Blackheath Care Ltd

Leah Lodge Care Home

Inspection report

Leah Lodge
Blessington Road
London
SE13 5EB

Tel: 02083182272

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20 December 2017

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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

This inspection took place on 19 and 20 December 2017 and was unannounced.

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

Leah Lodge Care Home is registered to provide care to up to 48 older people, some of whom were living with dementia. 18 people were using the service at the time of our inspection and two were in hospital.

The service has recently been refurbished. Bedrooms are located over three floors and are single occupancy with en-suite facilities. The ground floor is occupied by people who are elderly and the second floor with those living with dementia. The bedrooms on the first floor were not occupied at the time of our inspection. The provider was in the process of making new admissions to the home. There are several communal areas, a café, and hair salon and spa baths for people to use. There is a dining area and sitting room located on each floor and quiet areas where people can sit with their families or alone if they wish to do so. The building and accommodation are wheelchair accessible and there is a passenger lift. The service has three small gardens and the environment appeared well maintained, bright and welcoming.

The service had a registered manager who was also a general manager of the home. 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.

People who had complex needs were at risk of receiving care and treatment that was not responsive to their needs. Staff did not have sufficient knowledge and skills required to provide care to people at the end of their lives and those enduring a decline in their health because of dementia.

People were supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and the restrictions placed on them by a supervisory body under the Deprivation of Liberty Safeguards (DoLS). Staff understood their responsibility to obtain people's consent before providing care. However, records did not always show when consent had been given and where best interests decisions had been made. People who were unable to make decisions about their care were supported by their relatives where appropriate and health and social care professionals.

Staff maintained records of the care they provided to people. However, information about people's daily lives did not always provide sufficient detail of the impact of the care and support being provided.

Appropriate quality assurance checks and audit systems were in place. However, had not been effective in

identifying and resolving the shortfalls we identified about care provision at the service.

People were supported by staff who underwent regular supervision and a review of their practice. Staff had attended the provider's mandatory training to enable them to undertake their roles.

People's needs were met in a safe and timely manner because risks to their health and well-being were identified and managed. People received the support they required to take their medicines.

A sufficient number of suitably skilled staff were deployed at the service. New staff underwent appropriate recruitment checks before they started to provide care and support.

People were protected from the risk of harm because staff knew how to identify and report potential abuse. Staff minimised the spread of infection by following good hygiene practices. Incidents and accidents were monitored at the service to help staff in learning from mistakes.

People's nutrition and hydration needs were met. People had meal choices that took into account their preferences, cultural and dietary needs. People had access to healthcare services when needed.

Staff delivered people's care in a dignified and compassionate manner. People were treated with respect and had their privacy, dignity and confidentiality maintained.

People were involved in planning their care and support. Care plans reflected the support each person required and their wishes and preferences about service provision. People enjoyed taking part in a wide range of activities provided at the service.

People had opportunities to share their views about the service and felt that the registered manager listened to them. People using the service and their relatives knew how make a complaint. Complaints were investigated and resolved in line with the provider's procedures.

People using the service, their relatives and staff commended the registered manager and about the manner in which they managed the service. Staff understood their responsibilities and were clear about the reporting structures at the service to help provide effective care to people using the service.

People benefitted from the close working partnership between the registered manager and external agencies.

We found one breach of regulation in relation to person centred care and meeting complex needs. You can see what action we have 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. Staff followed appropriate safeguarding procedures to identify and report abuse.

Staff had sufficient guidance to manage the identified risks to people's health and well-being.

People's needs were met by a sufficient number of staff deployed at the service.

Medicines were managed and administered safely by competent staff.

Staff applied good prevention and infection control methods when delivering people's care.

Staff learnt from incidents and accidents.

Is the service effective?

Good

The service was effective. Staff received training and supervision to develop their skills and knowledge.

People's needs were identified and care plans reflected their choices.

People's care met the requirements of the Mental Capacity (MCA) Act 2005 and Deprivation of Liberty Safeguard (DoLS).

People were supported to maintain a healthy diet and to access healthcare services when needed.

Is the service caring?

Good

The service was caring. People were supported by staff who were kind and caring. Staff showed empathy in their relationships with people and gave them emotional support when needed.

Staff knew how people communicated their needs and encouraged them to make decisions about their care.

Staff delivered people's care in a respectful manner and upheld

their privacy and dignity. People were encouraged to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. People with complex health conditions were at risk of receiving care that did not respond to their changing needs. Staff did not have sufficient knowledge about end of life care.

People enjoyed taking part in a variety of activities provided at the service.

People using the service and their relatives knew how to make a complaint. Complaints were investigated and resolved.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led. People's care was monitored and audited. However, the checks were not effective in identifying and addressing the shortfalls we identified. People's records did not always fully reflect the care they received.

Staff understood the provider's vision to deliver person centred care.

People using the service, their relatives and staff commended the registered manager and their management of the home.

People using the service, the public and staff were encouraged to share their views about the home and the provider acted on the feedback received.

The registered manager worked closely with external organisations to ensure people received high standards of care.

Leah Lodge Care 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 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.

This is the first comprehensive inspection of the service since registration with the Care Quality Commission on 3 December 2016.

The inspection was carried out on 19 and 20 December 2017 by three inspectors and two experts by experience on the first day and one inspector who returned on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information we held about the service including notifications. Statutory notifications include information about important events, which the provider is required to send us by law. We reviewed the Provider Information Return (PIR) form sent to us. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan the inspection.

During our inspection, we spoke with 15 people using the service and six of their relatives and one visiting healthcare professional. We also spoke with seven members of care staff, a student on work placement, one laundry assistant, an administrator, home admissions advisor, head chef, head of housekeeping, head of activities, maintenance manager, deputy manager, operational support manager, sales and marketing support manager and the registered manager.

We undertook general observations and formal observations of how staff treated and supported people throughout the service. 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 looked at 10 people's care records, their risk assessments and 12 medicine administration records. We reviewed information about the management of the service including safeguarding reports, incident

records, complaints and policies and procedures.

We looked at 15 staff files that included recruitment, training and supervisions and medicine competency assessments. We reviewed feedback the service had received from people using the service and their families.

After the inspection, we received feedback from five health and social care professionals.

Good

Is the service safe?

Our findings

People were happy with the service they received. Comments from people using the service and their relatives included, "I am very happy to be here and I feel safe", "I haven't experienced any form of discrimination", "Yes I feel safe, because the staff look after us well", "I am happy with the care my relative receives and know they are safe" and "My relative is safe and well looked after here."

People's care was delivered by staff who knew how to minimise the risk of abuse. Staff had received training about how to identify and report concerns about people's safety and well-being. Staff understood the safeguarding procedures and knew they could escalate concerns to the registered manager and external authorities to help protect people from abuse. Staff told us safeguarding issues were discussed in supervision and records confirmed this. The local authority safeguarding team were informed of concerns about people's well-being to ensure investigations took place and appropriate plans put in place to keep them safe.

People received the support they required to protect them from avoidable harm. Risk assessments were carried out on people's needs including their physical and mental health, nutrition and hydration, skin integrity, falls, communication, medicines management and mobility. Health and social care professionals were involved when needed to identify and manage risks to people's health and well-being. Support plans contained adequate information for staff about how to deliver care to people in a safe manner and without unlawfully restricting their freedom. Staff knew the risks to the people they supported and records confirmed they supported them in a safe manner. Staff received updates on risks posed to people's health and well-being for example, when a person's mobility had declined. Records confirmed regular reviews and updates of risk assessments to ensure people received safe care.

People were protected from the likelihood of an emergency at the service. Personal emergency evacuation plans showed the support each person required to evacuate the building in the event of an incident. Staff attended regular fire drills and understood the action they were required to take to support people to evacuate the building safely. Staff told us and records confirmed they had an unannounced fire drill every month at different times of the day to determine their preparedness to support people in the event of an emergency. Regular checks were carried out on the premises and equipment. This included safety checks on fire exits, door guards, emergency lighting, extinguishers, evacuation equipment and fire alarms. Records of these checks and audits of the last six months showed there were no concerns. Appropriate contingency plans were in place to manage situations such as adverse weather, loss of utilities and high levels of unplanned staff absences. We observed emergency exits were free of hazards, well-lit and marked clearly.

People received care from staff who were suitable for their roles. Applicants underwent an appropriate recruitment procedure before they were employed at the service. New staff completed application forms and attended interviews for any vacant posts. The provider had obtained satisfactory references and criminal record checks, employment history and explanation of any gaps, photographic identity and the right to work in the UK before they confirmed new staff in post.

People's needs were met by a sufficient number of staff. Comments included, "They keep an eye on you" and "There is always someone around to help." However, one relative commented they had observed people were sometimes left in the lounge for long periods without any member of staff available. They had discussed this issue with the registered manager and said there was an improvement. Staffing levels were determined through an assessment of people's needs and recommendations made by health and social care professionals. Staff were happy with the staffing levels and said they managed to provide safe care in an unhurried manner. Staffing levels were adjusted to enable people to attend medical and health appointments and to take part in activities of their choice. Duty rosters were covered by regular staff. Staff told us they were able to attend training and take annual leave.

People received their prescribed medicines when needed. Staff had completed medicines management training and had their competency assessed to ensure their practice was safe. Staff had access to an up to date medicines management procedure and national guidance to refer to when needed.

Medicines were safely managed and securely stored in appropriate conditions. Staff knew the medicines people were prescribed and their side effects. Medicines administration records (MARs) contained sufficient details for identification and to minimise the risk of medicine errors. Staff followed the protocols on managing 'as required' (PRN) medicines. The GP reviewed people's medicines to ensure they were appropriate for each person's needs. Staff sought advice from the pharmacist when needed.Staff carried out weekly medicine checks and an external pharmacist carried out monthly audits. These ensured errors were identified and rectified in a timely manner. The registered manager reviewed the audits and ensured staff followed medicines management procedures. We asked the registered manager about the three medicine errors that had occurred in the past year. They told us and records confirmed the issues had been investigated, followed up with staff and that the GP and pharmacist were informed and the cases were now closed.

Staff told us the registered manager encouraged them to take responsibility for their work. The registered manager ensured staff learnt lessons from their mistakes and reflected on their practice to minimise the risk of a recurrence. The medicines issues were discussed in team meetings and one to one supervisions and improvements made when necessary.

People were protected from the risk of infection. One member of staff told us, "We practice good hand washing techniques to prevent spread of germs." Staff were trained in prevention and control of infection and understood their responsibilities to follow the procedures when delivering personal care, handling food and disposal of waste. Staff told us they had access to personal protective equipment (PPEs) such as disposable gloves and aprons. We observed staff use PPEs appropriately. The premises were clean and cleaning schedules were completed and audited regularly.

Good

Is the service effective?

Our findings

People received care from staff who received training for their roles. One relative told us, "[Family member] enjoys living here and has confidence in the staff." Staff told us and records confirmed they had good opportunities for training and gave examples of courses they had attended which included moving and handling, dementia, safeguarding adults, privacy and dignity, fire safety, nutrition and hydration, infection control, health and safety, Mental Capacity Act 2005 (MCA) and medicines management.

People's needs were assessed before they moved into the service. This helped to ensure the service and staff were suitably equipped to meet each person's needs in line with legislation and best practice guidance. Pre-admission assessment showed people's past and current medical history, current medicines, any known allergies, communication, moving and handling, personal hygiene, mobility, continence, eating and drinking and history. Staff contacted healthcare professionals involved in people's care to ensure that no information was missed. Each person's care plan included a 'hospital pack', which provided summary information about their physical, mental and social needs which was used when they went to hospital. Care records showed the support people required and daily observation reports showed that staff supported people as they required.

People's care delivery was provided by staff who had their practice monitored. One member of staff told us, "We have one to one meetings with our seniors to discuss our work." Another member of staff said, "It's important to know how one is doing in their work." Staff told us and records confirmed they had regular supervision. Staff records showed discussions were about safeguarding, health and safety, personal development, feedback from people using the service and complaints management. None of the staff had received an appraisal because they had been in post for less than 12 months. The registered manager told us appraisals were planned for the first quarter of 2018.

People were supported by staff who knew how to undertake their roles. One person told us, "They are good at what they do." New staff told us they received an induction to familiarise themselves with the people using the service, their care and support plans, policies and procedures and the environment. Staff were happy about the induction and their comments included, "It made for a great start", "I was introduced to the things I needed to know" and "My confidence to support people grew because of the induction." Staff told us and records confirmed they completed their induction that included the provider's mandatory training before they started to provide care on their own. Staff new to care completed a Care Certificate, which highlighted the standards expected of health and social care work personnel. New staff had a mentor who supported and worked alongside them to ensure they developed the skills required to support people independently. The registered manager monitored staff performance during their induction and confirmed them in post when they assessed their practice as acceptable.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff had received training related to the MCA and understood how to support people in line with its legal requirements.

People were asked for their consent before they received support. One person told us, "They do ask before they help me." Another person said, "They respect what I say on how I want things done." One relative said, "Staff do listen to what [family member] says." Staff understood their responsibilities to ensure that they offered and respected people's right to make choices and decisions about their care and support. Records showed staff sought people's consent and that they reported to the registered manager any constant decline for support. This ensured health and social care professionals were involved to support the person to receive appropriate care. Staff told us and records confirmed best interests meetings were held when a person was unable to make decisions about their care. However, care plans did not always reflect details of best interests discussions to ensure that these were promoted where people lacked capacity. In addition, where people had capacity and were living in the secure second floor we did not see the signed agreements of informed consent to some of the restrictions, such as not knowing the door code to leave the floor or having regular night time checks from staff. The registered manager told us they would ensure staff maintained records of decisions made about people's care.

People received care in line with DOLS authorisations. Staff knew which people were subject to a DoLS authorisation and the support they required. The registered manager understood and followed the correct procedures to apply to the local authority for authorisation when they assessed that a person was unable to make decisions about their care. The registered manager maintained a record of people subject to DoLS, although the list had not been updated to show the latest approval made by the local authority.

People received the support they required to eat, drink and maintain a healthy and balanced diet. One person told us, "The food is lovely and there is plenty of choice." Another person said, "The food is very good, we have meetings about our meals, we are given choices and quite a lot of food is served on our plates." One relative commented, "The staff check what [family member] is eating and they have put on weight and settled in well." People were involved in menu planning and staff took into account their wishes and preferences of what they liked included on their meals. People told us they were happy they received fresh food including bread that was prepared at the service. We observed people had access to drinks, snacks and fruit.

People's dietary needs were met. Staff sought advice from healthcare professionals when they had concerns about a person's eating and/or swallowing pattern to enable people to receive appropriate care. People at risk of malnutrition were weighed regularly and a referral made when necessary to healthcare professionals. Staff encouraged and supported people whose weight was declining to eat sufficient food to maintain a healthy weight. The head chef maintained a nutritional needs chart for each person and ensured they served meals in line with identified needs such as special diets, fortified drinks, small portion sizes, preferences and special requests for example cheese platters. People told us the head chef visited them at lunchtime to observe the food service and spoke to them about the meals served, recorded their comments and made changes when needed. We observed staff supporting people at lunchtime and supporting them in a dignified manner. The atmosphere was pleasant and we saw that staff maintained eye level with people who were seated which made communicating with them easier.

People received the support they required to access healthcare services when needed. One person told us,

"They do send you to the doctor if you ask." Another person said, "If am not feeling too well they get the nurse to investigate." One relative said, "Staff took the lead in involving the GP." Healthcare professionals commented staff involved them in a timely manner and followed their guidance to manage a decline in people's health. The service was supported by a local GP practice and had weekly visits from them. People were supported to attend hospitals for outpatient appointments and specialist treatment. Care records contained information about the support each person required to maintain their health, attending appointments and follow up visits to healthcare professionals. Records confirmed timely referrals and visits by healthcare professionals that included the GP, psychiatrists, hospice and palliative care nurses, speech and language therapists and community nurses.

Good

Is the service caring?

Our findings

People using the service and their relatives were happy in the manner staff delivered care. They told us staff were kind and compassionate. Comments included, "The staff are lovely", "I enjoy living here", The staff are very caring and nothing is too much trouble" and "The staff are very helpful and thoughtful." Compliments had been received by the registered manager from relatives which commended staff for the care they provided.

People were supported by staff who knew them well. One person told us, "They are good. If I don't want to come out of my room they try to know why." Another person said, "I am a good eater. If I won't eat they look into it." One relative said, "When my relative was admitted staff made them feel welcome and made an effort to get to know them and the things that mattered to them." Staff showed they understood people's routines and preferences. They told us they obtained more information about people through interactions with them and their relatives. Records confirmed staff supported people as they wished and respected their routines such as whether to have a shower or a bath and where to sit in the lounge. Each person had a list of clothes and belongings they had brought with them into the home. Their inventory was supplemented by photographs of the items such as their watch, pictures, and glasses to help staff identify them if they were mislaid. Clothing was labelled, including a button of a specific type for each person so that clothes would not be mixed up or lost.

People were involved in making decisions about their care. One person told us, "They do ask what I want to do each day." One relative told us, "My sister and I were involved in the care plan; and we always are involved." Staff told us and records confirmed they held regular review meetings with people using the service, their relatives where appropriate, and health and social care professionals to understand how they wanted their care delivered. Care records reflected how people wanted to spend their time at the service, what activities interested them, where and when they liked to have their meals and their preferences in relation to the care and support they received. Daily observation records showed people received care and support in the manner they preferred. A key worker system had been introduced to enable an assigned member of staff to be a link between a person, their family and health and social care professionals involved in their care. We could not assess the impact of the key working system because it was new.

People's care was delivered in a way that respected their privacy and dignity. Comments included, "The door is shut when they are attending to me in my bedroom; and speaking to me is done privately from others", "Staff do knock at my door and tell me what they are about to do or what they want, or what service they are going to do" and "I don't want them [family] to know and the staff don't tell them." Staff told us they treated people as individuals by asking them how they wanted their care delivered. People told us staff explained and involved them when providing their care. Staff told us they knocked on people's bedroom and bathroom doors before entering and closed curtains and doors before providing personal care. Staff were respectful when talking with people and when referring to their health conditions.

People's records were kept confidentially and securely at the service. Staff told us they shared people's information with third parties if a person consented when able to do so and on a need to know basis or

when authorised by the registered manager. The service used an electronic records system that included details of each person's pre-admission assessment, life history, care plan, risk assessments, activities information and specific information such as do not resuscitate decisions. Staff had different levels of access to the system via hand held devices and laptops, which made it secure.

People were supported to maintain relationships with friends and family. One person told us, "The manager never restrict our loved ones time to visit. Relatives and friends do come any time." One relative told us, "I visit at different times of the day, several days each week and the staff are always welcoming." Staff knew the relationships people wanted and the support they required to maintain contact. People told us staff invited their relatives to events at the home. They said staff supported them to spend time with family and friends on social visits. One person told us and the registered manager confirmed their family of 11 people was booked to have Christmas lunch with them at the service. People and their families used a café on the ground floor to socialise and used beverage making facilities available to prepare refreshments. Cake and fruit was available for people and their relatives. People told us staff contacted their family if they wanted to see them. Staff reassured people if they were in distress and/or encouraged them to speak with their relatives on the telephone if that is what they wanted.

We observed people enjoying spending time with their relatives and friends. They attended a Christmas tea dance where mulled wine and mince pies were served. People told us they enjoyed spending time with each other and had developed friendships at the service. Staff encouraged people to socialise with each other to minimise the risk of social isolation. We saw photographs of people engaged in activities and enjoying their colleague's company.

Requires Improvement

Is the service responsive?

Our findings

People with complex health conditions were at risk of receiving care that was not responsive to their needs. Three health and social care professionals commented that they had concerns about the staff's ability to deliver care that met the needs of people with complex needs. They were uncertain about staff's competence "to manage some of the more complex nursing based patients, including end of life care." In addition, one healthcare professional commented, "Staff did not understand other ways of providing holistic care to people which left them with an over reliance of use of medicines to manage some behaviours." We saw three records with limited indication in care plans that staff initiated discussions with people and their families about the residents' preferences in relation to their end of life care during the pre-admission assessment. After the inspection, the provider sent us copies of end of life care plans that were not made available during the inspection as they had not yet been included in people's care records.

People's daily records showed staff did not always understand the needs of people with complex needs. For example, when a person was nearing the end of their life, staff continued to offer services such as a cup of tea and/or meals, when this was inappropriate. One healthcare professional commended staff for being "keen to learn the concepts of palliative care." While staff told us they benefitted from the involvement of the hospice and palliative care teams, people's daily observation records indicated a lack of full understanding of the management of the needs of people with complex health needs.

We received negative feedback from healthcare professionals about dementia care at the home. Three healthcare professionals commented on this, one said, "Staff's knowledge and confidence of dementia care (particularly in managing behavioural and psychological symptoms) is not as high a level as it might be. This sometimes manifests in managerial staff being unable to contain their anxiety and being unable to work effectively on a solution-focussed care plan to support the staff delivering care." Other comments included, "Their knowledge of the link between behavioural and psychological symptoms in dementia and unmet needs could improve at times. When behaviour of a resident is very distressed there may be a tendency for senior staff to move towards a more medical model of care and treatment, for example asking for medication to be increased, rather than developing the psychosocial care plan with care staff." Staff were viewed as competent in managing, "particularly in less "acute" situations" and were able to provide care "in a more holistic way." Some of the actions staff took when managing a person's condition showed they did not have a full understanding of the behaviours of people living with dementia.

Staff had differing levels of understanding of what constituted end of life care. One member of staff told us, "We know how to make people comfortable, but it would be helpful to have some training on how to support the dying." Another member of staff said, "I know how to make a person comfortable. However, the seniors are there to help us manage difficult situations." Some care assistants were not able to demonstrate sound knowledge about end of life care and told us they relied on senior staff for guidance about this. This raised a potential risk of people not receiving effective care when they needed it. Some staff told us they had received specialist training in end of life care although this was not reflected in their personnel records. We raised this issue with the registered manager who told us that due to staff turnover and an ongoing recruitment programme, not all staff had received end of life care training.

Some people and their families were involved in the discussion of their end of life care. We talked to the deputy manager who highlighted the action they had taken to support one a particular person with end of life care. However, records were not complete to reflect the discussions held with the families about the person's end of life care. We saw three records with limited indication in care plans that staff initiated discussions with people and their families about the residents' preferences in relation to their end of life care. We asked the registered manager about this, who explained that some discussions were held although staff had not always recorded the conversations.

Two people initially assessed as able to live at the service had moved out. One person told us, "My sleep was being continuously disturbed by another resident." The person had then been moved to a different floor for people with complex needs. One health and care social care professional had commented that it appeared there was an oversight by the management in "that there are limitations to the home's expertise and sometimes people may need to be placed elsewhere if their needs become more complex." Another healthcare professional commented that "managers did not appear to have fully reflected whether they could manage the complex needs of people." However, one healthcare professional said they had meetings with staff after a person's passing to reflect on their practice. In spite of this we did not see evidence of where staff had reflected as a team on what they could have done better after a person had passed away, even though there was a safeguarding concern about their interventions. We received information about the outcome of the safeguarding investigation after our inspection which showed that the allegation was unsubstantiated.

The above issues raised concerns about staff's knowledge and skills about how to provide care that was suitable to meet the complex needs of people living with dementia and those who were at the end of their lives. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to be independent as far as possible. One person told us, "I do the things I enjoying doing. I style my hair and dress myself. I let staff do the rest." Another person said, "I help lay the tables." One member of staff told us, "We try and support people to retain the skills they have and do what they can for themselves." Staff told us and records confirmed they encouraged people to do for themselves the tasks they were assessed as capable of doing such as personal care and getting dressed.

People enjoyed taking part in activities. Comments included, "There is plenty to do and the staff always ask if I want to join in", "Art is my life and main occupation. I have enough to do in this area" and "They keep us entertained, dividing their attention between us." Relatives comments included, "There are lots of activities which [family member] enjoys", "They have activities like an afternoon tea dance regularly" and "My mother has blossomed in this environment and shown renewed interest in things she had stopped doing while at home." People told us they enjoyed playing skittles or indoor bowls at the service. People were supported to carry on with their hobbies such as attending piano lessons and pilates in the community. We observed people enjoying a piano and singing session that was conducted by a member of staff.

People had access to a weekly timetable including weekends about activities and forthcoming events which was displayed at the service. People told us and records confirmed activities they took part in included painting, arts and crafts, scrabble, cooking, flower arranging, film watching, sing- a-longs, visits to the cinema, a pampering morning and balloon volleyball. People told us they enjoyed visits and chatting to children from a local school that visited the home on a regular basis. Staff told us they carried out "Oomph" activities every week and that these supported an all-round approach to the wellbeing of people through the use of reminiscent music and simple routines to deliver physical and mental health benefits. People used the provider's electric car for trips to the cinema, shops and going out for meals.

People benefitted from a falls prevention exercise through creative activities. One person was at risk of falling because they did not always use their Zimmer frame. They explained to staff that they sometimes found it difficult to identify their walking frame which led to inconsistent use and a high number of falls. They suggested that if their walking frame was different from other people's it would help them identify theirs easily. This resulted in an initiative, "pimp my Zimmer" where people were encouraged to decorate their walking frames with items of their liking. We saw Zimmer frames that were decorated, highly visible and some people had chosen to have their name on the front. Staff told us it was easier to observe when a person did not have their walking frame and get it for them. The registered manager told us and records confirmed that the number of falls of people who were using walking frames had reduced since this initiative. Staff told us people living with dementia enjoyed a "fiddle my cushion". The cushions had designs which were colourful and tactile. We were told this made it relaxing for people living with dementia who enjoyed holding them, and appeared to reduce their anxiety.

People using the service and their relatives knew how to make a complaint. One person told us, "I would talk to the staff or the manager." Another person said, "Things are sorted out." They were confident that the registered manager would listen to them and address any concerns they had. People confirmed they had received a complaints procedure when they started to use the service and that this was explained to them. They understood how to escalate their concerns to external agencies if they remained unresolved. The registered manager sent out a letter to acknowledge having received a complaint detailing how they intended to resolve the issue. The registered manager maintained a record of complaints received. Records showed the registered manager and provider responded to complaints appropriately and ensured staff were aware of areas of their practice they needed to improve.

People using the service and their relatives had opportunities to share their views about the service. Comments included, "We meet up with the manager when we can and say what we want" and "We are able to talk about any issues." People told us and records confirmed their feedback was acted on. One person had commented in correspondence to the registered manager, 'Thank you in regard to lighting at the top of the staircase, now brighter, made a big difference.' The evening meal had been moved an hour later in response to their wishes. A poetry club and knitting group had been set up from suggestions made in discussions with people. A wine tasting and sausage tasting had been organised, the latter after one person had raised concerns about the quality of sausages served at the home to identify what people would prefer. A Cornish pasty supplier was changed because people found their pastries hard and difficult to chew.

There were plans to adapt the environment to meet the needs of people living with dementia. The home had some dementia-friendly elements. The lift buttons were large for ease of use. People's names were on their doors. Some of the bedroom doors had individualised signage which included large lettering and pictures or photographs to help people with memory loss find their rooms. Memory boxes were located outside some bedrooms and staff told us that these had been put together with the assistance of families where possible. However, there were no signage for bathrooms, and little use of colour to help navigation round the home. A senior manager told us there were plans to develop the environment to make it more dementia friendly. The courtyard garden had a non-slip, impact-absorbing surface to reduce the risk of falls. The other gardens were brick paved with paths wide enough for wheelchairs. There were some raised beds for people to use to grow plants.

Requires Improvement

Is the service well-led?

Our findings

People's records did not fully reflect the care and support they received. Staff used an electronic system to record the care they provided to people through an app on a mobile phone or tablet. Some of the records were paper based. Managers told us the electronic recording of information saved time because it left staff with more time to care for people. One healthcare professional commented they had observed that some members of staff found it difficult to navigate the system and to locate information about people. Another healthcare professional commented, "As it is a new service it has taken a while for systems to develop, but we don't have any significant concerns on how the service is managed." We noted two support plans were not on the system. We asked the registered manager who explained staff were new to the system and going through a learning curve. Minutes from a senior care team meeting showed the registered manager and staff had discussed the electronic recording system and the need to support each member of staff "through the learning process."

The registered manager monitored staff training and professional development needs to ensure they provided the support to make them effective in their roles. However, the audits had not identified the concerns raised about staff's competence in managing conditions of people with complex needs. This may have put people at risk of receiving inappropriate or unsafe care.

We looked at records that staff maintained about the care they delivered to people. Staff had the option to use the drop down menu to select the service a person had received or to describe in their own words what they had observed. It was not always clear what follow up action staff had taken in response to changes in people's moods and behaviour. For example, one person's records showed they were 'unhappy' over a period. Without any explanation about the reason for them being unhappy, we were unable to tell what action staff had taken to ensure the person's needs were met. This could result in staff not identifying people's needs in a timely manner. The drop down lists that staff completed, for example in relation to activities resulted in formulaic records and did not create a sense of personalised observations, for example a comment about someone watching TV alone in their room as having 'a mental benefit', or visits from relatives as having an 'emotional benefit'. While such benefits may be the desired outcome, the lack of explanation on some of the automatic recording did not provide full information about the care people received.

People using the service and their relatives commended the registered manager and the manner in which they managed the service. Comments included, "The manager is good", "It's a well-managed service" and "Staff make every effort to provide a good quality service for people." People and staff described the registered manager as being passionate about delivering high standards of care. They said she was "approachable" "enthusiastic" and "highly visible" at the service. Staff told us there was an open and transparent culture about care provision at the service. One member of staff told us, "Leah Lodge is a home from home for people; and the residents are our priority. We talk openly about what's working and what we could do better." Staff understood the provider's vision to be "determined to be the difference" by providing person centred care. Staff showed an eagerness to learn and improve their practice.

Staff were aware of their roles and responsibilities. Staff had job descriptions and understood the management structure and the support available to them. Staff told us they were well supported by the management team which included the registered manager, a deputy manager and senior care assistants. They said they received guidance on how to support people and had regular updates about changes to people's health and well-being. Comments included "There is good team spirit here" and "Communication is excellent." The registered manager held daily, "Take 10" meetings which were attended by a member of staff from each department to share information about people's needs and planning of their care provision.

Staff said they were supported in their roles. One member of staff told us, "I enjoy working here and feel well supported." Another member of staff said, "The manager listens and is very helpful." Staff attended regular team meetings. They told us they received updates on areas that included staffing, training, activities programme, people who may be at risk and hospital admission and discharges. Staff had the opportunity to celebrate achievements at the service and reflect on training attended. Minutes of staff meetings showed areas where staff had to develop their practice for example, the need to improve the quality of incident reporting, avoiding laundry mix-ups and the detail of information shared at handovers to cover each person. Staff told us there was a senior member of staff available to provide guidance when faced with a difficult situation or for guidance. Staff said teamwork was good and that there were effective handovers at the start of each shift to share information about people.

People's care delivery was subject to checks and audits. The provider had appropriate quality assurance systems which were followed to ensure people received care that met regulatory requirements. Regular audits were carried out on medicines management, care planning, reviews, and record keeping to ensure staff were delivering care in line with the provider's procedures. Checks and audits of fire safety, health and safety of premises and equipment were up to date and showed that people lived in a well-maintained and safe environment. Complaints and incidents and accidents were monitored and analysed to identify trends. The registered manager discussed these issues with staff and ensured they learnt lessons to improve their practice and minimise the risk of a recurrence. Senior staff monitored staff's practice and gave them feedback to maintain high standards of care and/or how to improve their work when needed.

The registered manager was committed to meeting their registration obligations with the Care Quality Commission (CQC). Notifications were sent to CQC with sufficient details of the issue and the action taken to ensure people's safety. Staff said the registered manager had "an open door policy" which was in line of their responsibility under the duty of candour to encourage staff to be honest. Staff were confident and felt empowered to raise concerns about people's well-being. They said the registered manager acted on issues they raised. People using the service and their relatives told us the registered manager was known to them and they could telephone, email and visit at the service to discuss any concerns. They felt their views were valued and considered to make the necessary improvements at the service.

People using the service and their relatives shared their views about the service. The provider carried out surveys to develop the service. A resident's survey showed people were generally happy with the service provided at the home. The latest staff survey indicated they enjoyed working at the home and were content with their roles. Managers had responded to staff concerns that their uniforms were hot, by allowing them to choose their own dark trousers. Records showed action plans were put in place and implemented to improve the quality of care.

People's health and welfare improved because of the close working partnership between the service and other agencies. One healthcare professional commented care provision had improved and "there were several examples of good joint working to address the complex needs of residents with medical and mental health symptoms." The registered manager attended external meetings and benefitted from networking

with other registered managers of similar services managed by the same provider. This made them aware of the changes in the care sector and legislation around service delivery. The service worked with their communities and offered an opportunity to students who wanted experience of providing care in the community.

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 had not done everything reasonably practicable to make sure that people who use the service received care and treatment that is appropriate.