Healthcare Homes (LSC) Limited

Sovereign Lodge Care Centre

Inspection report

2 Carew Road
Eastbourne
East Sussex
BN21 2DW

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17 October 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Sovereign Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The inspection took place on the 16 October 2018. This visit was unannounced. A second inspection day took place on the 17 October 2018 and was announced.

Sovereign Lodge is situated in Eastbourne and provides accommodation, nursing and personal care for up to 64 older people. Some people lived at the home whilst others were there for short stays, otherwise known as respite. There were 60 people using the service at the time of inspection; 56 living there and four staying for respite.

Sovereign Lodge provided accommodation across three separate floors, each of which had separate adapted facilities. The ground floor provided care to people with mainly physical health needs, while the first floor specialised in providing care to people living with dementia. People that lived on the second floor were more independent and required less support from staff. There were numerous communal areas for people to relax in and a hairdresser on site. There was also ample and well-maintained garden space which we saw people enjoying during inspection.

At our last inspection in August 2017, the service was rated 'Requires Improvement'. During this inspection, we found some areas still required improvement. This is therefore the second inspection where the service has been rated Requires Improvement.

There was not a registered manager at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a home manager who had only been at the service for 8 weeks. They had already applied to be the registered manager and were currently going through the registration process with us.

A number of shortfalls were found within record keeping which demonstrated current auditing processes needed to be further developed. Although there was a care plan audit, this had not identified all of the issues we found on inspection. People's support needs were not consistently identified in their care plans, which were hand written and often difficult to read. There were limited assessments with regard to specific support needs, such as diabetes, swallowing difficulties and positive behaviour support. Documentation that was missing or incomplete was not always identified. Staff we spoke with had a thorough knowledge of people and their support needs, which meant where shortfalls were identified, there was limited impact to people. However, there was a potential risk that if unfamiliar or new staff were to read care plans, they would not have all the information they required to support people.

During observations of the lunch-time experience, we found staff were not always responsive to people, particularly if they became anxious or required support with food. Meal-times were task-focused and once staff had served people their meals, there was less interaction. This had already been identified by the home manager, however more improvements were needed to ensure people were always engaged with. For one person, changes in their health had not been responded to effectively or in a timely way.

People told us they felt safe. Staff demonstrated a good knowledge of how to safeguard people and there were suitable numbers of staff to meet people's support needs. Medicines were managed in such a way that people received them safely. Checks of the building and equipment were completed regularly by the maintenance person and ensured the environment remained safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Staff had received a wide variety of training and people and their relatives were confident that staff had the right skills and knowledge to support people effectively. Staff spoke positively about their induction into the service and said regular supervision was given. People had access to health professionals to promote their health and social well-being. Their nutritional needs were met and they spoke highly about the quality of the food. The building had been adapted to meet the needs of people.

Everyone we spoke to was complimentary of the staff team and described them as, "Kind, caring and passionate." It was evident that staff knew people well and strong relationships had been built with people and their families. People's independence, privacy and dignity were promoted.

Staff were knowledgeable of people's communication needs. There was a clear complaints policy and people, relative's and staff knew how to raise concerns. Complaints were resolved in a timely way and people were satisfied with outcomes. People had choice and control over the activities they wanted to participate in each day. These were tailor-made to people's likes and dislikes.

Although improvements were required in people's documentation, people, relatives and staff spoke highly about the new home manager. They felt that a transparent and supportive culture was promoted and many improvements had already been made. The home manager valued feedback received and used this to improve the lives of people. They were passionate about future plans for the service and encouraged continuous learning to ensure best practice could be achieved.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines safely.

There were risk assessments for people and the building to ensure they and the environment remained safe.

There were suitable numbers of staff to meet people's needs that were recruited safely.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs. They had a good understanding of mental capacity and choice.

People were supported to have input from health and social care professionals when they felt unwell.

The building had been adapted to meet the needs of people.

Is the service caring?

Good

The service was caring.

People, relatives and professionals all felt that the staff team were kind, caring and enthusiastic about supporting others.

We observed some genuine, caring interactions between people and staff.

People's independence, dignity and privacy was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff did not always respond to people or their needs in a timely way.

Staff had a good understanding of people's communication needs and supported them to share their views.

People and their relatives were confident about the complaints process and that any issues would be listened to and actioned.

Relatives were positive about how their loved ones were supported with end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality audits had not identified inconsistencies within care documentation. People's needs were not always reflected in their care plans.

People, relatives and staff spoke highly of the home manager and felt they had made positive changes in the short time they had been in post.

Views of care provision were valued, actions taken to improve and feedback given to demonstrate the changes made.

Sovereign Lodge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 16 October 2018 and was unannounced. It was undertaken by two inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second inspection day took place on the 17 October 2017 and was undertaken by two inspectors.

Before the inspection, we checked the information we held about the service and provider. This included previous inspection reports and any statutory notifications sent to us by the home manager. A notification is information about important events which the service is required to send to us by law. We also viewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of people's complex needs, some people were not able to tell us about their experiences. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 22 people, 10 relatives and four professionals about their experiences. We spoke with 10 staff, including the home manager, operations manager, deputy manager, chef, maintenance person, nurses and care staff. We spent time reviewing records, which included eight people's care plans, four staff files, medicine administration records, staff rotas and training records. Other documentation that related to the management of the service such as policies and procedures, complaints, compliments, accidents and incidents were viewed. We also 'pathway tracked' the care for five people who lived at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care.

Good

Is the service safe?

Our findings

People told us they felt "Safe and secure", living at Sovereign Lodge. When we asked why they felt this way, comments included, "I feel safe here because staff are so good", "They always wear gloves and aprons when they help me wash" and, "They know all about the medicines I need and give them to me at the right time." Relatives and professionals were confident that people were kept safe. One relative said, "The carers are very attentive to my relative-they stay in their room, but staff support them by carefully attending to their basic needs and personal hygiene in familiar surroundings. They talk to my relative and make them feel 'at home'. That is why I think they are safe." Other relative's quotes included, "My wife is hoisted by two carers and they always show care and consideration-they ensure she is comfortable and not in any pain during the hoists" and, "From the beginning I have never doubted the excellent care and safe procedures provided by Sovereign Lodge." One professional told us, "I am very happy with staff levels – there are always enough to meet people's needs. They are also good with managing infection control."

We observed that staff were aware of risks to people and took action to minimise these. An example of this was for a person who stood up and began to walk unsteadily to the door. Staff reacted immediately and supported the person to go where they wanted to. For a person that received 1-1 support, staff worked and communicated well together to ensure they were never left unattended. People had assessments that included risks linked to moving and handling, falls, eating and drinking, oral hygiene and skin care. Several people required bed rails to keep them from falling out of bed and appropriate assessments had been completed to analyse the risks associated with using this equipment such as entrapment.

The provider had completed background checks on new staff as part of the recruitment process. This included applications to the Disclosure and Barring Service, which checked for any convictions, cautions or warnings. References from previous employers were also sought with regard to their work conduct and character and these were evidenced in staff files. This process ensured as far as possible that staff had the right skills and values required to support the people who lived at Sovereign Lodge.

From our observations and from reviewing rotas, we saw there were sufficient numbers of staff to meet the needs of people. Continuity of care was important for people and therefore staff mainly worked on one specific floor. However, for one shift each week, they were based within a different area of the home. The home manager told us this ensured that staff had the expertise to work anywhere within the home, in case of any absences. They said, "This helps to enable a solid skill mix and improve staff development, familiarity and knowledge of all people living here." Staff told us that agency staff were rarely used as the team worked together to cover any absences. A nurse told us, "I have been here five years and agency has only been used a couple of times. This is good because staff know people and their support needs well."

People received their medicines safely. Medication Administration Records (MAR) charts showed when people had received their medicines and staff had signed the MAR to confirm this. We observed nursing staff administering medicines throughout the inspection and this was done professionally. Staff remained with the person to ensure the medicine had been taken before signing the MAR. Staff supported people to take their medicines which were ordered, received, administered and disposed of safely. Storage arrangements

for medicines were secure and temperatures of storage areas were monitored to ensure medicines were stored at the correct temperature. Staff had completed training in the safe administration of medicines and records showed that this was up to date. They also had their competency assessed by a member of the management team to ensure they had the skills and knowledge to give medicines safely. Staff told us that if any errors occurred, this would be investigated and staff would have additional training and their competency re-assessed.

One person was required to have their medicines covertly. Covert medication involves administering medicines in disguised form, for example in food and drink, where a person is refusing treatment necessary for their physical or mental health. There was clear guidance on what support was required. The person's mental capacity had been assessed and their GP and a pharmacist consulted before medicine was given. Another person had a risk assessment for taking their own medicine without staff support, and this too had with discussed with their GP.

People were protected against the risk of abuse because staff knew what steps to take if they believed someone was at risk of harm or discrimination. Staff were aware of signs of potential abuse and who to report to with any concerns. We found that all potential safeguarding concerns were reported appropriately and advice sought where needed.

Incident and accident reports detailed information of the incident, immediate and on-going actions taken and reflected on lessons learned. An example of this was for a person who had fallen and sustained an injury. The home manager met with the person, their relative's and health professionals to discuss the incident. Additional equipment was sourced to ensure that the risk of reoccurrence was minimised. The home manager also held a 'lessons learned' supervision with the staff involved, to ensure practice was reflected on and improved. Each month, the home manager analysed incidents to look for patterns or trends, which meant they had continuous oversight of risks to people.

People lived in a safe environment. Daily, weekly and monthly safety checks were completed by the maintenance person for the building. These included fire safety, maintenance of the building and people's bedrooms, electrical equipment and water temperatures. External professionals regularly assessed gas and electrical safety, lift maintenance and risks related to asbestos and Legionella. There was a maintenance book for staff to write any concerns in and the maintenance person signed and dated when actions were taken. The maintenance person had a thorough knowledge of the service and potential environmental risks to people. They told us, "I am always informed what requires sorting but my priorities are always people first." Fire drills were completed at least four times a year, with alarms and equipment tested weekly. Staff were part of fire awareness days with a professional from the fire service, to ensure they had the skills and knowledge to support people in an emergency. Fire procedures were displayed throughout the home and there was a 'Fire grab bag' by the front door. This held all the information staff would require in the event of an emergency and included contact details and the service contingency plan. People also had Personal Emergency Evacuation Plans (PEEPS) that gave staff information about what rooms people were in and what equipment they would need to evacuate safely.

We saw good practices with regard to infection control. The building was clean, warm and well-maintained. Staff had received training and were knowledgeable of how to prevent the spread of infection. There was alcohol gel and hand soap available throughout the building and we observed this was used frequently. Staff also wore Personal Protective Equipment (PPE) such as gloves and disposable aprons when supporting people. Any substances that could be harmful to a person's health were stored safely and the laundry system was well organised with sluice facilities available if required.

Good

Is the service effective?

Our findings

People told us they thought the service were effective because, "Staff know what they are doing" and "There is lots of choice in everything. If I don't like what's for lunch, staff give me lots of choice for other things." Another person told us, "There is so much choice and flexibility. I can eat at any time. They even offer midnight snacks for people that want them." Relatives agreed that the service was effective. One relative told us, "The Staff are excellent –they anticipate people's' needs by responding to little things that matter and encouraging them to do things they are capable of." Another said, "In my opinion, staff are very well trained. They seem to know how to deal calmly with challenging behaviour and frustration - it is very reassuring."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made for people that did not have capacity and any conditions were being met.

People were offered choice in all aspects of their care. We saw staff using objects of reference to support people to make decisions. Staff also had a good knowledge of how the Mental Capacity Act applied to people they supported. For people that lacked capacity, there were assessments for specific decisions such as consenting to their photograph being used or consenting to care received. These assessments reflected the person's views and those involved in their care, such as professionals and relatives. Any decisions made were in the person's best interest and the least restrictive. An example of this was for a person with a history of repeated falls. Mental capacity assessments and best interest decisions had been frequently reviewed. Although a suggestion was made for a restrictive practice, the home manager had implemented a less restrictive way of supporting the person to stay safe.

People's nutritional needs were met. Although no one was in need of a specialised cultural diet, the chef was aware of religious cultures. Several people were receiving a fortified diet; this means that additional nutrients were added to meals without increasing the portion size to aid the person to gain weight. The provider had used a Malnutrition Universal Screening Tool (MUST) to assess whether people were at risk from being underweight. Those assessed as being underweight were weighed weekly and this was reviewed regularly. Some people required food to be soft or pureed to reduce the risk of choking. We observed that food was prepared in ways that met each person's needs. Each person had their own diet sheet so that the chef knew about specific dietary requirements, preferred portion sizes and preferences for food and drink.

People told us that they enjoyed the food at Sovereign Lodge. We were told, "The food is gorgeous" and "I look forward to meal times because food is very tasty." Relative's also spoke highly about the quality of the food and the chef. Comments included, "The food is excellent" and, "The Chef is delightful –they come down

to chat and they are very jolly with residents, they really care." There was a dining room on each floor and each one resembled a pleasant restaurant environment. There were fresh linen tablecloths, cutlery, condiments and flowers on each table. There were menus with pictures of food, laminated on the wall and meals were well presented and nutritious. There were two main meal choices and vegetarian and gluten free options also available. We saw one person change their minds about their meal choice and staff immediately offered alternatives. The chef served food on a different floor at each meal-time and used the opportunity to ask people how they had enjoyed their food. They also spent time each afternoon chatting to people and relatives. We saw the resident meetings regularly discussed menus with people and that suggestions for meal choices were added. The chef told us that they did research by going into restaurants to get menu ideas for people. They said, "I want the food here to be top quality and a real restaurant experience for people. I don't want food options to be bland either so do what I can to offer people exciting menus to choose from. I want to make it the best experience for them."

Staff had the skills and knowledge to meet people's needs. They told us training was, "Good" and "Thorough." Training included safeguarding, mental capacity, basic life support, equality and diversity and moving and handling. Staff had received more specialised training in dementia to meet the needs of people. They had also requested challenging behaviour training to support them with a person requiring 1-1 support and found the knowledge gained useful when working with them. Nursing staff had completed clinical training, which included stroke awareness, wound care, pressure sores and end of life. They were supported to maintain their nursing registration and given time to complete any relevant learning associated with this. We were told that nurses would be receiving further specialised training as part of a new programme and this would include courses on multiple sclerosis and sepsis. The management team checked staff competence in managing medicines, moving and handling, mental capacity, dementia and infection control. Staff were assessed by observation and assessment of their knowledge through workbooks.

Staff told us that they received a thorough induction programme where they learned about their roles and responsibilities and shadowed an experienced member of staff. Records showed that staff received a large welcome pack which contained everything they needed to complete the 12-week induction process. There were workbooks to complete following each new training course and staff would meet with a member of the management team to discuss what they learned and whether they required any further learning. New staff also completed the Care Certificate as part of their induction. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. A new staff member told us, "Induction was very good. It went back to basics. I had as long as I needed to shadow and they put me with confident staff so I could always ask questions." Following induction, staff were supported by regular supervision and yearly appraisals, where they could set goals, reflect on good practice and identify further training needs.

The service supported people to maintain good health with input from health professionals on a regular basis. Records showed that people were supported to have access to health professionals when they were unwell. The GP visited the service two days a week and had built good relationships with staff and the home manager. There was a reflexologist who supported people who stayed in bed and a tissue viability nurse that visited people requiring wound care. Professionals felt that staff were responsive to people's needs and always sought advice if health deteriorated. One told us, "They know when to refer and do this appropriately." Another said, "They monitor people closely and know when things aren't right." One person had become unwell and started to lose weight. Staff sought feedback from nurses and introduced a fortified and high fibre diet. These interventions worked well and the person's weight increased.

The design of the building had been adapted to meet the needs of people. There was specialised equipment, such as hand rails and electronic lifts, to support people to get in and out of the bath. Each floor

had cosy, quiet areas, with armchairs, lamps, knitting and books. There was an easy access garden, with wide, flat paths. The garden was well maintained; there were numerous seating areas and raised beds so that people could do their own gardening. The dementia floor had bathroom doors painted in bright yellow to support people with dementia or a visual impairment with orientation. There was a bus stop in the corridor, with a bench, plants and 'Sovereign Lodge timetable', which gave the illusion of being outside. Staff told us this was designed for people who could wander or become confused. We saw a person sitting at the bench and staff asked them where they would like to go. The person said the number of a bus on the timetable that would take them to the dining-room. Staff linked arms with the person and led the way, chatting cheerfully. There was also a panel on the wall with locks, switches and keys attached. Staff told us this was for one particular person who enjoyed playing with these.

Good

Is the service caring?

Our findings

Every person we spoke to felt that staff were, "Kind", "Caring", "Happy" and "Nice". Other comments included, "We have a laugh here. The staff are good friends to me", "Excellent, very good staff. They know their jobs well, are very helpful and always willing", and "If you have to be in a care home, this one should be it. I can't rate it highly enough." One person told us that they had lived at other homes and Sovereign Lodge was, "By far the best." They said, "Staff look after you very well, I come and go as I please and the food is excellent. I love it here and am very happy."

Although people were not always able to communicate verbally, we could see that they were relaxed around staff that they knew well. One person was being supported by staff to walk to a chair. When they sat down, they smiled at the staff member, gave them a hug and said, "I do love you." Another person who was unable to communicate verbally, smiled and patted a staff member's hand. The staff member smiled back and said, "That's a nice smile, thank you. It's brightened my day." There was lots of friendly chat between people and staff and staff showed interest in people's well-being and interests. One person was drawing and wanted to share their picture with staff. The staff member said, "I like it, it's lovely" and engaged the person in conversation about it.

Relatives spoke highly of the kind and caring nature of the staff team. Comments included, "Across the board, staff are respectful, friendly and discreet", "They put the residents first, nothing is too much trouble for them", and, "They know my wife extremely well in such a short time – it's like one big happy family." One relative told us that the home manager had approached them the day before and organised a meal for them and their relative. "They heard it was a special anniversary and told us they had planned a special celebration meal for us. I was very surprised and touched that they thought of us." Professionals were also positive about the support staff provided. We were told, "They are very good and competent" and, "They know each resident well."

Staff told us they genuinely enjoyed working at Sovereign Lodge because, "The atmosphere was warm and cheerful" and, "I like getting to know people and their relatives." One staff member had been at the service a long time and told us, "I stay here because I can go home at night and sleep and keep a smile on my face. All the time I am smiling I am happy to keep working." We observed staff to be happy, bright and engaging with people. The activities co-ordinator had also recently been awarded a 'Making a difference 'award for their hard work and enthusiasm.

Staff demonstrated a good understanding of promoting independence and supported people to do as much on their own as possible. We saw staff supporting people to mobilise independently with walking aids and they were patient, encouraging and praising. Another staff member was supporting a person with eating. They put food on the spoon and then encouraged them to feed themselves. Where this wasn't possible, hand over hand support was given. Some people had specially adapted crockery to enable them to eat and drink independently. One person told staff that they were struggling to have soup in a bowl and asked for help. Staff offered the soup in a mug instead, so they could maintain their independence. One relative said, "My relative can't do much on their own anymore but staff encourage them to do what they

can and that's important."

People told us their privacy and dignity was respected, one person telling us, "Staff always treat me with dignity and check that I am happy with the support given." We observed that people being supported to the bathroom were treated in a discreet and dignified manner. People had their own bedrooms that were decorated with photographs and other personal belongings to make it feel more homely. Communal areas were also personalised. Artwork in the corridors had been chosen by people and based on their hobbies or histories. For example, staff told us that most people had grown up in London and so there were canvases of London buses and attractions for familiarisation. Staff were polite and knocked on people's doors to ask permission before entering. Confidential information was handled appropriately by staff and confidential records were locked away in the office. Staff had all received training regarding confidentiality and were knowledgeable of the home's policy on sharing information on a 'need to know' basis only.

Staff had received equality and diversity training and demonstrated a good knowledge of treating people fairly and as individuals. Their knowledge was assessed in a workbook where they then discussed practical examples for people living at the service. Before moving into the home, people were asked about their religious preferences and how the staff could support them to meet these. Staff respected all people and their preferences. For example, we saw one person holding a cuddly toy that staff told us was extremely important to them. Staff ensured they always had this with them and if it needed to be moved, gently explained why and asked the person's permission.

People were involved in making their own decisions and encouraged to express their views. We saw staff asking people how they were and how they would like to be supported. People were offered choices, such as what they wanted to do or drink. We saw that people took part in monthly meetings with the home manager, chef and activities co-ordinator where they could express preferences or concerns. The home manager told us that the message to people was always, "It's your meeting, you tell us what you want to talk about." Some people had asked for meetings separate from relatives and this was respected. People also received an annual survey that asked for their views on the service.

Requires Improvement

Is the service responsive?

Our findings

At their previous inspection, Sovereign Lodge were requiring improvement in responsive. This was because there was not consistent oversight of complaints and staff did not always engage with people on a regular basis. At this inspection, we found significant improvements had been made to the management of complaints. However, there were still some areas where staff were not as responsive as they could have been.

Similarly to our previous inspection, staff did not always engage with people regularly. Several SOFI's were completed across both inspection days, on all three floors, while people were having their lunch. On some floors, there was a bright and pleasant atmosphere and people were supported by cheerful and engaging staff. However, on others the lunch-time experience felt task focussed. For example, there were lots of staff available when food was being served, but once everyone had their meals, staff went to do other things. For two people, there was little or no contact from staff when they were being supported to eat. Another person appeared anxious and was shouting out but staff did not respond to them as they were serving lunch to other people. There was a further incident where a person was upset and calling out but staff did not respond until we asked them to support. They reassured the person and explained to us the person became distressed if they spilt food, but did not give an explanation as to why they didn't respond more quickly. The home manager had completed observations of the lunch-time experience and had already identified that this was an area for improvement. Staff had been spoken with as a team and on an individual basis and the home manager encouraged staff to sit and eat with people as they wanted to promote a social experience. The home manager and deputy manager had already started to plan ways they could improve staff practice in this area, such as workshops and training scenarios.

We found that for one person, changes to their health had not been responded to in a timely way. One person with diabetes was required to have their blood sugar levels tested twice a day. There was a diabetes protocol that stated if the person's levels were irregular, advice should be sought from the GP, however there was no further explanation of what 'irregular' meant. Since September 2018, the person's sugar levels had been much higher than what was usual for them on nine occasions, but there was no evidence to suggest that the GP had been consulted about this. Staff explained this was because the person was on end of life care and being closely monitored by nursing staff. When we fed this back to the home manager, they immediately organised for a GP review the following day. They also updated the person's care plan to reflect with more detail what normal sugar levels looked like to the person and what actions to take if they were above or below. Although the GP was not concerned for the person's safety or well-being, it is important that staff continually monitor, review and respond to changes in people's health.

People told us they thought the staff were responsive to them and that their opinions mattered. We were told, "Everyone is very approachable", "They always ask me whether I like it here and what could be done better" and, "They're very responsive to me, especially if I'm not feeling well." Relatives agreed, telling us, "I talk to the nurses and we review things. If there's any changes we talk about actions" and, "I find the nurses very impressive. They discussed everything with me when my relative moved in."

People took part in activities that encouraged social interaction and wellbeing and had complete choice and control over what they wanted to do each day. One person said, "There's entertainment every day – no day is wasted – I would absolutely recommend this place." There was a wide range of activities offered that included movie memories, pampering, singing, ukulele, visiting theatre groups and reminiscence sessions. People had been out on trips to cafes, garden centres, air shows and shops. The service had recently had a summer fete and harvest festival that people were still talking about and a Guy Fawkes celebration had been planned. There were photographs of people doing various activities throughout the home and it was clear they were really enjoyed. The service had maintained links with a local school and had facilitated trips there as well as the children coming to visit people at the home. We observed the activities co-ordinator doing chair and dance exercises with people and the atmosphere was lively and vibrant. People were smiling and laughing and visitors were also joining in. For people that chose not to participate in group activities, staff spent time 1-1 with them, doing alternative activities. For example, one person used to be a ballet dancer and staff spent time reminiscing with them about this and going through photos. Enjoyment of activities was consistently analysed and people's views and ideas listened to. For example, the home manager told us that people had shown an interest in participating in a singing competition and they were putting together a singing group for this. People also told us that birthdays were considered an important event. One person said, "Everyone sang to me, I got cake and presents. It was wonderful." The home manager had implemented a leaflet celebrating all the activities people had participated in since their arrival and this was displayed around the home.

From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Staff were knowledgeable of people's communication needs and were conscious of any aids needed to improve this. We saw staff supporting people to clean their glasses. When one person appeared to have trouble hearing, staff supported them to check their hearing aids were fully functional. Another person's communication plan stated they did not want a hearing aid and requested staff to speak loudly and clearly to them. We saw staff following this guidance when talking to the person. There was easy read and large font documentation available and the home manager also said they could access braille documents if required. There were pictorial signs around the building to support people with orientation. Activities and menus were also produced in word and picture format.

People's care needs were reviewed regularly by staff and management. One person per floor was allocated as the 'Resident of the day' which involved discussions by staff during each handover meeting. The person focussed on had their care plan and risk assessments reviewed and updated. They were visited by the chef, maintenance person, nurses and activities team to discuss their care needs and preferences. The maintenance person also checked their bedroom maintenance, including bed and mattress. The person's views of care provided were considered the most important aspect of this process and were fed back in meetings.

People and relatives told us that any issues they had were addressed immediately and this reassured them concerns were taken seriously. People said, "I speak with the manager and deputy and they always try to put things right" and, "I've met the manager and they were nice. I'd make any complaints to them if I needed to." Relatives told us, "The manager is extremely approachable" and, "They seem passionate about fixing things quickly and efficiently." There was a clear complaints policy and everyone we spoke to was confident of the procedure to follow if they had any concerns. The home manager had good oversight of complaints and an 'Open door' policy. There was evidence of the home manager meeting with people and relatives to discuss and resolve issues together, as well as feeding back concerns to staff to improve their practice.

Several people were receiving end of life care at the time of inspection. We spoke to relatives of these people and they were assured that their loved ones were being treated with dignity and respect. One relative said, "Staff really know how to care for my relative and are concerned that they are comfortable and cared for." Another relative told us, "At times my relative can be hard to manage and swears at staff but they are very skilful. Staff deal with my relative's frustration by calming them down and when they refuse to let staff touch them, they let them be and try again later. They also provided a new chair so my relative can get out of bed." For people that had Do Not Attempt Resuscitation (DNAR) forms, these were reviewed regularly by the GP, people and their families. End of life plans stated whether people had 'just in case' medicines prescribed and that these would always need to be reviewed with the GP before being given. In some people's end of life plans, there was also information about their burial and funeral preferences. On each floor, there were orders of service from people's funerals displayed on a notice board. The deputy manager told us this was so people and staff could always remember them.

Requires Improvement

Is the service well-led?

Our findings

At their previous inspection, Sovereign Lodge were requiring improvement in well-led. This was because there was not consistent oversight of documentation which meant information about people was not always up to date with their current needs. Care plans were handwritten making them difficult to read and analysis of themes and trends for accidents and incidents had not been considered. At this inspection, we found improvements were still required to ensure documentation met required standards.

There were quality audit processes in place. This included monthly audits of people's care needs, accidents, incidents, falls, complaints, themes and analysis, completed by the home manager and deputy manager. There were additional audits completed by the operations manager and an independent consultant. However, we identified a number of recording errors within care documentation, which had not been identified by the management team. This suggests that some improvements were required for the audit process to be efficient.

There had been little improvement to the presentation of care documentation. They were still handwritten and at times very difficult to read. The home manager was keen to make documents electronic however there were only two computers in the building which would make it difficult for staff to make relevant changes. The operations manager told us this was something the company were aware of and were obtaining quotes for more computers.

Not all documentation was reflective of people or specific to their support needs. For example, one person who had difficulties swallowing, did not have an assessment that specified what the difficulty was, what consistency their food should be and how staff should support them. Another person could display behaviours that challenged. They did not have any assessments to describe what the behaviours were, any potential signs or triggers and what staff should do to reassure them. People had emergency evacuation plans to keep them safe, however they lacked person centred information such as how they may react in an emergency, their understanding of evacuations or how staff should support with anxiety. We viewed other assessments for areas such as oral hygiene or personal care that stated, "Requires assistance" but did not specify what this was or what the person could do independently. An assessment for a person requiring support with wound care, stated a piece of equipment should be on the correct setting but did not specify what this was, or reflect any changes when the person lost weight. Another person had been referred to a dietician but this referral and actions already being taken by staff, had not been recorded. We also found some records had not been completed thoroughly or to a consistent standard, for example when recording 'as required' medicines, such as creams or patches. Overall, documentation did not contain person centred information such as people's preferences, what they could do independently and what they specifically needed support with. Through observations and discussions with staff, it was clear that they knew people and their support needs very well. Therefore, we considered the impact on people to be low. However, it is important that documentation is up to date and reflective of people's needs so that any new or unfamiliar staff would have all the information required to meet people's needs.

We discussed the care plan audit tool with the home manager and operations manager. This tool focussed

largely on whether documents were present, rather than looking at the quality of information. It was agreed that some improvements could be made to ensure quality and consistency throughout people's documentation. The home manager had also planned to do workshops with senior staff and nurses to ensure they were confident with how to complete documentation.

The provider had not ensured good governance had been maintained and records were not up to date and accurate. These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the home manager had only been at the service for eight weeks, people, relative's and staff already felt they had made, "A huge difference" to the culture of the home. We observed the home manager to be cheerful and engaging with people. They knew people and their preferences or interests. People told us, "I know who they are, they come and speak to me all the time", "They are very approachable and will discuss any issue at any time" and, "They are very nice, friendly and jolly – I like that." Relatives described the home manager as, "Dynamic", "Straight talking, honest and open" and, "They seem to find time to talk to everyone." One relative said, "Before this, management seemed quite remote. Now everything is addressed openly and done with lots of laughter. It's nice." Another said, "The manager listens, takes a step back and views each situation. They delegate tasks appropriately and use issues as learning curves for staff. It's really refreshing."

Staff were equally positive about the home manager. Comments included, "The manager prioritises people but is also there for staff", "They are a breath of fresh air to this place", "They listen and appreciate ideas" and, "When I first met the manager, I thought 'Wow'." Staff felt that good practice was recognised and rewarded and this made them feel valued. We saw an article in the previous week's newspaper where the home manager had organised an awards ceremony and lunch for staff to recognise years of service. The home manager told us they felt well supported by the regional director, operations manager and others within the organisation. They said, ""I get the support I need and they are quick to respond." "Quality care is what I love, and they seem to be quality first. The chief executive is also very approachable." The home manager received regular supervision and provider visits by the operations manager, who told us, "If we saw on the monthly statistics that something seemed out of ordinary, I would come in to do a support visit. It provided a fresh pair of eyes and new ideas."

Staff told us that since the new manager had started, there had been a lot of emphasis on communication and working together as a team. There were regular staff meetings and minutes showed staff could discuss anything they wanted. Recent topics had included discussions on people's health needs and care plans. Staff had also raised concerns about staffing levels at night and the home manager listened and took action to address this. Every morning there was a 'Stand up' meeting that involved all heads of department, the home manager, deputy manager, maintenance person, activities co-ordinator, chef and a nurse from each floor. We joined one of these meetings and it included information on occupancy, admissions, discharges, staffing issues, concerns or complaints, maintenance issues and safeguarding concerns. The 'Resident of the day' was also discussed for each floor.

The provider sought people, relatives and staff views in annual questionnaires. Records showed that feedback had been analysed, issues addressed and findings fed back to those involved. Relative's told us, "They always ask me to fill survey's in and I'm happy to do it", "They seem to want to know what our experiences are" and, "I also attend the relative's meetings and brunches which I enjoy and appreciate." Relatives felt these social meetings gave them opportunities to meet other relatives, build relationships with staff and discuss any concerns. We viewed minutes for the breakfast buffet meetings and there was an emphasis on gaining relatives feedback on what was done well and what could be improved.

We saw numerous thank you cards from people and relatives. Compliments included, "I have nothing but praise for the care my mother is receiving. Every staff member I have met is cheerful, welcoming and responsive" and, "All the staff are lovely and extremely helpful – nothing is ever too much trouble."

The home manager was passionate about improving care for people and had already planned new projects for renovation of the lounges and peoples bedrooms. They had also designed a new training programme, that included more in-depth and higher-level qualifications in dementia for all staff. The home manager had also started building relationships with professionals from the local authority. They had recently met with the Placement Team to discuss peoples support needs and how staff training at Sovereign Lodge could be improved to accommodate this. An example of this was for a person requiring a specific health procedure. The home manager had sought out a specialist trainer to work with nurses to that they would be able to accept referrals for people with those needs.

During inspection we found the home manager, deputy manager and operations manager to be very responsive to concerns we identified. By the second day of inspection, improvements had already been made to people's documentation. There was a clear action plan which had already identified some of the issues found on inspection. Each concern had realistic time frames and a named individual responsible for specific actions. This immediate address of concerns demonstrated the management team's willingness to improve.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance had been maintained. Appropriate systems and processes were not in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1) (2a) (2b) (2c)