Anchor Trust

Godiva Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Godiva Lodge is a care home that provides accommodation and personal care for up to 40 older people living with dementia. There were 39 people living at the home at the time of our inspection visit.

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

Prior to our visit we had received statutory notifications and safeguarding information about medication errors in the home. In response to this the provider had reviewed the medication processes and had worked with health commissioners and the local pharmacy to improve procedures. At this inspection we found medicines were administered and managed safely.

Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were assessed but some identified risks were not always being managed effectively.

There was enough staff to keep people safe, but how staff were deployed in the home was not always effective or responsive to people's needs. Staff's suitability for their role was checked before they started working at the home.

The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People were looked after in a way that did not inappropriately restrict their freedom.

People were cared for by staff who had the skills and training to meet their needs. People's nutritional needs were assessed and people said they had enough to eat and drink. On the day of our visit we found some people's lunchtime experience could be improved. People had routine health checks and were referred to other healthcare services when their health needs changed.

The registered manager and staff had a good understanding of people's individual needs and preferences. Staff were kept up to date about changes in people's needs through a handover meeting at the start of each shift. People had a personalised care plan for staff to follow. Some care plans and daily records did not show how people's needs were routinely met.

The atmosphere in the home was friendly and homely, and care and support was provided in a person centred way. Staff promoted people's independence and respected their privacy and dignity. People were encouraged to maintain relationships that were important to them. People said there were things for them to do during the day to keep them occupied.

People and most relatives were confident any concerns or issues they raised would be dealt with promptly. However, we found how complaints were responded to needed improvement. People and their relatives were able to share their opinions about the service. Not all staff felt managers were available at the times they needed them or issues they raised with managers were listened to.

The provider and management team checked the quality of the service people received and implemented improvements. We found the process for auditing records and systems for checking the premises where not implemented effectively or consistently. Following the inspection the provider sent confirmation that the issues we had identified during our inspection with staff deployment and safety checks on the premises had been addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently Safe.

Staff knew what action to take if they had any concerns about people's safety or wellbeing. Risks to people's care had been identified but it was not always clear how these were being managed. There were enough staff to keep people safe but not enough to always respond to people's requests or needs. The provider had safe procedures for recruitment of staff and managing and administering medicines.

Is the service effective?

Good

The service was Effective.

Staff received an induction into the service and completed regular training to meet the needs of the people who lived at Godiva Lodge. Where people lacked capacity, the registered manager and staff understood the principles of the Mental Capacity Act 2005 so people's rights 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.

There was a regular team of staff who people were familiar with. Staff demonstrated they cared about people and supported people with personal care in a way that maintained their privacy and dignity. Staff treated people with kindness and patience. People were supported to maintain relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

People were satisfied with their care and knew how to raise complaints if they needed to, but how complaints were responded to needed improvement. Staff knew people well, and each person had a care plan that informed staff about their

individual needs and preferences. People were supported by staff to participate in activities and follow their hobbies and interests. Some care records had not been completed consistently and information in care plans was not always easy to follow or find.

Is the service well-led?

Requires Improvement

The service was not consistently Well-led.

People and relatives were mainly positive about Godiva Lodge and staff enjoyed working at the home. However, some staff said they did not always feel supported to carry out their roles. They said this was due to how staff were deployed in the home, and that they did not feel listened to by the management team. The provider and management team regularly monitored the quality of service people received through a series of audits and checks. Some environmental safety checks were not always completed regularly.

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.

At the last inspection of the service in November 2014 we found the provider was meeting the required standards and rated the service as Good.

This was a comprehensive, unannounced inspection that took place on 27 July 2017. The inspection visit was undertaken by two inspectors, 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.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information in the PIR during our inspection visit. We found the information in the PIR was an accurate assessment of how the service operated.

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.

We also spoke with Healthwatch about information they held about the provider. Healthwatch is an independent consumer organisation, which promotes the views and experiences of people who use health and social care services. They provided a copy of a report from their visit to the home in June 2016 and the action the provider had taken following their visit.

People in the home were living with dementia but several people could tell us what it was like living at

Godiva Lodge. We spoke with eight people who lived at the home and five relatives. We observed how people were cared for and supported in communal areas and how people were supported to eat and drink at lunch time.

During the inspection visit, we spoke with the registered manager, the provider's branch manager, two team leaders, seven care staff, the activity organiser, the assistant cook, the head house keeper and the maintenance man.

We walked around the home to view the environment. We reviewed five people's care plans including their daily records and medication records to see how people's care and treatment was planned and delivered. We checked how medicines were managed in the home and whether staff were recruited safely and trained to deliver the care and support people required. We reviewed records of the checks the provider and management team made to assure themselves people received a safe, effective, quality service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with, told us they felt safe at Godiva Lodge, one person told us, "I think it's safe here… We are well looked after." Another said, "We're definitely safe here. The staff look after us and the building is safe." Relatives thought their family member was safe, comments included, "Yes it's safe here. I've not witnessed anything to make me think otherwise." And, "They are very good here this is a safe place for [relative] to be." However, one relative told us their family member had managed to get out the coded front door. The registered manager said they had put systems in place to monitor this and prevent it from re-occurring.

Staff knew and understood their responsibilities to keep people safe and protect them from abuse and harm. One staff member said this was because, "We know customers [people who live at the home] very well, and would be able to tell if they were upset or unhappy. I am sure people are safe here." We saw people were relaxed in staff's company and people's behaviour demonstrated they trusted staff.

All staff, including non-care staff told us they would not hesitate to report concerns. Staff understood what constituted abuse and what to do if they suspected someone was at risk. Staff told us this included changes in people's behaviour, for example if people became withdrawn, anxious, or if they acted out of character for no reason. Staff told us if they saw anything of concern they would report it to a team leader and record what they had seen. Staff were confident action would be taken by the management team to keep people safe.

The registered manager understood their responsibility to report safeguarding concerns, and had referred concerns to the local safeguarding team and submitted notifications to us as required.

Staff said they would have no hesitation raising any concerns they had about poor practice within the home. One staff member told us, "We have a whistle blowing policy and I would have no problem reporting concerns."

Staff we spoke with understood risks associated with people's care and knew how to manage those risks safely. Risks to people's care were assessed prior to admission to the home so the provider was assured they could meet people's care and support needs.

Staff told us there were risk assessments in people's care plans that told them how to manage the risks, which they could refer to if they needed to. They said care plans were updated by team leaders when people's needs had changed so they continued to have accurate information to provide safe care to people. There was a staff handover meeting at the beginning of each shift to inform staff about changes in people's risks, or care needs.

However, we found not all risks were continually managed effectively. Some care plans were not always sufficiently detailed to show how risks were managed, particularly in regards to people's skin care. For example, two people's care records showed prescribed creams had run out. Other daily records were either

missing or were not clear about what creams or lotions were to be used. Body charts had been completed to show where people had skin conditions but there was no skincare plan to show if the condition was monitored and improving. For example, one person had eczema, which caused their skin to become dry and itchy. Staff told us the person had a body wash prescribed and they applied cream to the person's skin. There was no information in the person's care plan to inform staff about how this condition was being managed. Staff told us the person's skin condition was not managed consistently because prescribed items were not on a repeat prescription. We discussed this with the registered manager and district manager during our feedback. They said this would be looked into to make sure skin conditions were managed consistently.

Staff were aware which people were at risk of falling due to poor mobility and their dementia, and there were procedures to reduce the risk of falls to people. Where people had been identified at risk of falls, action had been taken to reduce the risk of injury by using safety mats, and regular monitoring by staff.

Accidents and incidents in the home were recorded. The records were checked and monitored by the provider and the registered manager to identify any trends or patterns. Where patterns had been identified for people at risk of falls, for example during the night, increased monitoring had been implemented.

Staff had a good understanding of people's mobility skills and who required equipment to help them move. People's care plans and risk assessments provided instructions for staff if people required assistance moving around. We observed staff helping people who walked with the use of a walking frame. They walked at the person's pace and people were not rushed. We also observed staff on two occasions using a hoist to move people. People were transferred safely and staff were competent and confident using the equipment.

Where people required assistance to move around staff understood how to reduce the risks of skin damage to people. We were told if staff noticed any changes to people's skin they reported this to the team leaders so they could contact the district nurse or GP. Staff told us, "People at risk have pressure relieving mattresses on their beds and we encourage people to use pressure cushions on their arm chairs." We saw the correct equipment was in place to reduce the risks of skin damage such as pressure relieving equipment and mobility aids to safely transfer people. The registered manager told us there was no one with pressure damage at the time of our inspection.

We asked people and relatives if there were enough staff available to keep people safe. Comments included, "There are enough staff, they are nice. I don't press a buzzer but I do shout for help sometimes and the staff come quickly." And, "I would say that there are enough staff. They are nice [the staff]." Relatives told us, "There seem to be enough staff. [Relative] is well looked after and he's happy here."

However, relatives and staff told us there were times when there was no staff available in the communal lounge areas where people spent most of their time. One relative told us, "The staff are very caring and respectful but there are only two staff on. I don't think that's enough staff." Another said, "There is a general lack of supervision of the residents in the lounge. To be honest I think this is due to a shortage of staff. Look around now where are the staff, there isn't any. Mind you there is often staff outside smoking."

One staff member said, "There is enough staff to keep people safe, but it's really busy at certain times. We are supposed to have an 'all hands on' system where the managers, team leaders, domestic and kitchen staff come and help, particularly at lunchtimes and to cover staff breaks. But this is not happening." Another told us, "There are supposed to be two [staff] on each unit but this is not always the case."

There were times during our inspection when we observed there was no staff presence in the lounge areas.

For example, in the early afternoon, in one lounge we saw an altercation between two people, there was no staff in the area to supervise people. We went to find a member of staff to let them know. Although the situation had resolved itself when the staff member arrived, one of the people involved was known to become agitated in the presence of certain others, and the situation could have escalated. Following our visit, the district manager took action to make sure there would be sufficient staff available to provide supervision to people who spent time in the lounge areas.

We were told the usual staffing level during the day was eight care staff, and two team leaders, as well as the deputy manager and registered manager during the week. In addition to this there were, two staff in the kitchen, a head house keeper and a domestic, a laundry assistant, the activity co-ordinator and the maintenance man. The registered manager told us they did not use agency staff to cover staff absence as they had 'bank staff' they could call on at short notice. We looked at the staff rotas for the past two weeks; these confirmed what we had been told by the registered manager.

The provider had safe recruitment processes for employing staff that ensured risks to people's safety were minimised. We checked two staff recruitment files. Records showed the provider obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS provides information about a person's criminal record and whether they are barred from working with people who use services. Staff told us they had to wait for checks and references to come through before they started working in the home. These checks supported the provider to make appropriate recruitment decisions, so people could be confident staff were of suitable character to care for them. The registered manager told us they were currently recruiting staff to the team, and interviews were taking place on the day of the inspection.

We looked at how medicines were managed in the home and found they were managed safely. People told us they received their medicines when they should have them. One person told us, "My medication is done properly. Some of my medication I do myself. We usually get our medicine on the dot." Another said, "The staff do my medicine and they do it correctly. If I was in pain I would tell the staff and they would give me a pain killer."

Prior to our visit there had been several medication errors in the home which had been referred to the local authority safeguarding team for investigation. In response to this the provider and registered manager had worked with the local authority and health commissioning teams, as well as a local pharmacy to implement safer procedures for management and administration of medicines. This had resulted in all staff responsible for administering medicines being retrained and re-assessed as competent to do this safely. The provider had implemented new procedures such as checking medication administration records (MARS) and tablet amounts after each administration round, which had reduced the number of errors. There were guidelines for staff to follow for PRN (occasional use) medicines. People told us, "If we have a headache we just need to ask and we would be given a pain killer." We found medicines were stored and disposed of safely in accordance with current guidelines.

MARs we looked at had been completed correctly and included a photograph of the person to minimise the risk of giving medicines to the wrong person.

The team leader administering medicines had a good knowledge of the guidelines for use of anti- psychotic medicines, and those used specifically for people living with dementia. Staff discussed how appropriate health professionals were contacted to ensure that the National Institute for Clinical Excellence (NICE) guidelines were adhered to regarding these groups of medicines.

There were procedures to ensure the premises and equipment in the home remained safe. People told us the home was always clean and tidy.

However, we were told by staff that a member of domestic staff had left and were not being replaced and that the head housekeeper was the only full time member of domestic staff. We asked staff how this had impacted on the cleaning of the home. They told us, "Sometimes a unit will not get done [cleaned] which to me is unacceptable." They told us the night staff carried out some routine cleaning and had a check list to complete. This included cleaning all the chairs in the lounge areas and cleaning the pressure cushions. We found this was not always being completed. There was an unpleasant odour in one lounge area. We established this came from under the pressure cushion on the chair we were sitting on and when we lifted this, it was wet underneath.

The provider employed a maintenance person who carried out routine checks around the building and carried out repairs. The maintenance man told us they no longer tested the hot water temperature in the taps in people's rooms, only the boiler temperature. We discussed our concern that this would mean if valves in people individual rooms failed, the water could run hotter than the recommended safe level. They confirmed there was the potential this could happen. We discussed this with the managers during our feedback, they were not aware of this. Following our visit the registered manager confirmed hot water testing in tap outlets had been reinstated.

Good

Is the service effective?

Our findings

People and their relatives said they (or their family member) received effective care and support. One person told us, "I am well looked after here." A relative told us, "I think the staff are trained well. They do things properly."

Staff told us they had the right skills, training and experience to carry out their role effectively. Recently recruited staff said they completed an induction which involved working alongside experienced staff members before they provided care on their own and completed the Care Certificate. The Care Certificate sets the standard for the fundamental skills, knowledge, and behaviours expected from staff working in a care environment.

Staff said they received regular training to refresh their knowledge and keep their skills up to date. We asked staff about their training, they said they had completed training to meet the needs of people living at the home. This included moving and handling training, safeguarding, and dementia awareness. Staff were also encouraged to complete a qualification in social care. Training records showed that staff training was monitored by the provider to ensure staff skills were updated regularly.

The registered manager had a good knowledge of dementia care and kept their learning up to date through the provider's Personal Development and Leadership academy. They told us about the dementia care training they had previously completed with the Alzheimer's Society, which they said, "Inspired me in regard to dementia care and living in people's reality." We spoke with care staff about their knowledge of dementia, their training and experience, and how this was updated. Staff spoken with had all completed accredited training on dementia, provided by 'Anchor Care Homes'. The focus of this training was to continue to improve the lives of people living with dementia and to increase staff understanding. One staff member told us, "You never stop learning about someone who has dementia. There's always another clue each day."

During our visit we saw staff put their training into practice by, using equipment to move people safely, communicating and interacting with people living with dementia effectively and safely administering medicines. Staff told us their knowledge and learning was monitored through observations of their practice and supervision meetings with the team leaders or managers during which they discussed their personal development and training requirements.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They explained, "If I had any concerns, I would arrange for a capacity assessment and best interest meeting." Where people did not have capacity, decisions were made in their best interests in consultation with family and others involved in the person's care.

Staff understood the principles of the Act and assumed, where possible, that people had capacity to make everyday decisions. One staff member told us ''It's about making sure people have choices and about keeping them safe when they cannot look after themselves. I think that is what deprivation of liberty means, lawfully keeping someone here and safe because they can't decide for themselves." Staff recognised the importance of respecting people's right to make their own decisions. Staff told us seeking consent from everybody was part of their everyday practice. We saw examples during our inspection visit, where staff offered people choices, such as, where to sit, what to do or what they wanted to eat and drink.

People at Godiva Lodge were living with dementia and had restrictions on how they lived their lives. People were under constant supervision and were unsafe to leave the home on their own. The front door was coded to keep people safe. Applications for DoLS for people who lived permanently in the home had been authorised and documents to confirm this were available on people's care files.

We asked people for their views on the range and choice of meals provided. People were positive about the food and said they had plenty to eat and drink. People's comments included, "The food seems to be okay, I'm never hungry", and, "I have enough to eat and drink. The food is very good." One person told us, "The food is excellent. For breakfast we get something cooked and cereals, toast, tea or coffee. We then get a choice of drinks in the lounge, cold drinks or tea or coffee. For lunch we have sandwiches, tea or coffee, and soup. The soup's lovely. We can just ask for more food if we want it. They do their absolute utmost to try to please me. We don't go without much that's for sure."

People told us there was a choice of meals available, for example, one person said "We chose what we would like to eat at the meal table. Everything is fresh." A relative told us, "[Name] has a choice of food. The food looks very good and appetising."

We spoke with the cook who said there were two options of meal available and other options if people preferred. They knew who needed special diets such as diabetic or pureed and who required their meals fortified to provide additional calories if they were prone to losing weight. We saw during our visit people offered pureed food and fortified drinks.

People's nutritional needs were monitored and assessed. If people were at risk of losing weight the provider used a recognised assessment tool such as Malnutrition Universal Screening Tool (MUST) to assess the risk and a care plan was completed. People had daily fluid and food charts to record the food and drink consumed and their weight was monitored. Referrals were made to the GP, dietician and Speech and language team (SALT) if concerns were identified. Records we viewed showed 11 people had MUST care plans completed and these people were weighed on a weekly basis.

People told us they had regular health appointments to maintain their health and welfare. For example, "The doctor and optician will visit me here," and, "We can have a doctor to visit us if we need one. We go out to the optician." A relative told us, "[Name] has had a massage and a chiropodist visits to look after her feet. The doctor visits regularly, I'm not sure about the dentist to be honest."

Records showed people's health and welfare was monitored and referrals made to health professionals

when needed. Some people at Godiva Lodge had multiple health issues. There were entries from health professionals in some files which detailed contacts and visits requested by the staff in order to treat and monitor health conditions such as diabetes. Staff were observant to changes in people's moods and behaviours and understood when changes might be a sign of ill health, and made referrals to the GP.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff and told us they were kind and caring. One person said, "I don't think that we're lacking much here. I think that we are treated very well. They will stop to have a laugh and a joke with me." And, "The staff are very caring and respectful." A relative told us, "The staff are very kind and caring, nothing is too much trouble for them. The staff know [relative] and look after him well."

During the day we observed interactions between staff and people who lived in the home. Staff were kind and compassionate in the way they interacted with people and frequently reassured people by touching their arms and hands. Staff bent down to speak with people at their level and they knew people's preferred names and addressed them in the way they preferred. Staff had developed relationships with people and were seen laughing and joking with people. One staff member told us, "I love working here."

Staff knew people very well and understood their likes and preferences. People told us, "The staff know me, they know what I like and what I don't like." A relative said, "They know [Name], they know what she likes. They are brilliant with her and they always dress her nice."

Staff told us they worked with all the people living at the home so got to know their likes and dislikes. One staff member said, "We don't use agency staff we use our own bank staff. We are recruiting for more bank staff. We feel it is important that they know our residents well. That's what person centred care is all about, really knowing the needs of the people in our care.'' People's care plans provided staff with information about people's backgrounds, their likes and dislikes and some of their personal history. This supported staff to have meaningful conversations with people.

We saw staff interacted and communicated with people in an effective way. A staff member told us about communicating with one person who was hard of hearing, "[Name] is very hard of hearing, deaf. On one side he can hear a bit and we tend to talk clearly and loudly without shouting and he will get that. All staff communicates like this. If we are doing an activity or something more is going on, we write it down so he can read it, he can understand that as well." Staff were aware dementia may impede or prevent a persons' ability to communicate effectively. We asked staff how they would recognise changes in people who were unable to communicate how they felt. One staff said, "They may be quiet, their mobility may change, they may have a pained expression. Maybe more sleepy, off their food, not drinking, and their colour may change. It would be necessary to tell the team leader right away.''

Staff respected people's right to privacy and dignity, especially when personal care was provided. People told us staff maintained their privacy. They told us, "I have privacy here because when I go to my room I can lock my door," and, "They do everything they possibly can to respect my privacy. There's nothing to complain about here." Staff upheld people's dignity. We saw one staff member adjust a person's skirt to preserve their dignity whilst sitting in the lounge. Another staff member intervened when a person stood in the dining room and attempted to pull down their trousers. During our observations staff spoke discreetly to people when they asked about personal care and escorted people to bathrooms or their bedrooms to deliver this in private.

We observed staff transfer people using a hoist. They reassured the person using the hoist during the transfer and moved the person from the lounge to the toilet in a dignified manner.

People were supported to do things for themselves where possible. One person told us, "We are independent. We can make our own decisions. We can go to bed whenever we want to and get up at whatever time suits us." A relative told us, "[Name] is free to get up in the morning whenever she wants to. She can also go to her room in the evening when she likes." Staff told us how they promoted people's independence. Comments included, "We always try to give choices and support them to do what they want to do." And, "We have timescales but people get up when they get up, there is no routine here."

We saw staff knew what to do to relieve people's anxiety. During our visit one person became agitated several times during the day. Staff knew how to use distraction techniques to divert the person's attention and to calm the person. Throughout the day staff dealt with the person in a positive and consistent manner.

The environment supported people who liked to walk, as it was spacious with places for people to sit in the corridors and in the reception area. There was a friendly relaxed atmosphere, with some people who lived in the home interacting and socialising with others.

People were able to maintain relationships with family and those closest to them. All the people and relatives we spoke with said that there were no restraints on their relatives or friends visiting them at any time. Comments included, "My visitors are encouraged for come." Relatives told us, "We are very happy. We're made to feel very welcome. We're offered a drink when we come to visit but we can always make ourselves something to drink as well."

A relative told us they felt involved in the family member's care, for example "We are always kept informed about what's happening here. I feel like we have a very good relationship with the home."

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with how they were looked after. One person told us, "If you need any help they're always ready to help, even when you're in your room." A relative told us, "[Name] always looks well cared for. She's always clean. When she first came here I wrote in on her "about me" form that she likes to wear a scarf that matches her outfit and they do that for her. I'm pleased with that."

People told us that staff responded to their requests for help and assistance. They said, "When I ask for help they come as fast as they can. I find them alright," and, "There's always someone to help when I need help. I don't press the buzzer I don't need to because there's always someone around."

However, on the day of our visit we found staffing arrangements were not sufficiently effective to ensure there was enough care staff to respond to people's needs and requests. During our observations there were several occasions were we had to go to find staff to let them know people needed assistance. For example we noticed a call bell in a toilet ringing for around 10 minutes. We heard the person calling out for help. We went to look for a staff member but couldn't find one in the area. Eventually we found a staff member to assist them. We saw another person in the corridor who appeared to be lost and confused and who was asking for help. We couldn't find any staff around to help.

People's lunchtime experience differed depending on the unit where they lived. We observed staff on the lounge areas worked very hard to serve food and support people with their meals. People were shown the different options of food so they could choose their preferred meal. People were served their food on 'tea plate' size plates, and small portions of food were offered to people. Some people ate very little and others cleared their plates. People in some lounges were not encouraged to eat their food, and plates were removed still full. Where people had eaten all their meal we did not see people offered second helpings. The meal was a choice of beef casserole with potatoes and vegetables or cheese salad. The cheese portion on the salad was small and no carbohydrates were served with the salad. We spoke with the managers about this during our feedback, and following our visit they discussed this with the cook who agreed, bread should have been offered with the salad.

Interactions from staff during lunch were very task focused. Where people required assistance to eat they did not always get undivided attention from staff as they were busy serving food and supporting others. In two areas, there were times when people were left unsupervised. When there was no staff presence in one dining room, one person who needed support with their walking got up and started walking around.

We noted there were several members of staff taking a breaking outside, while other staff were busy serving people their lunch. So they were not available to support people.

From our discussions with staff they all felt there were sufficient staff to keep people safe, but not always enough to respond to people's needs, particularly at peak times. For example: first thing in the morning and during meal times. Staff told us about two people who needed constant supervision or reassurance from staff which meant staff were not available to support other people. Staff told us there should be an 'all

hands on' approach from management and other staff to assist care staff but this was not happening.

Following our visit we were informed the district manager had taken immediate action and had undertaken an unannounced visit to the home the following day which had resulted in the 'all hands on approach' being reinstated and two people being referred to social services for a reassessment of their needs as it was felt they may no longer be appropriately placed at Godiva Lodge.

Staff had a handover meeting at the start of their shift which updated them with people's care needs and any incidents since they were last on shift. We were told there was a handover three times a day by the team leaders where care staff were given information about the people on the units they would be working on. The handovers were recorded and records were available for staff to read so they could remind themselves about what had been discussed.

We observed the afternoon handover. The staff team coming on duty were well informed about the needs of people. However, we noted that people's food intake was not discussed during the handover. Staff coming on duty would not have known which people had not eaten their lunch so they could ensure these people had sufficient to eat during their shift. . Following our visit the registered manager told us they had implemented a handover procedure for people's food and fluid intake.

People had an assessment of need competed before they moved to Godiva Lodge. The registered manager was confident the assessment process was robust and ensured that the needs of the person could be met by the home before they moved in. Care plans were developed from the assessment information, and were available for staff to refer to.

We looked at five people's care records. Care plans reflected how people would like to receive their care, and included background information, health needs, preferences, and life stories. Care plans contained, "All about my life" and "This is me" documents which included information about family members, and people's likes and dislikes. This was used to support people's care needs and ensure staff knew people's preferences. Staff told us, "Each resident has a life story, when people move in we ask families to fill this out. We then discuss this and take snippets of this to have a conversation with the resident. We then add to the life story as new information is given." Care plans were person centred but some initial assessment and life story information was very limited. One person had a 'This is me' booklet which had not been completed.

We found care records were not easy to follow, and we were unable to find some related information in care files. Some documentation did not appear to be in the appropriate place and it was difficult to locate risk assessments. Some daily monitoring was not always recorded.

Staff encouraged people to maintain their interests and to socialise with others if they wished. People told us there were things to get involved in. Comments included, "I like Country and Western music, I play music in my room. We get a lot to do here, I like the quizzes best of all." Another person said "I join in with the activities that they do here. I like to play games." Relatives told us, "There are things to do here. [Name] likes to sing and often when we come in they are having a sing song. They also paint her nails." And "They have special days like the 1920's day when they had spam, we came to that it was very good. There was a Wimbledon day, we enjoyed that too. They had strawberries and cream." Although one relative told us, "There are hardly any activities going on. There's musical therapy on a Friday [Name] enjoys that."

We asked the activity co-ordinator about the activities in the home. They told us, "We like to try and provide an activity on every unit every day, 90% of the time it happens. We include meaningful activities like washing up, folding towels cleaning handrails, a few ladies like to feel useful. A lot of residents love animals and dogs

and we have 'pat the dog therapy' every two weeks. That goes down really well."

The organiser told us when they had taken on the role they had created activity boxes. They said, "These are plastic storage boxes with a variety of activities in them; staff can take a box to a unit for people to use….the care staff here are very involved and join in a lot."

People were supported to follow individual interests. We were told how one person whose dementia was quite advanced and who had limited mobility, enjoyed football and films. "If football is on, he is glued to it." Another person liked knitting. The organiser told us, "I have a big box of knitting needles and wool and they enjoy rummaging in there."

In the afternoon on the day of our visit, we saw staff supported people to read newspapers and look at books and photograph albums. People were listening to music, and watching the television. Some people preferred to spend time in their rooms.

Some people like to practice their religion and we were told the local church provided a monthly service.

People we spoke with had no complaints about the service they received, they told us, "I have no complaints about this place at all. I've never made a complaint but if I did have a complaint I would tell them." And, "There's nothing you can complain about here. If I had a complaint I would tell the manager."

Relatives told us they knew how to make a complaint if they needed to, for example "I've never had a complaint but if I did I would feel comfortable speaking to someone about it. I would go to the office if I had a complaint." Another relative told us they had made complaints and had not been happy with the outcome. They said, "18 months ago I wrote a four page letter to [previous branch manager]. I've had meetings with the manager and nothing happens." We spoke with the registered manager who advised they had received complaints from the relative and had thought this was resolved. They said they had spoken to the relatives but had not written to them about the findings

Complaints information was on display in the reception area for people and relatives to refer to. The registered manager kept a record of complaints and the action taken to investigate people's concerns.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with said they liked living at Godiva Lodge, people told us "I think that this place is well managed," and "It's nice here. It's alright living here." A relative told us, "It's perfect for us; it's a weight off our minds knowing that [name] is cared for. She changed when she came here, she's really happy now."

The home had a registered manager who understood their role and responsibilities. For example, they had completed a PIR as requested, understood what statutory notifications were required to be sent to us and the ratings from the last CQC inspection were displayed in the home.

The registered manager said they were well supported by the provider, and felt. "They genuinely want you to succeed.'' On the day of our visit the provider's district manager was at the home and supported the inspection process. The branch manager visited the home every week, during these visits they met with the registered manager, audited medication records, checked care plans, and observed care and support on the units.

Other provider representatives carried out routine visits and audits of the home. An annual survey was sent to people who used the service and staff. The findings of the survey where sent to the registered manager and action had been taken to address people's feedback.

The registered manger told us, "We are constantly monitoring to see how things can be improved". They told us, "Healthwatch visited last year, I found their feedback really useful in regard to suggestions about the environment and dementia care. Following this we are trying to make the environment more homely."

The registered manager held regular meetings with the management team and care staff to keep them up to date with what was happening in the home. They told us, as well as team leader meetings and staff meetings, they had a daily '10/10 meeting' (ten minutes at 10am) with the management team, to discuss any daily actions.

The registered manager told us how they kept up to date with current good practice in dementia care. They said, "Anchor [the provider] are very helpful with this and we have a Dementia Care Lead who provides, training, advice and support. They also have the 'Inspire' programme which is dementia specific. This is an accredited scheme and they come and observe practice and interactions, we have just been re-accredited. At the moment we are looking at person centred dementia care and the environment." They also told us two staff had been nominated for the British Care Awards.

The registered manager worked in partnership with other professionals to ensure people received appropriate care and support. This included social workers, G.P's, the district nurse team and the local authority contracts team.

Most staff said they enjoyed working at the home. One staff member told us, "I enjoy it because I get a sense of accomplishment and knowing I have done my best to make someone's day a bit better. This is my first job

working with dementia care."

The management team were knowledgeable about the care and support needs of people living at the home. Staff were clear about the management within the home and were complimentary about the team leaders who led and managed the shifts.

Staff gave mixed feedback about being supported by the team leaders and managers. Some staff felt they were not always given positive feedback. One staff member said, "When we do something and go that extra mile you don't get recognised. When we [care staff] do something wrong we get pulled in but not when we do something positive." Another said, "On the floor we have fantastic staff, we are here to support and love our customers. It is so sad we don't get recognised for our work."

Some staff told us they did not always feel listened to. They said this was because they had raised issues with the registered manager and deputy manager but they never received feedback so did not know if anything had been done. For example, "Management expect you to do the paperwork and everything. I find it quite stressful. There are supposed to be two [staff] on each unit but this is not always the case. We have really struggled and I have seen the team leaders sitting on their bums doing nothing, it's not good. I find it very frustrating."

Some staff also felt the management team did not have a presence in the home and spent a lot of their time in the office. We asked staff what they would change. They said managers should spend more time on the floor checking staff were okay and if they needed any help.

Following our feedback to the registered manager and district manager, the district manager visited the home the day after our inspection and spoke with staff. Staff on duty raised their concerns with the district manager who told us all the management team and available ancillary staff would be supporting care staff on the floor at peak times, and, "Over the next few weeks I will be meeting with all staff to gain more of a picture of the issues in the home."

The provider and management team used a range of quality checks to make sure the service was meeting people's needs. These included checks to ensure care plans were reviewed and kept up-to-date. Medication records were audited to make sure people had received their prescribed medicines. Accidents and incidents were recorded and monitored for trends or patterns, and cleaning and safety checks were made on the environment.

We found audits and checks were not always robust or carried out regularly. For example, we were told that all care plans had been audited recently by the managers, we found several records that were not up to date or were missing.

We found several checks required to manage the fire risk assessment had not been completed. The registered manger told us this had been the responsibility of a team leader who was no longer in post and that they had taken over this responsibility. They acknowledged there were gaps in the records. Following our visit the registered manager confirmed they had completed all the outstanding fire safety checks and had identified a member of staff to carry out checks routinely.