Nicholas James Care Homes Ltd

Charles Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on 19 May 2016 and was unannounced.

Charles Lodge provides accommodation for up to twenty-seven older people, a majority of whom are living with dementia and who may need support with their personal care needs. On the day of our inspection there were twenty-two people living at the home. The home is a large property situated in Hove, East Sussex. It has a large communal lounge, dining room, conservatory and gardens.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Risk assessments had been undertaken for generic risks. They considered people's needs and abilities as well as hazards in the environment. People were encouraged and enabled to take positive risks. People's independence was not restricted through risk assessments, instead risks were assessed and managed to enable people to be independent. However, not all risks had been assessed. For example, one person administered their own medicine. The registered manager had not ensured that a risk assessment was in place to identify and mitigate the risks this may have created. Another person was able to access the community independently. However, there was no risk assessment in place to identify the hazards, the likelihood of risk occurring or what measures were in place to mitigate any risks. We have identified these as areas in need of improvement.

There were sufficient numbers of skilled, competent and experienced staff to ensure people's safety. People were cared for by staff that had a good understanding of adult safeguarding and who knew what to do if there were concerns over people's safety. People told us that they felt safe. One person told us "There are always people around". There were safe systems for the storage, administration and disposal of medicines and people were supported to have their medicines safety and on time.
People's consent was gained and staff offered explanations before assisting people. Mental capacity assessments and deprivation of liberty applications had been undertaken to ensure that, for people who lacked capacity, appropriate measures had been taken to ensure that were not deprived of their freedom unlawfully.
People had access to relevant healthcare professionals to maintain good health. Records confirmed that external healthcare professionals had been consulted to ensure that people were being provided with safe and effective care. Healthcare professionals confirmed that people received appropriate support to maintain their health. One healthcare professional told us "Staff always raise any concerns they have regarding a person's health or welfare, either when we visit or by telephone".

People had access to their choice of food and drink and had a positive dining experience. For people at risk of malnutrition staff had ensured that they had undertaken appropriate measures to monitor and

encourage them to eat. For example, the completion of food and fluid records. For one person who was frequently refusing food and who disliked eating their meals with a knife and fork, staff had offered the person a choice of finger foods. People were happy with the food. One person told us "The food is so excellent, we're worried about putting on too much weight".

Positive relationships had been developed between people and staff. Staff knew people's needs and preferences well and demonstrated care, compassion and kindness. People were treated with respect and their privacy and dignity was maintained. One person told us "They treat us with respect and ensure confidentiality".

People were involved in decisions that affected their care. There were regular resident meetings that provided people with an opportunity to make their thoughts and feelings known. People told us that they felt listened to and able to make suggestions. People told us that they knew who to go to if they had any concerns but that they had nothing to complain bout. One person told us ""If I had any complaints I would see the manager and if it was serious and unresolved I would tell the owner, fortunately I have no reason to complain". People's preferences and needs were assessed upon admission and care plans were regularly reviewed to ensure that people continued to receive appropriate support.

People had access to a wide range of activities and entertainment to meet their social needs. People told us they were happy with the activities that were offered and that they were able to choose how they spent their time. Some people were supported to go to local cafes and parks.

There was a positive, welcoming and friendly atmosphere within the home. People, relatives and staff were all complimentary about the management and leadership of the home. There were quality assurance processes in place that were carried out by the registered manager and provider to ensure that the quality of care provided, as well as the environment itself, was meeting the needs of people and delivered a service they had the right to expect.

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 home was not consistently safe.

There were generic risk assessments in place to ensure people's safety. However, the registered manager had not identified the potential risks to people when undertaking specific activities.

There were sufficient numbers of staff working to ensure that people were safe, staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People received their medicines on time, these were dispensed by trained staff and there were safe systems in place for the storing and disposal of medicines.

Is the service effective?

Good

The home was effective.

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

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who lacked capacity and had worked in accordance with this.

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

Is the service caring?

Good

The home was caring.

People were supported by staff that were kind, caring and compassionate. Positive relationships had been developed.

People were involved in decisions that affected their lives and care and support needs.

People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Good

The home was responsive.

Care was personalised and tailored to people's individual needs and preferences.

People had access to a wide range of activities to meet their individual needs and interests.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Good

The home was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Charles 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on the 19 May 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Prior to the inspection the provider had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. Other information that we looked at prior to the inspection included previous inspection reports and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eight people, three relatives and five members of staff. After the inspection we contacted a healthcare professional who visits the home on a regular basis. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for three people, medicine administration records (MAR), three staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounges and dining areas during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in May 2014 and no areas of concern were noted.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that they felt safe. When asked why they felt safe, one person told us "There are always people around, and they come in and out of the room to chat". Another person told us "It's safe as there are security doors on the stairs and on all external exits and entrances. People have to check in and out and there are key pads on the stairs". However, despite these positive comments we found an area of practice that required improvement.

People's freedom was not restricted and they were able to take risks. People's needs had been assessed and risk assessments were devised and implemented to ensure their safety. For example, one person was assessed as being at high risk of falls. The registered manager had taken appropriate measures to ensure their safety and had referred the person to the falls prevention team. They had been assessed and a falls prevention plan had been implemented to minimise the risk of falls. Observations showed the person independently walking around the home with their mobility aid, as advised in their mobility risk assessment and care plan.

However, the registered manager had not ensured that risks in relation to activities that were specific to people were completed. The registered manager had demonstrated good practice and promoted independence by enabling a person to administer their own medicine. The National Institute for Health and Care Excellence – Managing Medicines in Care Homes, states 'Care home staff should assume that a resident can take and look after their medicines themselves, however, an individual risk assessment should be completed to find out how much support a resident needs to carry on looking after their medicines themselves.' It advises that risk assessments should include the person's choice, if self-administration poses a risk to the person or others, if the person has mental capacity and the dexterity to take their medicines, how the medicines will be stored and how often the risk assessment needs to be reviewed. There was no risk assessment, in regard to the self-administration of medicine, for this person. This meant that the registered manager had not taken sufficient measures to ensure the person's safety when taking their medicine. The registered manager had demonstrated good practice and had recognised that one person was able to access the community independently. However, the registered manager had not assessed the potential risks of this, the likelihood of them occurring or identified the measures that needed to be taken to minimise them. We have identified these as areas of practice in need of improvement.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure the building was maintained to a good standard. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered as each person had an individual personal evacuation plan.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and

helps prevent unsuitable people from working with vulnerable groups of people.

There were sufficient staff to ensure that people were safe and cared for. People and staff told us there was sufficient staff on duty to meet people's assessed needs and our observations confirmed this. One relative told us "There are plenty of Staff around and the wonderful thing is they are familiar faces. In some care homes the staff change every three months, most of these have been here over three years". People's individual care plans showed that a dependency tool had been used to identify the amount of support required according to their needs. The registered manager confirmed that this was used to inform the staffing levels and told us that these were increased if people were unwell or needed additional support, for example if they were at the end of their life. Staff told us that the registered manager was responsive to change, one member of staff told us "When the lift broke the manager made sure that more staff were working so that there was enough of us to assist people who were upstairs". When people required assistance staff responded in a timely manner. The home had recently installed a new call-bell system and people confirmed that staff responded to them promptly. One person told us "We used to talk through a telephone if we wanted help, but now we press a button. They come quickly most times".

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. (A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace).

People were assisted to take their medicines by staff that had undertaken the necessary training and whose competency was regularly assessed. In order not to be interrupted the member of staff responsible for dispensing and administering the medicines wore a red tabard, this made everyone aware that they weren't to be disturbed, therefore minimising the risk of any medication errors occurring. People's consent was gained and they were supported to take their medicine in their preferred way. For example, one person's care plan advised staff that they needed staff to put the tablet into their mouth, that they took one tablet at a time and with a drink. Observations of another person being supported to take their medicine showed staff placing the tablet into the person's hand so that they could independently take their medicine. People were asked if they were experiencing any pain and were offered pain relief if required, this complied with the provider's policy for the administration of 'as and when' required medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief. One person, who was able, had chosen to administer their own medicine.

Each person had a medicine administration record (MAR) sheet which contained information on their medicines as well as any known allergies, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People and relatives told us that they received support with their medicines and had these on time.

Accidents and incidents that had occurred were recorded and action had been taken to reduce the risk of the accident occurring again, for example risk assessments had been updated to reflect changes in people's needs or support requirements. One person, who had been assessed as being at high risk of falls, had appropriate care plans and risk assessments in place. The registered manager had demonstrated good practice and had enabled the person to continue to be independent whilst walking using a mobility aid, however, the person had continued to have falls, despite staff following the guidance provided by the falls prevention team and risk assessments. After each fall staff had completed a 'Post fall incident report form', this analysed the factors that might have contributed to the fall such as the environment, trip hazards and

the person's condition.

Good

Is the service effective?

Our findings

People were cared for by staff with the relevant skills and experience to meet their needs. People and relatives confirmed that staff were competent, well trained and efficient. One relative told us "I am happy about the staff's interaction with my relative, they are all aware of their needs". People and relatives told us that people's health needs were met and that they received support from healthcare professionals when required. One visitor told us "You can sense the fact that they are well cared for when you walk in".

Commitment to staff's learning and development was demonstrated from the outset of their employment. New staff were supported to learn about the provider's policies and procedures as well as people's needs. An induction checklist was completed to ensure that all new staff received a consistent and thorough induction. Staff had undertaken induction workbooks and two new staff were working towards the Care Certificate. The Care Certificate is a set of standards that social care and health workers should work in accordance with. It is the new minimum standards that should be covered as part of the induction training of new care workers. In addition to this staff that were new to working in the health and social care sector were able to shadow existing staff to enable them to become familiar with the home and people's needs as well as to have an awareness of the expectations of their role.

Staff had completed essential training as well as courses that were specific to the needs and conditions of people, for example, courses for caring for people living with dementia. Most staff held diplomas in health and social care, or were working towards them. There were links with external organisations to provide additional learning and development for staff, such as the local authority and the dementia in-reach team. (The team provides advice, training and information for care homes that provide care to people living with dementia.) Staff told us that the training they had undertaken was useful and enabled them to support people more effectively.

People were cared for by staff who had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss people's needs and any concerns. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive. One member of staff told us "I have supervision, the manager is very approachable and always listens".

People's communication needs were assessed and met. Care plan records for one person stated that the person wore hearing aids, it advised staff to ensure that that person was supported to wear these and to ensure that they were switched on. Observations of staff's interactions with people showed them adapting their communication style to meet people's needs. Staff told us that they knew people well and that when a person was unable to communicate their needs verbally, they were able to recognise any change in their behaviour or condition to ensure they received appropriate support. One member of staff told us "I was helping one person to stand from their chair this morning, I could tell straight away that they weren't having a good day so assisted them to sit in their armchair and have a sleep instead of assisting them down to the lounge". Effective communication also continued amongst the staff team. Regular handover and team

meetings ensured that staff were provided with up to date information to enable them to carry out their roles. For example, records of a handover meeting showed that staff had been informed that a person had had a fall.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had arranged for mental capacity assessments to be undertaken for some people, was aware of DoLS and had made the necessary applications. Observations showed that consent was gained before staff supported people. Staff showed a good understanding of MCA and DoLS and the implications of this for the people that they supported. One member of staff told us "It's for their protection, we are not allowed to let them out of the home alone". Another member of staff told us "If someone lacks capacity we involve their relatives or we word things differently, maybe use simple language so that they are able to understand and can make a decision". A relative told us "My relative has a DoLS now, we were consulted about this, it is only to protect them and keep them safe from harm and getting lost".

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians, mental health teams, falls prevention teams, and district nurses. Healthcare professionals told us that the home responded promptly to people's health needs. One health professional told us "The staff always raise any concerns they have regarding a person's health or welfare, either when we visit or by telephone". People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. One person told us "Staff are always vigilant. I have paracetamol if I am not well". Relatives further confirmed this and explained that they were kept informed if their relative was unwell. One relative told us "They ring me if my relative is not well, even at night". Another relative told us "They always call immediately if things go wrong. My relative was taken ill and they sent for the ambulance".

People's skin integrity and their risk of developing pressure wounds were assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. Observations and records confirmed that people at risk of developing pressure wounds had received the appropriate preventative treatment. People had access to district nurses to provide treatment for any wounds as well as appropriate pressure relieving equipment. For people who had any redness or sore areas these had been recorded on body map charts. Body maps showed the location of these areas and advised staff of what cream the person needed to have applied. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushion and mattress that was appropriate as well as the setting that the mattress was required to be.

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) as well as a Prideaux nutritional risk assessment were used to identify people who were at a significant risk,

and these people were weighed each month to ensure that they were maintaining their weight. Records showed that referrals to healthcare professionals had been made for people who were at risk of malnutrition, these included referrals to the GP. Advice and guidance provided by the GP had been followed, for example for one person who was at risk of malnutrition, it had been advised that the person had fortified drinks and observations confirmed that these had been provided. The person's daily food and fluid intake was monitored through the completion of food and fluid charts. Staff had also taken appropriate measures to ensure that the person had access to food of their choice and that it was presented in an appropriate way. For example finger foods were provided for one person who disliked eating meals with a knife and fork.

People had a positive dining experience. People were happy with the quantity and choice of food available. One person told us "The food is so excellent we're afraid of putting on too much weight." Most people chose to eat their meals in the main dining area. This was well presented and created a pleasant environment for people to have their meals. Tables were laid with tablecloths, napkins, vases of flowers and condiments. People were able to sit with their friends and we observed people enjoying conversations with one another. People were provided with choice and were reminded of the available menu choices in written form and through photographs. Observations also showed people were encouraged to have regular drinks and snacks of their choice throughout the day.

Good

Is the service caring?

Our findings

People were cared for by kind, caring and compassionate staff who knew them well. People, relatives and healthcare professionals confirmed this. We asked people about the staff, one person told us "Brilliant". Another person told us "The best and kindest care staff". A third person told us "Nothing is too much trouble". Records of a residents meeting showed that one person had commented, 'Happy with home'. Another person had stated 'Happy with room, warm and cheery'. Relatives confirmed that they were happy with the care provided. Comments in a recent relative's survey stated 'The care home is the best possible place for my relative, they are provided with special care and attention at all times and by all the staff'. Another relative had commented 'I wouldn't want my relative anywhere else'. A healthcare professional told us "The staff are always caring and show understanding of each person's needs".

People and staff had developed positive relationships and it was apparent that staff knew people's needs and preferences well. Staff told us that they took time to get to know each person by talking with them and their families and that this enabled them to get to know each person and form relationships with them. Observations confirmed this. The Alzheimer's Society advises that staff should take time to listen to people's feelings and show patience and understanding when supporting people who are experiencing signs of distress or anxiety. Staff were observed spending time with people, holding their hands, talking and engaging in conversation with them about their interests and feelings. People were encouraged to communicate with one another and there was a friendly, warm and sociable atmosphere. People enjoyed interacting with one another and it was apparent that caring relationships had been developed between people as well as with staff. There was an emphasis on ensuring people who were new to the home, felt comfortable and welcomed. This was demonstrated through the 'Charles Lodge Greeters'. A poster was displayed on the notice board, it displayed photographs of two people who lived at the home, and stated 'We are happy to introduce ourselves to you and have a chat to make you feel at home the best we can'. Observations showed one of these people spending time talking to each person and interacting with them.

The Social Care Institute for Excellence (SCIE) report 'Dementia Gateway, keeping active and occupied' identified that the use of doll therapy can sometimes benefit people who are living with dementia. It states 'Benefits might include comfort and companionship for some people living with advanced dementia in care homes. That there may be a reduction in behaviour that others may find challenging, as well as increased communication and purposeful activity where attention is concentrated on caring for and tending to the doll'. Observations showed one person caring for a doll. A member of staff told us that the person had been talking about babies whilst they were being supported to get up that morning, and that they had said to the member of staff "Where are the babies"? Observations showed the person being supported into the lounge and a member of staff was overheard saying "Shall I find your baby"? The person was given the doll and was observed calmly attending to the doll, stroking its face and talking to it. Another person, who was sitting beside the first person, also enjoyed interacting with the person and the doll. The person continued to care for the doll throughout the morning and staff were observed interacting with the person about their doll. One member of staff was overheard saying "Are you okay holding the baby, would you like me to hold him for you so you can drink your tea"? The person indicated that they were okay and wanted to continue holding the doll. A member of staff assisted the person to place a hat on the doll's head, this appeared to

make the person happy as they were seen smiling and thanking the member of staff.

People's differences were acknowledged and respected. People were able to maintain their identify, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected in regards to people's religion. One person received regular visits from their church and took part in communions; there was also an in-house church service that people could attend if they wished. A relative told us "I was amazed that they knew my relative was Buddhist and they were very supportive. As a surprise they arranged a Chinese New Year for them." People's religion in regard to their diet was respected, people were offered alternative choices if the menu choices of the day incorporated a certain type of food that they were unable to eat due to their religion.

People were involved in their care. Records showed that people had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and relatives confirmed that they felt fully involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. One relative told us "They tell me everything about my relative and I cannot fault them, they are not ticking boxes, they really care". Another relative told us "They always listen". Observations showed that relatives were involved in their loved ones care. They had been informed of any changes in their relative's needs and condition and were observed talking with staff about the care their relative received.

There were resident and relative meetings that provided people and relatives with an opportunity to be kept informed and to raise any concerns or suggestions that they might have. Staff told us that people used these meetings to make their thoughts known. One member of staff told us that people had made suggestions for changes to the menu during a recent meeting, as well as asking for more trips out to local areas. They explained that changes had been made as a result of people's feedback. People had commented that they would like to go out of the home more often, as a result people had been supported to go for cups of tea at local cafes and our observations further confirmed this. Observations confirmed that people were asked their opinions and wishes on a daily basis and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect and that they took time to talk, explain information and listen to their needs. The registered manager had recognised that people may need additional support to be involved in their care, they had involved people's power of attorney's in people's care and explained that if people required the assistance of an advocate then this would be arranged. (An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.)

People's privacy was respected. Information held about people was kept confidential, records were stored in locked cabinets and offices and handover meetings where staff shared information about people were held in private rooms to ensure confidentiality was maintained. Care records showed that people had been asked where they preferred to discuss their care needs. One person's care plan contained a document that stated 'Is there anywhere in the home that the person feels more comfortable to discuss issues pertaining to themselves'. The person had indicated that they preferred to discuss this in their room and were able to confirm that staff respected this. One person told us "They treat us with respect and ensure confidentiality".

People confirmed that they felt that staff respected their privacy and dignity. One person told us "They always knock, they ask for permission to do any task and they are discreet". Another person told us "They never intrude when I am in the bathroom". Observations of staff interacting with people showed that people were treated with dignity and respect. For example, when discussing information of a personal nature, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way.

Staff showed a good knowledge of how they maintained people's privacy and dignity. One member of staff was a dignity champion, there were plans for the member of staff to attend additional training so that they could share good practice with other staff. Staff told us that they ensured that people's privacy and dignity was maintained. One member of staff told us "This is their home, we're visitors in their home, we have to respect that, and we do". Another member of staff told us "I always ensure that I knock on people's doors, that I use a towel to cover people when I'm assisting them and involve them as much as possible, encouraging them to do as much as they can for themselves".

Independence was encouraged. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves. Care plan records for one person stated that the person enjoyed going out for walks independently, visiting an external social club and meeting family and friends. The person confirmed that they were able to do this. Staff were mindful of the importance of encouraging and maintaining people's independence. One member of staff told us "We try to maintain their independence as much as possible, for as long as possible". Observations showed other people choosing how they spent their time, some people, who had been assessed as being at risk of falls, were able to walk independently and safely around the home using their mobility aids.

Good

Is the service responsive?

Our findings

People were central to the care provided. People and relatives told us that they were fully involved in decisions that affected people's care. One relative told us "I discussed medicines, showers, hairdressing, change of clothing and laundry when my relative came in, I expect that was a care plan". This was further confirmed by a healthcare professional, who told us "The manager liaises with people and their families to ensure person-centred care".

People's social, physical and health needs were met. People's needs had been assessed when they first moved into the home and care plans had been devised, these were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. (Person-centred means putting the person at the centre of the planning for their lives.) Records showed, and people and relatives confirmed that they had been involved in the development of the care plans. The registered manager had implemented a system known as 'resident of the day', this enabled each person's care plan to be reviewed on a certain day each month. People and relatives had given their consent for their care plans to be reviewed on a monthly basis by the care staff, unless changes occurred before this time, these reviews took into consideration changes in people's needs and care was adapted accordingly. The registered manager was responsive to people's changing needs. Feedback within a recent relative's survey contained a comment, which stated 'My relative wants a bigger cup of tea, the cup they have is too small and they want more'. This had been listened to and implemented. There was a notice in the kitchen advising staff of this and observations confirmed that the person was provided with mugs of tea.

In addition to the information in people's care plans a document titled 'This is Me' was completed. This identified the person's interests, hobbies and employment history and provided staff with an insight into people's lives before they moved into the home. Staff told us that this was helpful and provided them with useful information that helped them to care for people in a way that was specific to them. Staff confirmed that the information within the document had helped them to provide care and activities that were specific to the person's interests and preferences. One person's 'This is Me' document contained information about their employment as a seamstress. Staff were aware of this and one member of staff told us "I sometimes sit with the person and encourage them to touch different fabrics, feathers and ribbons, they like tactile things, they used to be a dressmaker".

The provider employed two activity coordinators who each worked different days of the week. Staff told us that they complimented each other well. For example, one of the activity coordinators also worked some hours as a carer, this had enabled them to build up a rapport with some people over time and as a result they were able to engage more effectively with them. Both activity coordinators attended regular forums to share ideas with other people in similar roles within other organisations, they told us that these helped to inform their practice and provided ideas and opportunities to develop the activities that were offered. Activity assessments were used to assess each person's needs in regards to the types of activities that would be appropriate and of interest to them. Staff told us that this was devised to ensure that all staff were able to support people to participate in activities and assist them to know which type of activities were the most suited to the person's needs and abilities. The activity assessment form indicated if a person would prefer

small group activities, spectator activities or to partake in one to one activities. It also identified if the person preferred creative, physical or more knowledge based activities. It was apparent that staff knew people's needs and preferences well and activities had been designed to incorporate these as well as to acknowledge the times and type of activity that should be offered. For example, a member of staff told us "I try to do activities that suit the people that are joining in, there isn't a set structure, it is based on what people want to do and who is taking part. I also base the activities around the time of day. For example, I do a more physical activity in the morning, then a sedate activity after lunch to allow people to rest after their meal and then we may do a quiz later in the afternoon". Observations confirmed that this took place. People had access to a wide range of activities and external entertainers. Records showed that people had enjoyed external entertainers, taking part in quizzes, singing, reading books and craft work.

Staff told us that activities were provided to stimulate people's interests and ensure that there was a connection with what was happening in the world. For example, for the Queen's ninetieth birthday a vintage cream tea had been organised, some people had chosen to wear tiaras or crowns and the event had been enjoyed by visitors too. People and staff told us that they were supported to access the local community and often visited local cafes and parks and our observations confirmed this.

The registered manager was responsive to people's needs and abilities. Aspects of the environment had been tailored to ensure they created a more effective environment for people. For example there was clear signage informing people of their bedrooms and the location of bathrooms. On each person's door there was a sign that enabled them to know which was their room. These were personalised and individual to the person's interests or background. For example, one person had been in the Royal Air Force (RAF) and had a picture of a plane on their door. Staff told us that these were useful to people to enable them to recognise their rooms but also assisted staff to have a better understanding of people's background and were sometimes used as a prompt to initiate conversation. Bright red coloured crockery and bright blue toilet seats had also been provided to ensure that people with sensory impairments and those that were living with dementia, were able to use the facilities provided. Further measures to ensure people were encouraged to orientate to the date, time and place were provided. There was a notice board that displayed the day, date, season and weather.

The registered manager had implemented a daily reminiscence newspaper for people. This was called 'The Daily Sparkle' and was provided by an external organisation. These newspapers were provided each day and provided articles that would have been in the news on the same day in years past. There were also quizzes, puzzles, singalongs and entertainment to provide opportunities for reminiscence. Staff told us that these were sometimes used to engage in conversations with people and that people enjoyed completing the quizzes as a group. Observations showed people picking up the newspapers and reading them.

There were activities to ensure that people who were unable or chose not to go to the communal lounge, were not isolated in their rooms. Activities were adapted to meet their needs and activities such as listening to music, spending time talking and listening with the person and bird watching. Observations of people in their rooms confirmed that these activities took place.

People were able to have choice in all aspects of their lives, they were able to have a choice of male or female care staff, what they wanted to do with their time, how they wanted to be supported and what they had to eat and drink. Observations confirmed that people were treated as individuals and encouraged to make choices about the care and support they received.

There was a complaints policy in place. Complaints that had been made had been dealt with appropriately and according to the provider's policy. The registered manager encouraged feedback from people and their

relatives, there were comment cards for people to complete and instructions provided as to how they could make comments about the home on external websites. People and visitors told us that they didn't feel the need to complain but would be happy to discuss anything with the manager. One relative told us "There are informative notices on the board or I just have conversations with the staff to comment on day to day occurrences". Another relative told us "We can make a difference". One person told us "If I had any complaints I would see the manager and if it was serious and unresolved I would tell the owner, fortunately I have no reason to complain".

Good

Is the service well-led?

Our findings

People, relatives and staff were complimentary about the leadership and management of the home. They told us that they were encouraged to make their feelings known and that these were listened to and acted upon. One person told us "Everything runs very smoothly".

The home was part of a wider organisation; the provider had a number of homes throughout the South. As part of the support provided by the provider the registered manager was visited on a regular basis by the operations director and area manager. The management team consisted of a registered manager and senior care staff.

The provider had a philosophy of care that stated 'We aim to provide all our service users with a safe, secure, relaxed home-like environment, where their care, well-being and comfort are of prime importance'. The philosophy of care was embedded in the culture of the home and the practice of staff. There was a friendly, warm and homely atmosphere and a positive culture. People appeared to be at ease, happy and comfortable. People, relatives and staff confirmed this. One member of staff told us "It is a calm, relaxing, homely and peaceful environment". Another member of staff told us "It is homely and friendly, there is a good team. It is a happy home". When asked what Charles Lodge did better than any other home, one member of staff told us "We're not task orientated, we are person-centred, and it is about the residents". People also confirmed that the home complied with the provider's philosophy of care. They told us "This is considered to be the best care home in the area, it was recommended to me by another person who was already in here and my neighbours all agreed".

People, relatives and staff told us that the home was well managed. Staff told us that the manager was approachable and receptive to any ideas and suggestions that they made. One member of staff told us "The manager is a very good role model, there is very good leadership and management". Another member of staff told us "The manager is very approachable, absolutely, one hundred percent". A relative confirmed this, they told us "The Manager is always about and hands on, she knows all the residents and they know her".

There were good systems in place to ensure that the home was able to operate smoothly and to ensure that the practices of staff were effective. There were quality assurance processes and regular audits conducted. These ensured that the registered manager was meeting the requirements of legislation and people were receiving care to the standards that they had a right to expect. In addition to regular audits the registered manager also conducted weekly 'walkarounds' of the home. They explained that this enabled them to monitor the physical environment as well as observe staff's practice. The registered manager held a monthly meeting with staff working in the different departments of the home to feedback their findings. They explained that this had improved communication amongst the staff team and ensured that any actions required were completed.

The registered manager ensured that staff were encouraged and empowered to develop within their roles. Some staff had been encouraged to become champions, this included champions in infection control, dignity and end of life care. The registered manager explained that it recognised staff's skills and abilities

and enabled other staff to have someone they could go to for advice or support.

There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority and the dementia in-reach team. The registered manager worked closely with external health care professionals such as the GP and district nurses to ensure that people's needs were met and that the staff team were following best practice guidance.

The registered manager kept their knowledge and skills up to date by attending regular manager's meetings with other managers of homes that the provider owned, enabling them to share areas of best practice amongst the different managers. They demonstrated an awareness of the implementation of the Duty of Candour CQC regulation and had implemented this in practice. (The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'.) Observations showed that a relative had been informed that their relative had fallen. Relatives further confirmed that they were kept informed. One relative told us "It is open and transparent". The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.