

Anchor Trust

Godiva Lodge

Inspection report

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Date of inspection visit:
16 August 2018

Date of publication:
12 September 2018

Ratings

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

Summary of findings

Overall summary

We inspected this service on 16 August 2018. The inspection was unannounced.

People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Godiva Lodge provides accommodation and personal care for up to 40 older people living with dementia. There were 37 people living at the home at the time of our visit.

The accommodation is set out over the ground floor which is divided into four areas, called households, where people live. Each area has 10 bedrooms, assisted bathrooms, toilets, a communal lounge/dining room and a kitchenette where snacks and drinks can be prepared, and meals from the kitchen are served.

At our previous inspection in July 2017, we rated the service as Requires Improvement. This was because the service was not as consistently safe or as responsive to people's needs as it should have been, and the service was not consistently well led. For example, risks to people's care were not always managed safely, particularly regarding people's skin care. People did not always receive personalised care, and at times staff did not respond to people's needs in a timely way. How quality monitoring systems were implemented did not ensure the home was consistently well led.

Following our feedback at the last inspection, the district manager made an unannounced visit to the home the following day. They took action to ensure people received the care and support they required. They provided an action plan that addressed the shortfalls and advised they would support the home to improve. At this inspection we found the required improvements had been made.

The registered manager, at the time of our last inspection, resigned in October 2017. The home was managed and supported by the deputy manager, the regional support manager and the district manager until another manager was appointed.

The home had a registered manager who registered with us in July 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home provided safe care for people who lived at Godiva Lodge. Staff understood what might constitute abuse and the action to take if they had any concerns. There were enough staff available to meet people's needs and staff were deployed effectively within the home. Staff understood risks related with people's care and knew how to manage risks to minimise harm. The suitability of staff was checked during recruitment procedures to make sure they were safe to work at the home. People's medicines were managed, stored

and administered safely.

People had an assessment completed before moving to the home to make sure staff could meet their care and support needs. Staff received training and had the knowledge and skills they needed to meet people's needs effectively. The registered manager and care staff understood the principles of the Mental Capacity Act (MCA) and how to put these into practice. Capacity assessments were completed and where required Deprivation of Liberties authorisations to keep people safe were in place. People's nutritional and healthcare needs were assessed and kept under review. People had sufficient to eat and drink during the day.

People at Godiva Lodge were living with dementia, during our inspection visit we saw they looked contented and settled. People said staff were helpful and understanding, and we saw friendly and caring interactions between staff and the people they cared for. Staff maintained people's privacy, and treated people with dignity and respect. The managers and staff had a good understanding of people's individual needs and preferences. People had personalised care plans for staff to follow and staff were kept up to date about any changes in people's care.

The atmosphere in the home was friendly and homely, and care and support was provided in a person-centred way. There were things for people to do during the day to keep them occupied and visitors were welcome at the home. People and relatives knew how to complain if they needed to and complaints received had been responded to in a timely manner.

Staff felt supported by the registered manager and the management team, and were happy working at the home. All the staff we spoke with told us there had been improvements to the service people received and to the environment since the new registered manager started.

The registered manager had good knowledge and experience of providing person centred dementia care. They were passionate about making improvements to the home to ensure people living at Godiva Lodge had good experiences, which improved their quality of life.

The provider and management team checked the quality of the service people received and implemented improvements.

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 felt safe with staff, and there were enough staff to provide the support people required and to keep them safe. The management team and staff understood their responsibilities to safeguard people from harm. Staff knew the risks identified with people's care and how to support people safely. The provider checked the suitability of staff before they were able to work in the home. Medicines were stored and managed safely and people received their medicines as prescribed.

Is the service effective?

Good ●

The service was Effective.

Staff received induction and training that supported them to meet the assessed needs of people effectively. The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The rights of people who were unable to make important decisions about their health or wellbeing were protected. People's nutritional needs and health needs were assessed and monitored to maintain people's health and wellbeing.

Is the service caring?

Good ●

The service was Caring.

Staff cared about people who lived at the home and provided care and support in a way that maintained their privacy and dignity. The atmosphere within the home was calm and relaxed and people were comfortable in the company of staff. Staff treated people with kindness and patience.

Is the service responsive?

Good ●

The service was Responsive.

Staff knew people well, and each person had a personalised care plan that informed staff about their individual needs and preferences. People's care and support needs were regularly

reviewed and staff were kept up to date about changes in people's care. There were activities for people to participate in if they wished. People and relatives knew how to complain and complaints had been responded to in a timely manner.

Is the service well-led?

The service was Well Led

The registered manager understood their responsibilities and provided good leadership. Staff felt valued and supported by the managers and enjoyed working at the home. The management team were committed to provide a quality service and the provider had processes to regularly review the quality of service people received.

Good ●

Godiva Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 comprehensive inspection took place on 16 August 2018 and was unannounced. The inspection was undertaken by one inspector, an assistant inspector, a specialist advisor and an expert by experience. The specialist advisor was a registered nurse who was experienced in dementia care. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The commissioner had recently visited the home and had no concerns about the service.

Before the inspection visit, the provider completed a Provider Information Collection (PIC). 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. The PIC was detailed and we were able to review the information in the PIC during our inspection visit. We found the information provided was an accurate assessment of how the service operated.

During our inspection we spoke with the registered manager, the district manager and three team leaders about their management of the home. We spoke with eight care staff, and the chef manager about their role at Godiva Lodge. We also spoke with the administration assistant and the maintenance man.

People at Godiva Lodge were living with dementia and some people were unable to tell us in detail about their experience of living at the home. However, several people could tell us what it was like living at Godiva Lodge. During the inspection we spoke with seven people who lived at the home and seven relatives/visitors. We observed care and support being delivered in communal areas and we observed how

people were supported to eat and drink at lunch time.

We reviewed four people's care plans, daily records and medication records to see how their care and treatment was planned and delivered. We looked at three staff recruitment files, staff training records, and records of complaints. We reviewed checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Is the service safe?

Our findings

At the last inspection we rated safe as Requires Improvement. This was because risks associated with people's care and topical medicines were not always managed safely. At this inspection we found improvements had been made and rated safe as Good.

People told us they felt safe living at Godiva Lodge. One person said, "I am very happy here, the staff are brilliant, I feel very safe here".

Staff had received training in safeguarding people from abuse and understood their responsibilities to protect people from avoidable harm, neglect and discrimination. The provider had safeguarding policies and procedures for staff to follow if any safeguarding concerns were identified. One staff member told us, "I have never seen anything here, but if I had any concerns about a person's safety I would go straight to the office." Another staff member said, "You can tell by someone's body language if something is wrong. I would report it straight away; we report all injuries to our team leader." A team leader told us, "When staff report issues to us [injuries or unexplained bruising] we go and check the person and then seek medical advice. We document it and if there is no explanation we tell the manager." Records showed some people had 'bruise charts' completed which were well documented with any actions taken recorded. These were accompanied by a flow chart on how to manage unexplained bruising, for example to refer this to the local authority safeguarding team. The registered manager knew the procedure for reporting concerns to the local authority and to us (CQC).

There was enough staff to keep people safe. The provider used a dependency tool, based on people's individual needs to identify how many care staff were required. The registered manager told us they had reviewed all the dependency assessments and were confident people's needs had been accurately assessed. They said the usual complement of care staff was eight during the day, two care staff on each household, who were supported by two team leaders. There was also non-care staff that included housekeepers, laundry assistant, activity organisers, and kitchen staff.

Staff told us that staffing levels in the home had improved recently. One staff member told us, "Staffing levels aren't a problem. There have always been the required staffing levels since I started." Another staff member told us, "I have seen a difference since the new manager has started, we have lots of new starters." We looked at the staff rotas for the previous three weeks and found staffing numbers were planned as we had been told. There were times on the rota when bank staff and agency staff had covered staff sickness, and when care staff numbers had reduced to seven. A team leader told us "We are in such a better position now with staffing." The registered manager and team leaders told us the use of agency staff had reduced since new staff had been recruited. They said agency staff were still used to cover staff vacancies but this was on night shifts not during the day.

The provider followed a thorough recruitment and selection process to ensure staff were of suitable character and safe to work in the home. Recruitment checks included a Disclosure and Barring Service (DBS) check and obtaining appropriate references. The DBS helps employers to recruit suitable staff by checking

people's backgrounds and police records to prevent unsuitable people from working with people who use care services. Care staff confirmed they were unable to start working with people until all pre-employment checks had been received. We looked at the recruitment documents in three staff files, which confirmed the required checks had been made before staff started working in the home. The provider's recruitment policy encouraged services to include people who lived in the home in the staff interviewing process. The registered manager told us some people living at Godiva Lodge actively participated in the recruitment process for staff.

At the last inspection we found not all risks identified with people's care had plans in place to show how the risk was managed or minimised. At this inspection we found this had improved. Assessments had been completed for identified risks, and care plans informed staff how to manage the risk safely. Staff knew about risks associated with individuals, and there were processes in place to regularly monitor and manage risks.

The provider used recognised risk assessment tools to identify risks to people's health, such as risks associated with skin damage, malnutrition, falls, and moving and handling. People's care plans were regularly reviewed and their risk assessment scores were updated when their needs and abilities changed. Where people were at risk of falling, the provider had a comprehensive Falls Prevention Plan that addressed their physical health conditions, eyesight, medication, and any risk of dehydration and malnutrition.

Where people were at 'high risk' of skin damage due to poor mobility, staff moved people regularly to reposition them to reduce the risk. Care plans we viewed contained clear instructions for staff about how to reposition the person safely. Where people needed special equipment such as airwave mattresses or pressure relieving cushions, we saw these were in place. Pressure relieving mattresses were checked to make sure they were maintained at the correct setting for the person to reduce the risks of skin breakdown.

Some people required equipment to help them stand or transfer. During our inspection visit care staff use equipment confidently and safely. For example, we observed staff on three occasions using a hoist to transfer people into chairs. During the procedures they reassured the person they were safe and continually explained what they were doing. For example, one staff member said, "The hoist is going up now," and then, "We are going down now."

The provider had a system to record and monitor any accidents and incidents. The registered manager and staff recorded accidents and incidents, which were shared electronically with the provider. Records showed actions had been taken to address any injuries that had occurred. The registered manager and the provider analysed records for any trends or patterns of incidents and to see if there was any learning from events and to minimise the risks of re-occurrence. For example, where people were at risk of falling, they were referred to the GP for referral to the falls clinic.

We looked at how medicines were managed in the home to make sure people received their medicines when needed and as prescribed. We found that medicines were stored, administered and ordered correctly.

Medication was administered by team leaders and managers who had completed medication training, and been assessed as competent to safely administer medicines. A team leader spoke positively about the medication training they had received. They said, "We have to do the Boots online test, which includes four modules. Then we have to answer questions which include scenarios like 'what would you do if'. Following training we watch someone trained giving out the medication and then they watch us until we are confident." Another told us, "The deputy manager observes us every three months to assess our competencies." We observed a team leader while they administered medicines to people. We found they were knowledgeable about the medicines prescribed, such as known side effects and followed the

recommended guidelines for the safe administration of medication.

At the last inspection we found how topical medicines, such as prescribed creams and ointments, were managed required improvement. Some people did not have topical medicines applied as prescribed and records were not always completed to show when these had been applied. At this inspection visit we found this had improved. Where people had been prescribed topical medicines a body map was kept with the MAR (Medication administration record) to show where these were to be applied. Creams were documented on the MAR and there were 'daily care charts' to record when creams had been applied.

Each person had a medication care plan which listed any side effects and when medicines should be reviewed. There were daily checks on MARs and 'care charts' by team leaders to make sure these had been completed. We looked at the MARs for nine people, there were no gaps or omissions on the MARs we viewed. Where people were prescribed medicines 'PRN', when required, such as pain relief or laxatives, there was a copy of the PRN plan for each person.

We asked the registered manager and a team leader about the use of antipsychotic medication often prescribed for people living with dementia who may become agitated or distressed. No one was prescribed anti-psychotic medicines. The managers were aware of the effects and risk of over use of such medicines on older people, but were equally aware that people's dementia needs could change and they may need this type of medicine.

The provider had procedures to keep people safe in the event of an emergency which meant people had to be evacuated out of the home. Each person had a personal emergency evacuation plan (PEEP) and there was a summary of what assistance and equipment each person would need to evacuate the building, in the entrance to the home.

The provider's policies and procedures protected people from the risks of infection. Personal protective equipment (PPE) such as plastic gloves and aprons were available for staff to use. Staff were aware of their responsibilities to wear PPE during personal care and at other times. One staff member told us, "We always wear gloves and aprons during re-positioning." However, on the day of our inspection we observed some staff members were not wearing PPE when serving meals. The District Manager told us they would expect staff to wear this and said they would address this with the staff team.

On the day of our inspection visit, the home, overall, was clean and tidy. However, the carpets in two areas of the home had an odour. The Registered Manager was aware of this and explained they had recently tried to clean the carpets but this had made it worse. They were in the process of arranging for different flooring for these areas.

The provider had systems in place to make sure the premises remained safe for people, visitors and staff. Routine checks were made on the premises, including checks on equipment to make sure it was safe to use and fire safety checks. A fire risk assessment was in place and the provider was actively working on the action plan produced from this. Some of the actions that had been recommended as 'high or medium risk' had exceeded the timeframe in which completion was advised. The registered manager explained the actions they had taken to address the risk and there was evidence of a scheduled date for completion. During our visit we found the taps in one toilet and bathroom were not working. We discussed this with the maintenance man who advised engineers had been on site the previous day and had not reinstated the supply. They confirmed this had been rectified.

Is the service effective?

Our findings

At our last inspection we rated effective as 'Good'. At this inspection people at Godiva Lodge continued to receive good effective care.

People and their relatives said they (or their family member) received effective care and support. One person told us, "I live here, they look after me well." Another said, "They [staff] know how to move me, I don't feel scared."

We looked at four people's care records. An assessment of people's care and support needs had been completed to ensure the person's needs could be met by staff. This included their physical, mental and social needs. Care plans had been developed from people's assessments.

Staff received an induction when they first started working in the home and completed refresher training to keep their skills up to date. A staff member told us about their induction to the home. They said they had completed training and worked alongside more experienced staff. This staff member told us they felt confident to ask questions so they had a good understanding of their role. A staff training matrix showed staff completed essential training on an ongoing basis to ensure they had the knowledge and skills to care for people safely and appropriately. The registered manager and team leaders monitored staff completion of training to ensure their skills were kept up-to-date.

During our observations we saw staff put their training into practice safely and effectively. For example, moving people safely using a hoist, asking people for their consent, wearing protective clothing during personal care routines and an awareness of dementia care in the way staff engaged and communicated with people. Staff spoke positively of the training and felt that they had enough training to do their jobs well. A new staff member told us, "The shadow days were really good and helped me get to know people."

The administrator told us about the 'Anchor dementia initiative' which was promoted on the notice board in reception. They said the provider had a 'dementia specialist', who visited all their homes providing training and assessing the dementia care delivery.

Staff told us about their dementia training. One said, "The dementia training is really good, the trainer was very good. I learned so much and brought that training back to my working practice." A team leader also told us about their dementia training, stating this was 'excellent' and that it had included both online and face to face training. They said the training had made them think about what it might feel like to have dementia as they had used blindfolds and other props. Team leaders had good understanding of dementia. They understood the possible risks involved in caring for people with varying degrees of dementia and the degenerative process, and changing needs of people living with the disease.

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 specific 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 when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Managers and staff worked within the principles of the MCA. The registered manager and team leaders had a good understanding of MCA and how to put this into practice. People had capacity assessments completed when they moved to Godiva Lodge which clearly identified where people required assistance to make specific decisions and what decisions they could make for themselves. Best interest meetings had been held when people required support to make decisions. Where people required restrictions on their liberty to keep them safe from harm, for example, if they left the home alone, DoLS had been applied for and authorised.

Care staff received training to help them understand the MCA, and knew they should assume people had the capacity to make their own decisions. Staff knew the importance of obtaining people's consent before providing care and support. During our inspection visit staff routinely asked people for their consent before they carried out any tasks or care. Staff used simple questions so people could understand and gave people time to respond. One staff member explained, "Mental capacity is all about making decisions and where people can't make decisions we act in their best interests." Another staff member said "We ask people questions and give them a choice. Like what they want to wear in the morning or with their personal care. We don't just assume."

People were encouraged and supported to have enough to eat and drink. People's nutritional needs and preferences were discussed and assessed when they moved into the home and kept under review if people's needs changed. The chef manager had a good understanding of people's needs and preferences. The chefs had a 'Dietary Preference' form for each person that was completed when they moved into the home. This included any allergies, health conditions or preferences along with instructions about any assistance they required to eat their food. Where changes occurred the team leaders completed a 'notification of special request form' which was given to the chefs. This made sure any changes to a person's dietary needs was picked up quickly and acted upon.

'Hydration and Nutrition stations' with snacks, fruit and drinks were available in various areas of the home to encourage people to eat and drink. Each lounge/dining area had a small kitchenette where people had access to drinks and snacks, and where meals from the main kitchen were served. During our inspection visit we saw people enter the kitchenettes to get themselves drinks or something to eat. For example, we observed one person get themselves cereal and milk, and another helped themselves to a drink. A relative told us they could also make themselves hot drinks when they chose.

Staff were aware of people's nutritional needs. They knew which people required their food prepared in a special way, for example, a soft diet or their drinks thickened if they were at risk of choking. One member of staff told us, "We know about people's nutritional needs as there is a form inside the kitchen cupboard which tells us who needs thickener. If there are changes we are told in handover and the form is changed." For new staff unfamiliar with people's needs and preferences there was a visual aid in the kitchen to guide them to a person's favourite drink. For example, next to a picture of the person it said, "tea with two sugars". Communication books were provided in each kitchenette where the chef encouraged feedback to be given about the food.

We observed the lunchtime meal in the four areas of the home. This was the main meal of the day. Staff offered people a choice of meals, either by asking for their choice of beef casserole or vegetable risotto or by

showing them plated meals of the two options. Where people took time to decide, staff were patient and did not rush people. We asked people for their views on the variety and quality of food offered. People generally responded positively and made comments like, "It's delicious" and "I enjoyed my dinner."

Where people required assistance to eat their meal staff were available to offer the support people required. In one lounge we saw a person pour a drink onto their meal. A member of staff immediately responded, they talked kindly to the person and offered to change their meal, which they did. We noted there was not a choice of puddings. People were given plums and custard, only if they declined this were they offered an alternative.

People's healthcare needs continued to be met by staff. Any concerns were referred to the GP. The GP visited the home every week to see people who had requested a visit or who were unwell. We saw from people's records that they had regular appointments with health professionals. For example, where people were at risk of choking the speech and language therapist (SALT) had visited and prescribed special diets to reduce the risk. We saw staff followed the advice of health professionals. Staff told us about one person whose sleep pattern had become disturbed. For example, at times they were awake all night and stayed in bed during the day. Although the sleep pattern was regularly documented there was nothing to show that staff had considered why this was happening or if the person required a medication review. The registered manager told us they would review this and refer the person to the GP.

Peoples needs were well documented on the transfer document which was used if the person was admitted to hospital or moved to another care home. This document gave a summary of identified risks and the persons preferences. It provided all the information about the person so that the service providing care (such as the hospital) had the information they required.

Since our last inspection in July 2017 improvements had been made to the home environment. A room at the front of the home had been converted into a small lounge for people to use and a 'café' area set up in the main corridor. Many areas of the home had been redecorated in line with people's preferences, taking into consideration the needs of people' living with dementia regarding colour schemes. Records demonstrated people were involved in choosing the decoration. As bedrooms become vacant the registered manager told us these were being re-decorated and refurbished. We noted that not all bedrooms had lamp shades, the registered manager told us these had been ordered. There was an accessible garden with places for people to sit and enjoy the warm weather.

Is the service caring?

Our findings

At our last inspection we rated caring as 'Good'. At this inspection people at Godiva Lodge continued to receive a good caring service.

People appeared to be happy living at Godiva Lodge and were comfortable approaching staff, asking staff for assistance or just sitting in staff presence. We observed many occasions when they were smiling and laughing together. One person told us, "I'm very happy here, I have been in another care home but this is much more suited to me," This person's relative added, "The staff are excellent, I can't praise them enough."

Staff were kind and compassionate in the way they interacted with people and frequently reassured people, by touching their arms and hands. Staff spoke positively about working at the home. A staff member told us, "I love it here, it makes me happy. I don't think I will ever leave." Another said, "I personally love working here."

Staff were attentive of people's needs and seemed to genuinely care about the people they looked after. A staff member said, "There you go beautiful," to a person as they passed them their glasses. We observed a number of occasions when people held out their hands to staff and indicated they wanted a hug. On all occasions the staff member hugged the person, which clearly made them feel happy.

Staff were very patient when responding to people who, because of their dementia, had become distressed and verbally abusive towards them. They knew how to diffuse the situation by diverting the conversation to something the person enjoyed. A staff member told us, "It can be quite stressful at times but [name of person] doesn't mean it, they become anxious if they can't see a member of staff or if we are not sitting with them." On another occasion we saw a member staff comforting a person who was expecting a relative, but the staff member knew the relative would not arrive. They sat holding the person's hand and diverted their attention with a cup of tea and a biscuit.

Staff know people well, they called people by their preferred names and we saw examples of where people's past life experiences were celebrated. For example, one person used to be a nurse and thought they 'were in charge of the home'. The registered manager had made them a nurse's name badge that they wore, and they completed tasks within their capabilities. Staff said this had considerably reduced their distress and given a focus to their residence at Godiva Lodge.

People looked well presented on the day of our visit. People were dressed appropriately for the weather, their hair looked brushed and their clothing was clean. We asked one person if their clothes were laundered properly. They told us, "Yes, they collect it from my room one day and it comes back the next, all neat and tidy, they are very good."

Where possible people were supported to do things for themselves, for example washing and dressing. We saw people move around the home and walk in the garden without any restrictions. A staff member told us, "The good thing about this place is that it really encourages independence. We don't go in and take over. We

have good carers that show the others the way." Another staff member told us about how a person living at the home who had required a hoist to transfer, was now able to mobilise themselves. They told us, "[Person] is now 'palm to palm' and we don't need to use the hoist. One day they wanted to sit up in bed and then with determination and staff encouragement they were able to walk."

Staff treated people with kindness, dignity and respect. We observed a staff member position a person's skirt across their legs whilst they were in a hoist to maintain their dignity. Another staff member offered people hand wipes after dinner to clean their hands, and assisted people to do this if they needed help. We also observed a new staff member being shown around by a colleague and they were introduced to all the people they passed. A staff member told us "We know people well. You can tell by observing a person's behaviour if they don't want to do something. We don't force them. We allow the person time and come back later. We respect their wishes."

Staff had completed diversity training which they told us helped them to provide an environment where people's individual preferences regarding lifestyles was supported. One staff member told us, "We are all different, we accept people's individual preferences and choices and try to support these." A relative told us, "It is so inclusive here, they don't treat them like residents, they are all equal." The registered manager told us they tried to create an inclusive environment where people's diversity would be respected. Including people's sexual orientation and gender identity. There was information available on notice boards relating to LGBT (Lesbian, gay, bisexual and transgender) which stated, "Love has no gender" which encouraged people to be open and confident their relationships would be accepted.

During our inspection visit relatives of a person who had recently passed away visited the home. They told us, "It was great to know [name] was here over the last few months, it has been absolutely amazing, they were treated just like family and well loved."

Relatives said they could visit at any time and were always made welcome.

Is the service responsive?

Our findings

At the last inspection we rated responsive as 'Requires Improvement'. This was because, staff were not always responsive to people's needs, people did not always receive personalised care and complaints were not consistently managed well. At this inspection we found improvements had been made and we rated responsive as Good.

When we inspected the home in July 2017 there were times during our visit when there was no staff presence in communal areas where people spent their time. On three occasions we had to go and find staff as people needed support and were at risk of falling. During the lunchtime meal people who required assistance to eat did not receive individual attention as staff were busy supporting other people. We also noticed during the meal at lunchtime some staff were outside having their break. Staff told us that at busy times, such as first thing in the morning and at meal times, they struggled to meet people's needs safely as there was not enough 'eyes and ears' in the lounges to respond to people's needs. When we discussed this at our feedback meeting at the end of that inspection visit, the district manager advised there should be an 'all hands on' approach at peak times where team leaders, managers, kitchen staff and all other available staff should support on the floor. They assured us this would be immediately implemented.

At this inspection we found the responsiveness of all staff had improved. Staff were available in the lounges to meet people's needs and requests. There were times during the day when there was no staff in the lounge areas as they were assisting people with their morning routines or providing personal care. However, they were visible in the household and people who needed supervision were not left for long periods of time unsupervised. We saw at busy times non-care staff supported staff to ensure people's needs were being met. For example, at lunch time the chef manager and activities coordinator, supported the lunch time routine in one dining room and the team leaders supported in the others.

We were told team leaders supported care staff during busy periods, such as the morning while care staff helped people to get up. However, team leaders were responsible for giving people their medicines, which coincided with people's morning routines. This would mean if people needed support the team leader would have to stop giving medicines. This is not good practice and could lead to errors in people receiving their medicines. We discussed this with the registered manager and district manager. They said they would look at ways of providing staff with additional support at busy times. Such as, an additional staff member that supported between the four households. We also noted some households were busier than others, which meant there was less opportunity for care staff to spend time with people. The district manager had already identified this at their last audit and was working with the registered manager to find a solution.

At the last inspection interactions between care staff and people were mainly task focused. Staff had very little engagement with people outside task based activities such as providing personal care or assisting people to eat. During this inspection visit we found this had improved. Staff spent time with individuals or with small groups having conversations about their day, or discussing topics of interest. When staff passed by people they stopped and spoke to them, or made a positive comment about their appearance, such as "Oh, you look nice today".

When we last visited Godiva Lodge staff seemed rushed at mealtimes and assisted more than one person to eat at the same time. The registered manager told us, "We have done a lot of work around mealtimes to make sure people's support is right and that staff engage with people. It shouldn't be a 'conveyor belt' experience it should be enjoyable." At this visit people's lunchtime experience was relaxed and unhurried. People who needed assistance to eat received individual attention from staff. People were not rushed to eat their food and were offered more if they had eaten all their meal.

Staff had a good understanding of people's needs, likes and preferences. They responded to their dementia care needs in a positive, consistent manner. For example, one person needed reassurance where they were. Every time the person asked, 'Where am I,' staff responded, "You are at Godiva Lodge," and reassured the person they were safe. This was consistent with what was recorded in the persons care plan, which stated 'I would like to be reminded where I am as I sometimes forget', and asked staff to remind them they were at Godiva Lodge.

Staff told us they knew people well as they had time to read people's care plans and were kept up to date with any changes at the handover meeting they had at the start of their shift. A staff member told us, "We know people because we can read the care plans. We have plenty of time to read them."

We looked at the care records for four people. At the last inspection information in care plans was difficult to find and not all the required information had been recorded. At this inspection we found care plans were person centred, detailed and up to date. Information in care files was easy to find and provided staff with the information required to provide the care and support people needed to maintain their health and well-being.

People had plans completed for all aspects of their care and support. Such as personal care, mobility, skin care, nutrition, continence and health. People had communication care plans that were well documented, identifying any difficulties in communication and how these should be managed. In one sleep and rest care plan it detailed that a crash mat was in place and that the person lacked capacity to use the call bell system. Two hourly checks were completed during the night and at rest periods during the day, to make sure the person remained safe and well.

We looked at the care records for one person who often became distressed and displayed behaviours that upset others. There were charts completed in the persons care file to record and monitor this behaviour. There was information to show staff tried different approaches to calm the person. Staff told us the person required one to one intervention for much of the time, to provide constant reassurance due to their disorientation and confusion. The registered manager had made a referral for another assessment due to their increased needs and was waiting for the continuing health team to visit.

There were things for people to do during the day. The home had activity co-ordinators that worked Monday to Friday. They organised group activities for people and spent time with people on an individual level if they did not want to be part of a group.

The registered manager advised that the provider was changing the way activities were organised in the home. They would no longer have activity co-ordinators as care staff would be responsible for providing activities. The provider called this the 'Anchor Active' programme, which the registered manager told us supported staff to work in a more person centred, less task focused way. We discussed this with the managers, as from our observations, the current level of care staff would not allow time for staff to provide activities, as they were busy supporting people all day. The registered manager and district manager advised the provider had piloted the programme in other homes with very positive results for both people

who lived there and staff. They were confident current staffing levels were sufficient to support the programme, but advised staffing would be kept under review.

A variety of activities were available within the home to meet people's individual preferences. We saw people were encouraged to be involved in activities such as maintaining the garden and making bread. Rummage boxes were placed around the home with different topics of interest. For example, one box contained materials to use in the garden. During the day we saw people engaged in a game of skittles in one area and a game of 'ring toss,' in another. People who had been sitting quietly were seen to be smiling, taking part and cheering with care staff.

There was an 'old fashioned' shop where people could buy things, a hair salon, as well as large open seating areas to encourage people to move around the building. Doors to the garden were open and we saw people were encouraged to use the garden. Some people enjoyed walking in the garden and others sitting in the sunshine. The registered manager told us they were turning a room into a cinema area and had changed a room off the reception into a 'snug' for people to sit quietly.

Since the registered manager had worked at the home they had, implemented a 'walking club' where people went out for a walk at 11am supported by staff. They had also organised a street party with a brass band which they said had been a great success and was attended by staff, people and relatives.

The home also promoted dining events where they encouraged people from the four households to eat in the central dining room as an opportunity to socialise. The chef manager told us, "Tomorrow we have our cucumber, cocktail and cake day where we will lay the big dining room like a restaurant."

People were supported at the end of their life in the home. People had 'End of Life' care plans but some had little information recorded. A team leader told us that some people were reluctant to discuss their end of life wishes and had asked their family to make the arrangements. Another team leader told us although it was a difficult area to approach, they had recently had a conversation about this with a person and their relative so were able to record their wishes in their care plan. There was information in people's care plans about any decisions that had been taken about resuscitation should they have a cardiac arrest.

On the day of our inspection visit there was no one receiving end of life care. However, the relatives of a person who had recently passed away spoke with us about the support their family member had received. The relative told us, "I could never give any bad comment about this place, they brought the best out of my [family member] The quality of this place was far better than any others that we had seen. It really is a family home."

We looked at how complaints were managed in the home. Complaints information was displayed in the reception area for people and relatives to refer to. No one we spoke with had made a complaint.

At the last inspection in July 2017 complaints had not always been recorded in line with the providers complaints policy and procedure. At this inspection we found complaints had been recorded and responded to. The registered manager also used a complaints tracker with lessons learnt recorded.

We asked the registered manager if information such as the complaints procedure was available in formats to support people's disabilities or sensory loss. They told us there was no one using the service who required information in other formats than written English, but information was available in other formats, such as large print and pictorial, if people required this.

Is the service well-led?

Our findings

At our previous inspection in July 2017, we rated well led as Requires Improvement. This was because the service was not consistently safe or as responsive to people's needs as it should have been, and was not consistently well led. At this inspection we found the required improvements had been made and we rated well led as Good.

At the last inspection we identified shortfalls in the way the home was managed. We found risks to people's care were not always managed safely. People did not always receive personalised care, and at times staff did not respond to people's needs in a timely way. The way complaints were managed needed improvement and how quality monitoring systems were implemented did not ensure the home was consistently well led.

Following our feedback at the last inspection, the district manager made an unannounced visit to the home the following day. They made observations, spoke with staff and looked at records. They took action to ensure people received the care and support they required. They provided an action plan that addressed the shortfalls and advised they would support the home to improve.

In October 2017 the registered manager resigned. The home was managed by the deputy manager, the regional support manager and the district manager until another manager was appointed. A new manager had been appointed, who registered with us in July 2018.

The registered manager understood the responsibilities and the requirements of their registration. For example, they understood what statutory notifications were required to be sent to us, they had completed their provider information collection when requested and the ratings from the last inspection were displayed in the home.

We found there had been improvements in all areas where we had identified concerns at our last inspection in July 2017. For example, staff were responsive to people's needs and had time to spend with people engaging in conversations or individual activities. Risks to people's care were recorded and managed well. Staff morale had improved and a 'carer of the month' scheme had been introduced to acknowledge staff commitment.

Staff were motivated and enjoyed their work. They said they received good support from the registered manager and management team. Staff felt confident to raise issues or concerns with the managers. Staff told us they all worked well as a team and that communication had improved. A staff member told us, "Teamwork is great now." Another said, "I feel quite comfortable to ask if I don't know anything, which I didn't before." A team leader told us how much better the management of the home was now and how much they felt supported and "listened to".

Relatives and staff spoke positively of the new registered manager. A relative told us, "[Registered manager] has been so good, he is very active with meetings and trying new things around the home." Staff told us,

"Management was awful before, there was no support. But since the new registered manager arrived, the door is open and he is very visible. He makes it enjoyable to come to work again, he really lifts the place." Other staff comments included, "His door is always open and he is a lot more involved. Staff morale is better," and, "My suggestions weren't listened to before, they are now."

Staff also spoke positively about the team leaders. A staff member said "The team leaders are absolutely wonderful. They are always helpful and try and find solutions."

The registered manager told us, "We use a team approach, we work together to do what is needed and to make things fun. It's people's home. I think when I arrived staff had forgotten this."

There had been improvements to the environment since our last inspection. Several areas of the home had been redecorated and some rooms had a change of use. The registered manager told us, "The environment wasn't very dementia friendly, so we have done some work around people's life experiences. We have created areas of interest like a snug 'lounge', a baby corner, and a café. We are now creating a post office and a cinema."

The provider encouraged feedback from people. A comments and suggestion box was placed in reception, there was a 'You said We did' board and questionnaires were sent to people. We looked at the results from the providers survey for 2018. Results showed people were happy at the home and that they were treated with kindness by staff who were available when required.

The registered manager told us they had tried to involve people's families about what was happening in the home and with their relatives' lives. They said they had arranged relatives' meetings, but despite advertising this in the home, not many people had attended. They also told us how they were involving relatives in 'positive risk taking' to promote independence in a safe environment. This supports people living with dementia to have good life experiences and continue to use skills they have.

We asked staff if there was anything that could be improved. All said there was enough staff to support people, but more would be welcome. Staff mentioned that the home did not keep an emergency supply of continence products that people could use if their supply had run out, as people often used more than their allocation. We raised this with the managers during our feedback meeting. They agreed this was a good idea and said they would action this.

As part of their quality checks the registered manager told us they walked around the home every day at different times of the day. They had also carried out spot checks on staff including night staff. They said this gave them oversight of the staffing levels in the home, how staff engaged with people and an opportunity to talk with people and staff.

The management of the home had been increased since the last inspection and there were now two deputy managers in post. Both had recently been appointed. The registered manager told us the increase in deputy managers would mean as well as supporting the manager, they would be able to offer more support to team leaders 'working on the floor'.

The provider had processes and procedures to monitor the quality of the service people received. All staff received supervision to discuss their practice and personal development and had spot checks to make sure they worked to the provider's procedures. Management meetings and staff meetings were held to keep staff up to date with any changes with policies and procedures and to discuss initiatives implemented in the home.

The management team made regular checks of the quality of the service. For example, checks were made on people's daily records to make sure the care they received matched their care plans. Medicine administration records (MARs) were checked to ensure they had been completed accurately and medicines had been given as prescribed. The managers and the provider completed a range of other checks and audits to make sure they continued to learn and make improvements to the service. For example, incidents, accidents and complaints were monitored for any trends and patterns and for any learning from events. There had been no trends identified.

The provider had completed several quality audits since our last inspection in June 2017 which the registered manager used as an improvement plan. Copies of the audits and the improvement plan were made available to us. These showed there had been improvement of the service since the new registered manager had started.

The registered manager spoke positively about the support from the provider and the district manager who they said were, 'pro-active and involved'. The district manager visited the home regularly, to provide support and to check the management team were progressing the action plan from their last audit.

The management team worked in partnership with other health and social care professionals such as the local authority commissioners, the continuing health team, social workers, district nurses, GPs, occupational therapist, SALT team and dieticians.