory notification.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. The provider had failed to ensure that medicines were managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. The provider had failed to ensure that accurate records were in place for each person to ensure the care plan reflected people's assessed needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The provider had failed to ensure that additional training was provided to enable staff to have the skills and competencies to perform their roles.