Sira Care Home Limited

Garlinge Lodge Residential Home

Inspection report

6 Garlinge Road
Southborough
Tunbridge Wells
Kent
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Tel: 01892528465

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09 August 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 08 and 09 August 2016. Garlinge Lodge is a large house that provides residential accommodation without nursing care, for up to 14 older people. There were 12 people living in Garlinge Lodge at the time of our inspection, eight of whom lived with dementia or short term memory loss.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Staff knew how to raise an alert if they had any concerns about people's safety. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures were in place which included the checking of references.

Medicines were stored, administered and recorded safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

Staff knew each person well and understood how to meet their individual needs. Staff communicated effectively with people and treated them with kindness and respect. They had received all essential training and attended regular one to one supervision sessions.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they helped them.

A system was in place to assess people's mental capacity when necessary and hold meetings to decide particular decisions in their best interest, as per the requirements of the Mental Capacity Act 2005.

Staff provided meals that were in sufficient quantity and met people's needs and choices. People told us they enjoyed the food that was provided. Staff knew about and provided for people's dietary preferences and restrictions.

People's individual assessments and care plans were reviewed monthly or when their needs changed. Information about the service, the facilities, and how to complain was provided to people and visitors. People and relatives' feedback was sought during satisfaction surveys.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred routines. Staff promoted people's independence and encouraged people to do as much as possible for themselves.

People were not involved in the planning of activities that responded to their individual needs. The provider had not ensured that a suitable amount of activities and outings were provided to stimulate people's interests and meet their social needs. We have requested the provider to take action.

Staff told us they appreciated the registered manager's style of leadership. The registered manager was open and transparent in their approach.

The registered manager placed emphasis on continuous improvement of the service and carried out monitoring checks and audits to identify any improvements that needed to be made. However the provider had not identified a shortfall in regard to the provision of activities, a lack of outings to combat isolation and a lack of measures to maintain links with the community. We have made a recommendation about this and will check that action has been taken at our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective. Staff were appropriately trained and had a good knowledge of how to meet people's individual needs.

People were supported to make decisions and were asked to consent to their care and treatment.

The registered manager had submitted appropriate applications in regard to the Deprivation of Liberty Safeguards and had considered the least restrictive options.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them

with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not involved in the planning of activities that responded to their individual needs. The provider had not ensured that a suitable amount of outings and daily activities were provided to stimulate people's interests and meet their daily social needs.

People or their legal representatives were invited to be involved with the review of people's care plans. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager sought feedback from people, their representatives and staff about the overall quality of the service. However, they had not identified that the level of activities provided and the lack of outings was insufficient in meeting people's social needs.

Links with the community were not actively sought to reduce social isolation.

People, relatives and staff were complimentary about the manager's style of leadership. The registered manager knew each person well and had developed a good rapport with them.

Garlinge Lodge Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out by one inspector on 08 and 09 August 2016 and was unannounced.

The manager had not received and completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We took this into account when we made the judgements in this report. Before our inspection we looked at records that were sent to us by the manager to inform us of significant changes and events. We also reviewed our previous inspection report.

We looked at six sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities provided. We sampled the services' policies and procedures.

We spoke with seven people who lived in the service and one of their relatives to gather their feedback. Most people were able to converse with us. We spoke with the registered manager, two care workers, the cook, an activities provider, and one domestic staff. We also spoke with a local authority case manager, a local authority specialist assessor and a district nurse who oversaw people's care and treatment in the home and obtained feedback about their experience of the service.

At our last inspection on 28 March 2014, no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "There is always two workers around and they always come when I call them." A relative told us, "There seems to always be two members of staff and also the manager is always around" and, "I feel my mother is very safe here."

There was a sufficient number of staff to meet people's needs in a safe way. The service employed ten care workers. A cook and one domestic staff were employed on a full time basis. Staffing rotas indicated sufficient numbers of care staff were deployed during the day, at nigh time and at weekends. The registered manager was a registered nurse and visible in the service. They reviewed staffing levels taking into account people's specific needs. Additionally, two members of bank staff were available to supplement the care provided, should people need one to one support due to illness or end of life care. People's requests for help were responded to without delay.

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. All care staff had received training in the safeguarding of vulnerable adults. There was a detailed safeguarding policy in place in the service that reflected local authority guidance. This included information about how to report concerns and staff knew they should report to the local authority or the police if necessary. Staff were aware of the whistleblowing procedure in the service and staff we spoke with expressed confidence that concerns would be raised.

The premises were safe for people because the home, the fittings and equipment were regularly checked and serviced. Safety checks had been carried out throughout the home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, the electrical system, water temperature, Legionella testing, service logs relating to the lift, appliances and fire protection equipment. Equipment that was used by staff to help people move around were checked and serviced annually. Portable electrical appliances were checked regularly to ensure they were safe to use. Each person's environment, such as bedrooms and communal areas had been assessed for possible hazards.

People's bedrooms and communal areas were free of clutter. The premises were well maintained. The registered manager had an effective system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. On the day of our inspection, a toilet facility had broken down and a plumber was commissionned within the hour to carry out the repair.

Systems were in place to ensure the service was secure. A security system ensured that people remained safe inside the service and people were assisted by staff when they needed or wished to leave the building.

Staff had received appropriate training in fire safety and were familiar with the steps to be taken in case of a fire. There was appropriate signage about fire exits and fire protection equipment throughout the service. Regular checks on fire equipment were carried out and weekly fire drills were completed. There was a

detailed fire risk assessment in place. People had personal evacuation plans in place that detailed the level of support they would need in case of an evacuation. These were made accessible to emergency services in a dedicated bag by a fire exit. There was a business contingency plan in place concerning how the service would manage an emergency. An external fire protection organisation had inspected the fire alarm system, nurse call system, emergency lighting and had carried out a routine maintenance visit in July 2016.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. Appropriate logs were completed by staff and analysed by the registered manager on the day. Action was taken to minimise further risks of falls, such as the provision of pressure mats under people's mattresses or armchairs that alerted staff when people got up and may need assistance. The registered manager carried out monthly audits of falls and compared them to previous audits to identify and possible trends or patterns. As a result of such audits, a person was provided with bed rails and referrals had been made to the falls prevention clinic that had provided individualised exercise plans.

Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people needs changed. Staff were aware of the risks that related to each person. There were specific risk assessments in place for people who may be at risk of skin damage or malnutrition, and who were at risk of falls. People's risk assessment regarding falls took into account factors such as their history, medicines, mobility, sight, mental state and footwear. When a possible cause was identified, people were referred to a GP for a review of their medicines, to a physiotherapist, occupational therapist, to an optician or a chiropodist. Each risk assessment included clear measures instructing staff about how to keep people as safe as possible, taking into account people's individual circumstances and preferences. Staff helped people move around safely and checked that people had the equipment and aids they needed within easy reach.

All aspects of people's medicines were managed safely. Systems for ordering, stock control and returns of medicines were orderly and easy to follow. There was an effective system to pre-empt when stock of medicines may run out. The care workers who administered people's medicines completed the medicines administration records (MARs) appropriately. These included medicines to be taken 'as required', with clear protocols to follow. Staff also completed separate administration charts for topical creams and body maps. People had their medicines at the time they were to be taken. When people were given pain relief, protocols were in place and followed by staff. Care workers' competency had been checked in the administration of medicines.

All medicines were stored safely. The staff room where medicines were kept was locked securely when not in use. Medicines requiring refrigeration were stored in a dedicated fridge. The temperature of the fridge and the staff room in which it was located was monitored daily to ensure the safety of medicines they contained. Monthly audits of medicines were carried out to ensure the safe and effective management of medicines which include a drug error audit. When errors had been identified, measures had been put in place to prevent recurrence, such as additional one to one supervision and competency checks.

The home was clean, tidy and well presented. In each area of the home there were sterilising gel available and hand washing facilities. Laundry was segregated in a dedicated small laundry room and soiled items were cleaned at the required high temperature to minimise the risk of infection. Monthly infection control audits were carried out by the registered manager to identify any potential risks and actions that needed to be taken. There was an infection control policy in place that provided clear guidance for staff concerning the steps they should take to protect people from the risk of infection. The staff were knowledgeable of the policy, wore appropriate personal protection equipment and followed good hand hygiene practice. A person had contracted a virus when they had stayed in hospital and appropriate precautions were taken to

prevent the spread of the virus in the home.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

People and their relatives could be assured that staff were of good character and fit to carry out their duties. Disciplinary procedures were in place to use should any staff behave outside their code of conduct although this had not been warranted to date.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "I have known some of the care workers for a decade; I know I can depend on them for anything" and, "The workers are very knowledgeable, I have confidence in them."

Staff received essential training to enable them to carry out their roles effectively. New staff received a thorough induction that incorporated the Care Certificate during the first twelve weeks. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. The induction also included 'how to meet the needs of individuals' and 'how to promote privacy and maintain confidentiality'. Essential training was provided that included dementia care, mental capacity, safeguarding, infection control and manual handling. Assessments of staff competency in the administration of medicines, in the principles of dignity in care and in their understanding of their role in safeguarding had been carried out. Additional training that was relevant to people who lived in the home was offered and delivered to staff, such as Parkinson's disease, dementia care, and 'dignity, respect and communication'. The staff we spoke with were positive about the range of training courses that were available to them. A member of staff told us, "The training is very good and we get reminded when we need to get a refresher course."

Staff were encouraged to gain qualifications and progress their careers through the service. All care staff held diplomas in social care at Level two and three. A member of staff had a diploma awarded by a national awarding organisation in the principles of dementia care. Staff received one to one supervision sessions six times a year and were scheduled for annual appraisal of their performance. The registered manager carried out regular checks and observations to ensure that staff maintained good standards of practice.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options for each individual. The CQC had been appropriately notified when DoLS applications had been authorised. Staff were trained in the principles of the MCA and the DoLS and were able to tell us of the main principles of the MCA.

Staff sought consent from people before they helped them move around, before they helped them with

personal care and when they were helped with their meals. We observed staff enquiring with people if they could go ahead and help them. A person told us, "They always ask, always politely."

There was an effective system of communication between staff to ensure continuity of care. Staff handed over information about people's care verbally to the staff on the next shift twice a day. Information about accidents and incidents, referrals to healthcare professionals, people's appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. Updates were written on a notice board in the staff room and were inputted in a diary. A person who experienced an infection had just been prescribed a particular medicine and this was written on the board to complement the handovers. Follow up action was taken from one staff shift to another.

People told us they were satisfied with the standards of meals. They told us, "It is fine, very nice" and, "quite good actually, especially the roasts, they're delicious." We observed lunch being served in the dining area and in people's bedrooms. The lunch was freshly cooked, hot, well balanced and in sufficient amount. Menus were seasonal and the cook or staff consulted each person daily to check they were content with the options provided. People were offered a choice of two main courses, two desserts and alternatives if they had changed their minds. The daily menu was written on a board in the dining room. There was a folder with pictures of food and meals to help people living with dementia or confusion identify the menu and make their choice. A person had chosen to bypass a cooked meal and have cheese instead, and this was provided. Another person had requested an omelette and this was prepared for them. People were supported by staff with eating and drinking when they needed encouragement. In addition they were provided with snacks, biscuits or cakes in between meals. The cook maintained current records based on people's dietary needs, preferences and allergies. This information was kept in the kitchen and the cook referred to it daily.

People were weighed monthly or weekly when there were concerns about their health or appetite. Their body mass index (BMI) was calculated and risks of malnutrition were assessed appropriately. Fluctuations of weight were noted and food and fluid intake was appropriately recorded when necessary and examined by the registered manager. People were referred to the GP, a dietician, a district nurse or a speech and language therapist (SALT) when necessary, and their recommendations were followed in practice, such as helping them sit in a particular position when eating.

People's wellbeing was promoted by regular visits from healthcare professionals. People were registered with a local GP surgery. A chiropodist visited every six weeks to provide treatment for people who wished it. People were escorted to a local dentist and an optician visited twice a year or sooner when needed. People were offered routine vaccination against influenza when they had consented to this. When people had become unwell, they had been promptly referred to healthcare professionals. For example, to a fall prevention team and a physiotherapist. Staff responded effectively when people's health needs changed. A district nurse was visiting a person to dress wound on their leg. She told us, "The staff call us without delay."

The accommodation was comfortable, welcoming and pleasant smelling. The fabric of the home was worn in places and we were told a programme of ongoing re-decoration was in progress. People accessed different floors using a small lift. The house had been converted to provide 14 bedrooms with a basin. One bedroom had en-suite facilities. There were five toilet facilities, two bathrooms with a shower, a bathing hoist and aids, one lounge, a dining room and a spacious conservatory. There was a small garden that people could access if they chose to, which had a gazebo and garden furniture. A person told us, "My bedroom is small but it feels like my home and I have brought bits of my own furniture with me." There was pictorial signage in the home to help people gain information. Pictorial signs indicated communal areas, bathrooms and toilets to help people orientate themselves. Bedroom doors were personalised with people's photographs when they had consented to this, to help them locate their rooms.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "The staff are very kind people" and, "Everyone is very lovely, I could not ask for nicer people." A relative told us, "The staff seem very kind every time I visit and they take very good care of my mother."

We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. The staff approach was kind and compassionate. They were attentive to people's needs, checking on people's wellbeing while respecting their space and privacy.

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. People were assisted discreetly with their personal care in a way that respected their dignity. A person told us, "They show respect, and only step in when I need them." People were able to do what they wanted and follow their preferred routines. One person was shopping independently, another was smoking outside.

Staff knew how to communicate with each person. Staff were lowering their position so people who were seated could see them at eye level. They used people's correct and preferred names, and spoke clearly. They showed interest in people's response and interacted positively with them. One person had a hearing impairment and their communication care plans indicated how best to converse with them and be understood. Staff followed these instructions in practice as they used body language and wrote on a small board. The activities provider ensured the group activities were inclusive as they enunciated carefully for people to make sure they heard and understood.

Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. They had signed a statement of confidentiality upon entering the service. People were given the choice of having their doors open or closed; People's records were kept securely to maintain confidentiality. Information about the service was provided to people and their relatives in a welcome pack that included a resident's guide. This included the procedures to follow about how to lodge a complaint.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. The registered manager sat with people and talked with them while they reviewed their care plans. Each person had a 'key worker' allocated to them. Key workers are named member of staff with special responsibilities for making sure that a person has what they need.

People could be confident that best practice would be maintained for their end of life care. People or their legal representatives were consulted by the registered manager about how they wished the service to manage their care and treatment when they approached the end of their lives. People had end of life care

plans that detailed people's wishes about resuscitation, where they would prefer to be cared for at the end of their life and funeral wishes. There was appropriately completed documentation about resuscitation in people's care files and staff were aware of these. The local hospice provided guidance and support to the service when a person approached the end of their life, to ensure good practice in pain management.

Requires Improvement

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their needs. They told us, "The staff come when I call, every time, I don't have to wait long at all" and, "They know me well, they know what I need, they're a good bunch."

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments gave a clear account of people's needs in relation to their medicines, communication, breathing, nutrition, continence, skin integrity, sleeping pattern and mobility. They were person centred and noted people's interests, and their preferences about their daily routine. People were invited to stay for a meal or a day before they made an informed decision about coming to live into the home. When people moved in they had a four-week trial period built in their occupancy agreement to decide whether they wished to remain permanently.

There were risk assessments that were carried out before people came into the service, such as risks of choking or falls. This information was included in an initial care plan that was completed within one week when people moved into the service. Individualised care plans about each aspect of people's care were developed further as staff became more acquainted with people, their particular needs and their choices. People were encouraged to personalise their bedrooms as they wished and bring their own articles of furniture to make them feel at home from the beginning of their stay.

People's care plans reflected their current needs as these were reviewed and updated appropriately. The registered manager reviewed people's care plans on a monthly basis, or as soon as needed, for example following an illness, any incidents, a medicines review or a period of hospitalisation. They sat with people to discuss their needs and appraise their wellbeing. Every month, the registered manager contacted people's families, with people's agreement, or their legal representatives, to invite them to contribute to the reviews of care plans.

People's likes, dislikes and preferences were taken into account. Staff enquired with people what they liked or disliked, and recorded their preferences about all aspects of their routine and food. These included details of what type of food they favoured, for example a person liked to have a lot of cheese, a person disliked pasta, and another disliked onions. The cook was made aware of these preferences. Care plans were person-centred and included how people wished to be called, how much help they required from staff, what time they liked to go to bed or what type of breakfast they preferred. There was a 'This is Me' document that detailed people, dates, TV programmes, pets, religious preferences, and special interests that were particularly significant to people. A life history information sheet gave a summary of people's past employment and of their personal experiences to help staff appraise their perspective. These documents were written in partnership with people.

Staff placed emphasis on the promotion of good health. People were encouraged throughout the day to drink and remain hydrated in the hot weather. When a person has stated feeling unwell, staff had informed the registered manager and checked on them every ten minutes to monitor their wellbeing. One person who

had been self-neglecting in their own home had resumed independence with eating and walking since they had come into the service.

People and relatives we spoke with were aware of how to make a complaint. Detailed information on how to complain was provided for people in the residents' guide and displayed in the entrance. One relative said, "The manager is very approachable, if we had a complaint I would simply talk with him." No complaints had been lodged to date.

Some activities that were suitable for older people and people who lived with dementia were provided. However, the amount of activities provided was not meeting people's social needs on a daily basis. An activity provider came one hour a week to deliver a specialised programme of therapeutic activity for people who live with dementia; a personal trainer provided chair exercises to music one hour a week; and two volunteers, members of the local church, came to sit and chat with people once a week. A local authority specialised assessor told us of the "The limited stimulation provided; activities only take place for short periods on Monday, Tuesday and Wednesday afternoons and this disproportionately affects the more able residents." A person told us, "I don't join the weekly activities on offer, they're not my style, and there is nothing else which is a little depressing really, so I watch my TV which I am happy to do."

There were no other arrangements for any performers or entertainers to visit the service. People told us they "very much enjoyed the activities" and we observed eight people participating with enthusiasm in the course of the hour. We spoke with activity provider who confirmed they were only able to provide a generic programme of group activities that was not based on any of people's specific interests. Although they knew each person well, they had not consulted people's care plans, life histories or wishes, as they would not be able to provide one to one attention within only one contracted hour. Therefore there was a lack of personalisation to the planning of people's social activities and a lack of sufficient activities. This is a breach of Regulation 9 Health and Social Care Act Regulations 2014 and we have asked the provider to take action.

Special days other than individual birthdays were not celebrated. Several people had a special interest in the royal family, however the Queen's birthday had not been celebrated and as people did not take part in any art and craft activities, there were no displays of people's art work or handmade decorations visible in the home. One person enjoyed sports and was following the Olympic games on their television in their bedroom. There were no themed days to celebrate events or dates that may be of interest to people, such as the Olympics, Care Homes Open Day, St Patrick's Day, Valentine's day, Mothers 'day, Fathers 'day and others. One person told us, "Days come and go, we pass the time, not much difference really; I supposed there isn't much we can do, not a lot to look forward to."

No outings were offered to people to combat social isolation, and staff told us that unless families took people out, "They just don't go out, they stay in." One person chose to spend regular time in the garden, however other people remained in the lounge or their bedroms on two very hot consecutive days. One person told us, "I wouldn't mind going in the garden but I am not sure the staff could spare the time to take me and I don't want to be a bother." We spoke with four people and three of them told us they would welcome the opportunity to go on an outing if this was offered. One person enjoyed reading and told us, "I'd like to have books with bigger letters but where can one gets this, we are quite cut off and so far away from the town here." However, the centre of town was ten minutes' drive away and the local library was one road away from the home. As a range of options was not presented to people, they remained unaware of possibilities to reduce their social isolation and of how to retain links with the community.

We recommend that the provider ensures that outings are provided to stimulate people's interests and meet

their social needs. We will check this at our next inspection.

Requires Improvement

Is the service well-led?

Our findings

People were aware of who the registered manager was and were complimentary about his style of leadership. They told us, "He is nice gentleman who is very caring, very kind", "He comes and talk with us" and, "He is very involved and knows all that is going on." A relative told us, "The manager is kind and attentive; he knows his residents well and has a good rapport with them."

The registered manager had been in post for nine years and was a registered mental health nurse (RMN) and a registered general nurse (RGN). They were dedicated to the service and the people who lived in it. They reported 'never taking a holiday and working seven days a week'. If briefly absent, a senior care worker acted as deputy manager. The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The registered told us of their vision and values, "This is the residents' home. We respect their rights and make sure they are safe and secure. We must treat them as if they were members of our family."

Staff were positive about the support they received from the registered manager. They reported that they could approach the registered manager with concerns and that they were confident that they would be supported. They described them as, "Very approachable", "Aware of any problems and quite efficient."

There was a system in place to monitor the quality of the service provided. The registered manager carried out regular spot checks of the premises, staff practice and of care documentation at any time of day and night including weekends. When any shortfalls were identified, such as repairs needing to be done, action was taken to remedy them. A spot check had identified a shortfall in regard to food labelling and this had been remedied. The registered manager carried out monthly audits of accidents and incidents, infection control, care documentation, medicines, health and safety and 'dignity in care' staff practice, communication and environment. They commissioned an external auditor to survey all aspects of health and safety in the home. The registered manager told us, "Action is taken straight away whenever I see the need for improvement therefore monthly audits do not show many shortfalls". As a result of an audit, towels dispensers and soap fillers had been replenished.

People had an opportunity to give their feedback about the quality of the service. The registered manager talked with people at their monthly reviews and noted whether they were satisfied with their care and support. Satisfaction surveys were carried out annually. The last survey dated May 2016 included questions such as whether they liked living in Garlinge Lodge; whether staff responded to them in a timely way; how they liked the food, and whether they felt safe in the home. All people except one had stated being fully satisfied, and the registered manager had discussed their concerns and had provided appropriate reassurance. However, people's feedback had not been sought about the amount of activities provided. We recommend that people's feedback is sought about the amount of activities provided in the home.

Relatives were able to give their feedback about how the home was run and their feedback was acted on. A satisfaction survey had been carried out in May 2015 and analysed by the registered manager. Seven

relatives had taken part and had been invited to comment on staff attitude, the environment, the manager's response to any of their queries, and whether they would recommend the home to others. All comments were very positive and included, "We are extremely satisfied with the care mum is receiving; she always looks clean, we know she is well cared for; she enjoys the food and overall is very cheerful."

Visitors and healthcare professionals were invited to comment on the service and a survey of their feedback was carried out in May 2016. However only three people had contributed with their comments which stated staff to be 'helpful', 'friendly and always with a smile'. One comment stated, "The home doesn't have an institutional feel like some others."

The registered manager held regular meetings with the staff that were documented. Matters affecting the home or people living in it were discussed, such as fall prevention and manual handling, DoLS, infection control and menus. We noted a meeting held in December 2014 where ideas had been discussed about introducing more meaningful activities in the home. Staff had suggested music and 'animal therapy' to be considered. However this had not been implemented.

The philosophy of care claimed by the service stated to focus on people's "therapeutic, cultural, psychological, spiritual, emotional and social needs." It said that "This will be achieved through programmes of activities designed to encourage mental alertness, self-esteem, social interaction with other service users." However, the level of activities provided and the lack of outings was insufficient in fully meeting people's social needs on a daily basis.

Links with the community were not actively sought. Although two volunteers from the local church visited the home once a week, there was no other involvement with the community. The registered manager had not kept abreast of latest developments regarding caring for people who live with dementia, such as researching specialised websites or participating in forums with other care homes managers to exchange ideas. We discussed this with the manager who told us they planned to establish new connections with the community to benefit the home and enhance the experience of people who lived in it. We recommend that establishing links with the community are researched and provided. We will check this at our next inspection.

The registered manager had carried out improvements in the service. They had purchased new furniture, new carpets, curtains, one electric bed and a recliner chair, and had replaced several appliances in the kitchen and laundry room. An on-going redecoration programme was in process.

The service's policies and operating procedures were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were kept securely and confidentially. The registered manager was in process of replacing folders that were worn and breaking down. Records were archived and disposed as per legal requirements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not provide person centre care because people's care was not adequately and accurately assessed or planned for to ensure their social needs needs and preferences were met with a suitable provision of activities. Regulation 9 (1) (c) (3) Person centred care.