Healthcare Homes (LSC) Limited

Sovereign Lodge Care Centre

Inspection report

2 Carew Road
Eastbourne
East Sussex
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
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. 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 lived with a chronic health condition such as multiple sclerosis, diabetes or chronic obstructive airways disease. The first floor provides nursing care for up to 27 people who are living with a dementia or a mental health need. Both nursing units can provide care for people at the end of their lives and used community specialist support when providing this care. 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 62 people were living in the service with 24 people on the ground floor 27 people on the first floor and 11 people living on the second floor. This inspection took place on 10 and 11 of August 2017 and was unannounced.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Sovereign Lodge Care Centre was registered under new ownership in May 2016 and this is the first inspection since that change.

The management systems did not always ensure safe and best practice was followed in all areas. The provider could not demonstrate that all medicines were administered in a consistent way and accident reporting did not allow for auditing. Some care records did not ensure clear guidelines were provided for staff to follow. This meant important care instructions may not be passed on to all staff and could impact on the care provided. These areas were identified to the registered manager for improvement.

Staff did not always engage with people on a regular basis. They did not take all opportunities to engage with people in communal areas or in individual rooms in order to prevent the possibility of social isolation and promote person centred care. People were aware of how to make a complaint and felt that they had their views listened to, however complaints were not clearly recorded to confirm that they were used to improve the service. All these areas were identified to the registered manager for improvement.

People were looked after by staff who knew and understood their individual needs well. Staff were kind and treated people with respect, promoted their individuality and independence whenever possible.

Staff had a good understanding of safeguarding procedures and knew what actions to take if they believed people were at risk of abuse. Recruitment records showed there were systems which ensured as far as possible staff were suitable and safe to work with people living in the service. 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. Medicines were stored, administered and disposed of safely by staff who were suitably trained.

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 with whoever they wanted to.

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. People were given information on how to make a complaint and said they were comfortable to raise a concern or complaint if need be.

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.

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.

Medicines were stored, administered and disposed of safely by staff who were suitably trained. There were enough staff on duty to meet people's care needs. Appropriate checks were undertaken to ensure suitable staff were employed to work at the service.

The environment and equipment was well maintained to ensure safety. Risk assessments were used to assess potential risks. Staff responded to these risks to promote people's safety.

Is the service effective?

Good

The service was effective.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Staff had an understanding of the Mental Capacity Act 2005 and DoLS assessments had been made to determine peoples' capacity and appropriate referrals were made to the local authority if people needed to be deprived of their liberty to ensure their safety and well-being.

Staff monitored people's nutritional needs and people had 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. Relatives were

made to feel welcome and included as an important part of people's lives.

Everyone was positive about the care provided by staff. Staff knew people well and had good relationships with them.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were aware of how to make a complaint and felt that they had their views listened to, however complaints were not clearly recorded to confirm that they were used to improve the service.

Staff did not take all opportunities to engage with people and prevent the possibility of social isolation.

People had the opportunity to engage in a variety of activity that staff supported them with either in groups or individually.

Care was personalised and tailored to peoples' individual needs and preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management systems did not always ensure safe and best practice was followed in all areas. This included accurate and full record keeping.

The registered manager was supportive to staff and had a high profile in the service.

Systems were in place to gather information from people, relatives and staff and this was used to improve the service.

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 home, and to provide a rating for the home under the Care Act 2014.

The first day of inspection took place on 10 August 2017 and was unannounced. The inspection team consisted of three inspectors and one experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection took place on 11 August 2017 and the registered manager was advised of this visit.

Before our inspection we reviewed the information we held about the service. We considered information, which included share your experience forms which are generated when people contact us on line, 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. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we spoke with the local authority who commissioned care for people from the service. During the inspection we talked with eight people who use the service and 10 relatives. We spoke with various staff members including the registered manager, the deputy manager, the activities co-ordinator, the temporary chef, two registered nurses, the organisations training and development manager three members of the housekeeping team, the maintenance person and three care staff. Following the inspection we spoke with two specialist nurses who visit the service. We also spoke with Healthwatch for their views on the service. Healthwatch is the independent consumer champion created to gather and represent the views of the public on issues relating to health and social care.

We spent time observing staff providing care for people in areas throughout the home and observed people having lunch in the dining room. We used the Short Observational Framework for Inspection (SOFI) during the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed a variety of documents which included three people's care plans and associated risk and individual need assessments.

We looked at four staff recruitment files, and records of staff training and supervision. We viewed medicine records, policies and procedures, systems for recording complaints, accidents and incidents and quality assurance records.

Good

Is the service safe?

Our findings

People told us they felt safe living in Sovereign Lodge Care Centre. They said they felt secure, and able to get support whenever they needed it. One person told us," I feel safe. I have no worries and I have my confidence back." Another said, "I feel safe because I can always ring my bell for help." Relatives were confident that people were safe and this included being provided with safe and appropriate care. One relative said, "I know my wife is safe because all her needs are met. I have no concerns about her day to day care-she is not left in bed too long and this is illustrated in a chart which shows her routine. I am assured by this routine that she gets the correct and safe care." Another relative said "The nurses and carers are very attentive, residents are checked during the night and it is always recorded." Other relatives commented on the equipment used to keep people safe and one relative said, "I feel my mother is safe here. She has a sensor mat to which the carers respond to if she gets up at night."

Staffing arrangements included separate staffing for each of the floors. This included one registered nurse on each of the nursing floors and a senior carer on the second floor to monitor and review the care provided. Agency staff were used to cover known shortages mostly on nights. Staff turnover was high and the registered manager confirmed recruitment was ongoing with agency staff being used to cover shifts when necessary. There were enough staff to make sure people had their individual needs met. For example, bells were answered promptly and staff were available to respond to accidents and incidents promptly when they occurred.

People's medicines were managed safely. People received their medicines in accordance with their prescriptions. Storage facilities were appropriate and well managed. For example, medicine rooms were locked and the drug trollies were secured in these rooms when not in use. Staff gave medicines on an individual basis and completed the medicines administration records (MAR) chart once the medicine had been administered safely. Medicines were administered by registered nurses and senior care staff who had undergone additional training and competency checks. These staff were familiar with the ordering and storage arrangements and described the daily checks completed to ensure safe storage arrangements were maintained. For example, the checking of medicines that needed extra security. Staff administered medicines in a person centred way, checking what medicines were required and answering any questions on an individual basis.

Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing anxiety or pain. Each person had individual PRN guidelines for staff to follow. These provided guidance for staff about why the person may require their medicine and when it should be given. Records confirmed PRN medicines used were reviewed for effectiveness and this ensured they were used appropriately. Systems for variable dose medicines were also well managed. For example, one person had a skin condition that was treated with a varying dose of medicine. This was clearly reflected on the MAR and within this person's care plan. We found medicines were given in accordance with any changing requirements.

Staff including domestic and catering received training on safeguarding adults and understood their

individual responsibilities to safeguard people. One staff member told us if they had any concerns about possible abuse they "would tell the manager or the nurse in charge or use telephone numbers that were displayed outside the office regarding this matter." Staff felt they would be listened to if they had a safeguarding concern and the senior staff and registered manager would respond to these concerns quickly. Staff were aware of the services policies and procedures which included the contact number for the local authority to report abuse or to gain any advice. The registered manager had worked with the local authority over recent months on safeguarding matters and had reported safeguarding's appropriately in the past. For example, an incident resulting in a hospital admission was reported and discussed with the safeguarding team.

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the service. Checks included the completion of application forms a record of interviews, confirmation of identity, references and a disclosure and barring check (DBS). 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 the Nursing and Midwifery Council (NMC) which confirmed their right to practice as a registered nurse.

The provider had established systems to promote a safe and clean environment at Sovereign Lodge Care Centre. Systems to ensure the security of the service were in place with all visitors entering a reception area and signing a visitor's book before entering the service. Health and safety checks and general maintenance were established and completed routinely by the maintenance person. Emergency procedures and contingency plans were established for staff to follow and use. The 'on call' arrangements ensured staff had access to senior staff at any time for advice and support if required. A fire risk assessment had been completed and fire equipment was checked and maintained. Emergency information was accessible in the front entrance of the service and staff knew what to do in the event of a fire. This information included Personal Emergency Evacuation Plans (PEEPs) used to direct staff and emergency services on safe evacuation of people from the service in the event of an emergency.

Risks to people's safety and care were identified and responded to. Risk assessments were used to identify and reduce risks. For example, risks associated with nutrition, moving people and pressure areas were documented, and a risk management plan was then established. These plans were put into practice with staff ensuring people were moved with moving equipment safely with two staff when required.

Good

Is the service effective?

Our findings

People and their relatives had confidence in the staff that cared for them at Sovereign Lodge Care Centre. They told us staff knew what they were doing and were trained to look after people appropriately. For example one relative said, "I have no worries about the safety of my wife's hoist the carers are well trained, they have special training in manual handling every fortnight." We were told, "Staff work very hard". Feedback from visiting health care professionals was positive about the skills and competence of the staff and their willingness to improve the care they provided.

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 to 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).

Staff had completed training on the Mental Capacity Act (MCA) and DoLS. There were relevant guidelines in the office for staff to follow and staff understood the principle of gaining consent before any care or support was provided. Staff asked for consent before providing support and gave choices to people throughout the day. Staff knew and responded to people's choices. For example, one relative told us how staff had discussed their mother's wishes with them and the GP around resuscitation.

When people were thought not to have capacity to make specific decisions, staff worked in accordance with the Mental Capacity Act (MCA). The registered manager had worked with the senior staff to identify people who did not have capacity to make specific decisions and had reviewed any restrictions that may have been used as part of their care and treatment. Senior staff had then applied to the local authority for DoLS when appropriate. These had been recorded and included in people's individual care plans. The registered manager followed up these applications with the DoLS assessment team to ensure they were progressed as soon as possible. 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 had a commitment to learning and development. Staff that were new to the service attended a structured induction programme. This included formalised training and support in understanding people's care needs. Staff on the induction were positive about the training provided and how it prepared them for their role within the service. Shadowing senior staff was also part of the induction training along with the completion of the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers.

A programme of training had been established and staff had completed essential training throughout the year. This training was co-ordinated by a training manager who ensured staff completed the required

training. They also completed competency checks on staff whilst working in the service to ensure training completed was transferred into practice. The training programme was varied and reflected the needs of people living in the service. It included training on health and safety, infection control, food hygiene, dementia awareness, mental capacity and DOLS, safe moving and handling and safeguarding.

Staff told us that the training was appropriate and also provided an opportunity to develop their skills. One staff member said, "We get regular training and the office checks and sends you a reminder letter when you fall behind with any training. Generally the training is enough. They offer us extra training such as an NVQ." The registered manager confirmed additional training was being provided to support staff with developing roles, specific interests and changing needs of people living in the service. For example, some staff were attending specific training on infection control to take this lead role forward in the service. Care staff were encouraged to undertake a diploma in health and social care and the registered nurse were supported to update their nursing skills and competencies. For example, training from specialist nurses was provided on 'tissue viability.' The registered nurses were also supported in the training they were required to undertake to maintain their registration with the Nursing and Midwifery Council.

Staff were supported and received guidance in order to fulfil their allocated roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss their needs and any concerns they had. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us they found supervisions and appraisals helpful and supportive.

People were complimentary about the food and enjoyed the variety and choice. Comments included, "The food is too good, and I am putting on weight. They cater for everyone even vegetarians," and "The food is really good. We can have two cooked meals a day." The registered manager had worked with staff to improve the dining experience. This had included allocated dining areas with the catering staff serving the food to people.

People were supported to have enough to eat and drink when and where they wanted. For example, breakfast was still being provided late morning with the option of a cooked breakfast. This was important for people living with a dementia whose appetite and willingness to eat varied. Staff were available to support and encourage people to eat both in the dining rooms and in people's own rooms. Staff were not rushed and gave people time to eat at their own speed with the correct approach being used. For example, returning to people to check they were eating independently and assisting as needed. One person told staff their meal was too big, this was replaced with a smaller portion which was then eaten. Staff noted that a meal had become cold after sometime and offered to reheat to ensure still palatable. Alternative meals were offered if people were unhappy with their first choice and a staff member told us, "We watch and make a note of anyone not eating and always offer an alternative."

People's nutritional needs had been assessed and reviewed. When people lost weight or had difficulty in eating and swallowing staff referred to appropriate professionals for advice as necessary. Additional support and monitoring was put in place and recommended changes to food and drinks were implemented. For example, fluids were thickened according to the Speech and Language Therapist's directions and meals were pureed to reduce the risk of choking. Staff had a good knowledge of people's dietary choices and needs. These were communicated to the catering staff who responded to people's individual needs. One relative told us, "My wife meals are pureed and this is well presented. She has trouble swallowing and had to see the dietician. Her meals are nutritious and I think she enjoys them."

People were supported to maintain good health and received on-going healthcare support. People told us any health need was dealt with quickly. One person said, "If anyone is ill they send for the GP otherwise he

drops in once a week." Relatives confirmed health care support was asked for when needed and they were kept informed of any health changes. One relative told us, "When my dad came here, he was on 'end of life care 'but he has picked up with the care and medical support provided." Records and discussion with staff confirmed that staff liaised effectively with a wide variety of health care professionals who were accessed regularly. Specialist nurses were used for advice on specific care needs. Feedback from specialist nurses confirmed they contacted appropriately and their advice was followed with staff keen to provide the best care possible to people.

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 caring. One person told us, "You couldn't ask for better carers. They ask for permission before they do anything and always treat me with dignity and respect when they wash me. They listen to me and have a little chat." A relative said, "Staff are not task driven, they really do care about people's care and comfort even mine. I cannot fault them."

Staff were pleasant and kind in their approach to people. The SOFI and general observations showed interactions between staff and people were caring and professional. Staff demonstrated their concern for people's well-being and safety and attended to them with a genuine caring approach. For example, when a person injured themselves staff were quick to reassure and attend to the incident but were visibly upset for the distress caused to the person involved. A visiting relative said, "Staff often give my mum a hug. I feel this is a genuine gesture of affection." Visiting professionals commented on the staff describing them as 'extremely caring' and always helpful and cheerful. One staff member told us, "I love working here. I love helping and looking after the residents." Another told us, "I choose to care for the people and the care of the resident comes first." A relative also shared how staff had supported them through difficult times related to their parents care. "They have been very supportive, given me strength, private space, and made me cups of tea, just like today."

When staff supported people they did so with patience and worked at the pace that suited the person concerned. Staff had a good knowledge and understanding of the people they cared for. One relative told us how staff provided care in the most pleasant way possible. They said, "I am pleased with the way staff hoist people. The carers make it a more pleasurable experience rather than a chore." When moving people staff took their time and reassured not only the person being moved but people around so the movement was completed in the most sensitive way.

Staff responded to people's choices and their individual identity was promoted. People and relatives were consulted on people's choices preferences and interests. One relative told us, "Staff used the information that we provided as a family to understand my mother as an individual. She was a nurse and talking about this encourages conversation." People's preference on the gender of staff providing personal care to them was respected and recorded. People were called by their preferred name and this was recorded on their bedroom doors. These were also decorated with pictures that people could recognise, which helped them to recognise their own room. People's bedrooms were personalised and contained important individual memorabilia. People pointed out their own furniture which they had brought with them. One said "When she has settled in completely I shall bring in some smaller items of furniture from my home". 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. Beds were positioned to allow people to look out at the view when in bed. People's bedrooms were seen as their own personal area and staff did not enter without knocking and permission to do so. One staff member said "We always knock the door before we go in." People were supported to wear the clothes they wished and laundry was completed

and returned to people quickly. One relative said "The laundry wash her clothes and they not lose them." Staff completed nail care that included painting ladies nails. People's appearance was important to them and ensured they maintained their own identity. One relative told us staff had recorded what their relative liked to wear to ensure it was what she wanted.

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 spend their time in the privacy of their own rooms. Staff responded and supported people's privacy as part of their daily care. For example, staff asked people and assisted them to toilets and to change their clothing in a discreet way. One relative said, "They are good with my wife's incontinence, they make sure she is changed and has a supply of pads in her wardrobe." Staff understood the importance of maintaining people's independence and supported people to do as much for themselves as possible. One person told us, "They try to keep you as independent as possible by sharing little tasks. I wash my face, they do the rest. They ask what I can do and want to do."

Staff encouraged people to maintain relationships with their friends and families. Visitors were a welcomed and stayed as long as they wanted to. Staff engaged with them positively during these times. Relatives told us they could visit at any time and were offered beverages. One relative said, "I am impressed that you can come at any time I was here last week at 9pm." Another relative said, "I come every day, I get regular drinks. I ask lots of questions and get answers."

Requires Improvement

Is the service responsive?

Our findings

People and their representatives were involved in deciding how people's care was provided, they told us that they had discussed their needs with staff and that these had been reviewed. One person told us, "I go through my care plan every 6 weeks with the manager and the nurse." A relative said, "I contribute to the care plan and ensured a shave was given every day. I also spoke to the GP." People felt their care was tailored to their needs and reflected their choices and preferences. For example, two relatives told us staff responded to preferences on the type and level of noise and background music people wanted. One person did not like noisy places and the other enjoyed classical music on the radio. People and relatives told us there was a wide range of activities and entertainment that suited the varied needs of people.

Despite this positive feedback on the provision of person centred care we found care staff did not always engage with people on a regular basis. Opportunities for individual contact with people were not taken. The SOFI demonstrated that some people sitting in the communal lounge were not spoken to or offered drinks for over an hour. This meant people may become isolated. Two relatives we spoke with told us staff did not come to bedrooms to engage with people when they were there. This raised concerns that people were not receiving person centred care as visits varied in timing and length, one relative staying a number of hours. This was discussed with registered manager as an area for improvement.

The service had a complaints procedure. People and relatives told us about complaints and concerns they had raised with the registered manager recently. These had not been recorded and confirmed the complaints procedure was not being used routinely as required. This was an area for improvement and was raised with the registered manager for them to address. Although, some complaints were not recorded people and relatives told us complaints were dealt with. People and relatives told us they would raise any complaint if they needed to and would approach senior staff. One person said, "I would talk to the nurse or the manager." When concerns were raised we were told these were dealt with in a positive way. People and relatives told us they were listened to. For example one relative said, "I was cross that my mother was wearing clothes that were not clean, I told the staff, and it has not happened again." Another relative told us of their recent concerns about a damaged hearing aide. This concern was not documented but the registered manager confirmed this was being replaced.

A range of activities were provided throughout Sovereign Lodge Care Centre which were found to be stimulating. Communal areas were well used, and interaction between people and staff was promoted when activities were provided. People told us they enjoyed the singing and joined in with the activities as they wished, they complimented the activity staff. One person told us, "The person who does the entertainment is wonderful". A relative told us, "My parents enjoy the hustle and bustle of the lounge they like the sounds although they can't join in."

The service employed specific staff to organise and facilitate activities and entertainment that met people's individual need. The senior activities co-ordinator was found to be enthusiastic and planned a variety of activity including individual time for people in their own rooms. This had recently included aromatherapy for people who were being cared for in bed. Activities were arranged for small and large groups to respond to

how people preferred to socialise. These included singing, games, visiting entertainers and small animals that could be handled. A mini bus was available and used to take people on trips out of the home. People's beliefs were responded to with visiting religious leaders and a Holy Communion service held in the service. A programme of activity was available and advertised what had been arranged in a pictorial form. A copy of this was given to each person and displayed in key areas to promote discussion and awareness. People were encouraged and supported to celebrate special events that included birthdays and a recent wedding anniversary. One relative told us, "My parents celebrated their 70th Wedding anniversary, they had a message from the Queen and a lovely celebration."

The environment was light and airy and had been subject to some recent upgrading which included new flooring. The design of the service supported people living with a dementia. For example, suitable signage was used to enable people to find the toilets. Corridors were wide and had seating areas and objects of interest including those that could be picked up and handled safely, to allow interaction.

Before people moved into the home a senior nurse completed an assessment of individual need. These needs were discussed with the registered manager to ensure a suitable placement was progressed. For example, ensuring staff had suitable training to meet the assessed needs. The full assessment process includes 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.

Where people were less able to express themselves verbally people's representative were involved in the assessment process. Care plans were written following admission and reviewed on a monthly basis. 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. People's needs were diverse and included complex care needs in relation to health and behaviours that needed specific support. Staff had a good understanding of these people's specific care needs and responded to them appropriately. For example, daily handover reports included information on monitoring and support required for one person who was calling out and needed 'constant staff attendance.'

Requires Improvement

Is the service well-led?

Our findings

People were positive about the management of the service. One person told us, "They make sure the place is meticulously clean, they care and want everything to be good. I would recommend them to anyone." Another said, "The home is well managed, even the office staff are very good and involved." Most relatives were also positive about the management saying they were 'open and honest' and 'approachable.' However, some relatives were less positive and reflected on some communication problems related to a recent change in management. They understood the replacement of a manager was a big change and would take time for adjustments to take place. A new manager was appointed in March 2017 and had completed their required registration with the CQC. The registered manager had a high profile in the service and people and relatives knew who they were. Staff were positive about the new registered manager and told us, "They are willing to listen, to work with us and therefore really understand our problems." Visiting professionals told us the management ensured people's needs were responded to effectively.

Despite this positive feedback, 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, records relating to topical creams were not always accurate. The provider could not demonstrate that these medicines were administered in a consistent way. Accident reports including those of staff were recorded at service level together, there was no evidence that these had been audited to identify any trends or themes that could be used to improve safety'. Care records were hand written and in some cases difficult to read. Staff confirmed records were not clear and they could not read all of them. In addition some records were not full and did not cross-reference with risk assessments to ensure clear instructions were given to staff. For example, a risk assessment to support a person to go out of the home on their own was not completed and a risk assessment for self-administration of a medicine to support a person to administer their own medicines safely had not been completed. We did not find that this had impacted on people, however this meant important care instructions may not be passed on to all staff and could impact on the care provided. These areas were identified to the registered manager for improvement. She confirmed an awareness of the improvements required to records and told us new documentation was to be introduced across the organisation.

There was a clear management structure in place at Sovereign Lodge Care Centre that staff understood. There were identified roles within the service and head of departments were being established. The registered manager was instrumental in this and was working with staff to ensure a stable team. One staff member told us, "You can tell the manager things, she is keen to hear how things are. I think things have changed for the better since she took over." The registered manager was supported by a deputy manager and together they had an overview of the clinical care in the service. There was an on-call arrangement to ensure staff had senior staff to contact for advice and guidance if required.

Staff had confidence in the new management arrangements and told us they felt well supported and involved in how the service was developed. One staff member told us, "The new dining experience has been a real positive on all the floors. The new manager has a lot of insights and new ideas, but it's a two-way street, she listens to us and wants to hear our ideas." Another told us, "The managers will listen to our

concerns and there is a monthly staff meeting where we can raise issues. These are flexible and we can discuss 24 hour care." Staff said they felt appreciated and told us the registered manager thanked them for their work. When necessary the registered manager had used the organisation's disciplinary procedures when staff were not maintaining suitable standards within their designated role.

There were a number of quality systems were in place and these included a variety of audits. These included medicine audits, health and safety audits and infection control audits. These were used to improve practice. For example, medicine audits identified if medicines had been missed on the MAR chart, this was investigated and resolved to identify reason and any necessary changes needed to practice. Feedback was sought from people and those who mattered to them in order to enhance the service. This was facilitated through regular meetings, forums, satisfaction surveys and regular contact with people and their relatives. For example, one relative told us, "Staff take time and explain things, and to look after people's dignity. I feel people are taken to the tables for lunch too early, they get restless before the meal comes. Staff have been willing to discuss this and look for solutions and they know I'm not letting this matter go." Meetings with people were used to update people on events and works completed in the home changes in staff, and to gather feedback from people and relatives.

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