Bushby Care Ltd

St Georges Lodge Residential Care Home

Inspection report

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Date of inspection visit: 18 November 2015
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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection took place on 18 November 2015 and was unannounced. St Georges Lodge is a care home without nursing that is registered to provide care and accommodation for 26 older people. At the time of our visit there were 26 people living at the home who had a variety of needs and some of them were living with dementia. The building is a large detached Victorian house and accommodation is provided on both the ground and first floor.

The home had a registered manager. 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 and associated Regulations about how the service is run.

Staff had received training in the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards however, people's consent was not always being sought in line with

Summary of findings

the Mental Capacity Act 2015. Consideration of someone's capacity was not given in areas such as needing bed rails and capacity assessments and best interest decisions were not always recorded. This meant that peoples human rights were not always protected and decisions about their care was not always made in accordance with the law. This was identified as an area of practice that requires improvement.

People living at St Georges Lodge told us that they felt safe and there were policies and procedures in place to safeguard people, one person said "I've only got to press my bell and staff are here within seconds." Risks were identified and assessed and staff understood and supported individuals to make choices. Incidents and accidents were recorded and monitored by managers.

Medicines were managed, stored and administered safely and staff were confident and knowledgeable in administration of medicines. There were sufficient numbers of suitable staff and safe recruitment processes were in place. Staff covered gaps in the rota between them and this provided good continuity for people who were supported by staff who knew them well.

People told us that staff were well trained and knowledgeable, one person said, "The staff are excellent." We found that staff were well supported with training and supervision. People were supported to access health services and professionals including GPs, the specialist dementia care team, district nurses, and social workers. A visiting healthcare professional told us that "Staff are very thorough and aware of issues, they communicate really well with us and follow instructions." The nutritional needs of people were identified and monitored effectively and the chef had good knowledge of individual needs and preferences. People told us that the food was good and that they had enough to eat and drink.

People, relatives and professionals spoke highly of the caring nature of staff. Staff knew the people they cared for well and had developed caring relationships with individuals. One member of staff said "It's about putting the residents at the centre of what we do, if someone wants a pyjama day why shouldn't they? " People and their relatives were involved in planning their care and people told us they were happy with the care they received. People's confidentiality, dignity and privacy were maintained. People considered staff to be respectful and said that they felt they were treated with dignity, one person said "My eyesight is poor, the staff always tell me what they are doing and the reason why."

Peoples' care plans were personalised and reflected their individual needs and preferences. Staff were knowledgeable about the individuals that they supported and respected their right to make choices about their care and support. The complaints process was accessible people told us that they would feel comfortable to raise any issues or complaints with the managers or Provider. The Provider took an active role in seeking feedback from people and their relatives and friends and spoke to people individually through the auditing process as well as on a daily basis. People had mixed views on activities and opportunities for social engagement and this was fedback to the provider. Everyone told us that they enjoyed the external entertainers that came in for musical events three or four times a month as well as organised trips out but some people felt that there were not many activities on offer on a daily basis.

There was a comprehensive quality assurance system in place and the owner was actively involved with oversight of the service. There was an open culture and staff and people told us that the managers and owners were visible and approachable

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 the report.

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Individual risk assessments and care plans were in place and were regularly reviewed, as were environmental risk assessments. Medicines were managed, administered and stored safely.

People were supported by staff who had received training in safe guarding procedures and were knowledgeable about identifying the signs and reporting abuse.

Safe recruitment practices were in place and there were enough staff on duty to meet people's needs.

Good

Is the service effective?
The service was not consistently effective.

Consideration of people's mental capacity was not consistently evident in records. Mental capacity had not been considered where bedrails were in place which maybe restricting people's rights.

Staff received appropriate training and supervision and communication with people was good.

People's nutritional needs were being met and people had access to health care professionals.

Requires improvement

Is the service caring?
The service was caring.

People and visiting relatives and professionals spoke highly of the caring nature of the staff. Staff knew the people they cared for well and had developed caring relationships with individuals.

People's privacy and dignity were respected and confidentiality was maintained.

People were actively involved in the planning of their care.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People had individualised, detailed care plans that reflected their personal preferences and staff where knowledgeable about people's needs.

People attended residents meetings and there were feedback systems in place to capture people's views on the home. People told us they would feel comfortable to raise any concerns or to make a complaint.

Is the service well-led?

Good

The service was well- led.

People and staff spoke highly of the managers and provider and there was an open culture. The ethos of the home was about creating a comfortable homely atmosphere and this was well understood by all the staff. Systems were in place to gain feedback.

Staff were motivated and well supported in their roles and understood their responsibilities.

There were comprehensive quality assurance systems in place and audits had been completed regularly.

St Georges Lodge Residential 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 comprehensive inspection took place on 18 November 2015 and was unannounced. There were three inspectors that undertook the inspection. Before the inspection we looked at the previous inspection reports, and we reviewed information we held about the home including any safeguarding concerns that had been raised and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR), this was because the inspection was carried out at short notice. A PIR is a form that asks the provider to give some key information about the service, what the service does and what improvements they plan to make.

During the inspection we looked at areas of the building, including some people's bedrooms, the kitchen, the dining room, communal lounge and bathrooms. We spent time chatting to people and visitors to the home and observing staff interacting with people and providing care and support.

We spoke to 11 people living at St Georges Lodge, four visiting relatives, four care staff, the chef, the handyman, the deputy manager, the Provider, as well as visiting health care professionals.

We looked at eight staff files, the duty rota for the past four weeks, and the staff training matrix. We also looked at nine care plans and daily records, in addition we examined how medicines were obtained, stored, administered and disposed of. We reviewed policies and procedures, complaints and incident and accident files and quality assurance documents, minutes of meetings and the events file.

St Georges Lodge was last inspected on October 2013 where no concerns were identified.

Good

Is the service safe?

Our findings

People told us that they felt safe living at St Georges Lodge, they felt that they were looked after well and that there were enough staff on duty. People said “I do feel safe, there’s always someone around” and when asked about how staff respond to the call bell “They’re (staff) all very good, you don’t have to wait long before someone comes,” a family member said “Staff are lovely here, they do checks at night and come quickly if you call.”

We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member said, “If people can do things for themselves, we let them”. Another staff member told us, “I know it’s difficult for us sometimes if people want to take risks but if they know what they’re doing, it’s up to them.” We noted care plans contained a section where risk management was addressed. An assessment was carried out on admission and reviewed yearly, in which the degree of risk deemed appropriate by both people and staff was agreed, for example if someone wished to leave the home unaccompanied. This demonstrated that staff had a good understanding of how to identify and manage risks to individuals whilst respecting their right to decide to take risks. Risk assessments indicated that some people were at high risk of falling, for example one person was found to have fallen seven times in a four week period. It had been noted in their care record that the GP had been informed which indicated that there was oversight and analysis of these incidents.

The staff members we spoke with had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect that any abuse had occurred. They were aware that a referral to an agency, such as the local authority Adult Services Safeguarding Team should be made, in line with the provider’s policy. One staff member told us, "I would let my manager know if I saw abuse happening”. Another staff member said, “The training was very good. I feel confident that I would know what to do”. Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. This showed that staff had a clear understanding about their responsibilities to report any safeguarding concerns that they had and that they knew how to do this.

People told us that there were enough staff on duty to meet their needs. The person in charge on the day of the inspection said “We don’t use agency staff, we have a small team and we know each other really well and cover for each other so our residents get very good continuity, I think this helps to make it a homely place, we want everyone to feel at home.” We asked staff members the question, “Do you think there are enough staff on duty to consistently care for people safely?” One staff member said, “There’s no problem really. I think there’s enough staff”. Another staff member told us, “I have the time to spend with the residents. I don’t feel rushed”. We noted that call bells were responded to in a timely manner on the day of the inspection and people told us that they were confident that staff responded quickly. One person said “I’ve only got to press my bell and staff are here within seconds.” We looked at the staff duty rota for the previous four weeks. The rota revealed staffing levels were consistent across the time examined, with three to four carers plus either the manager or their deputy, with two carers on night duty. There was also kitchen, domestic and maintenance staff on duty. The provider used existing staff where possible to cover vacant shifts left by sickness or annual leave. We asked how safe staffing levels were established by the provider. The provider did not use a formal tool to assess the changing care needs of individuals. The Deputy manager told us that issues concerning changes in people’s condition or the arrival of new admissions were discussed in staff handover and adjustments to staffing were agreed by the manager where necessary.

All of the staff we spoke with had worked at the home for several years. We found that appropriate checks were undertaken before staff began work. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the registered manager had undertaken appropriate recruitment checks to ensure staff were of suitable character to work within the care industry. There were also copies of other relevant documentation including character references, job descriptions and identification documents in staff files.

There were safe procedures in place for the storage and administration of medicines. We examined the Medicines

Good

Is the service safe?

Administration Records (MAR) for 10 people. We also observed the dispensing of medicines and examined the provider's medicines management policy. Staff told us there was regular yearly training provided in medicines management and the provider conducted regular direct observation of staff administering medicines. The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. We noted staff locked the medicine trolley when leaving it unattended and did not sign MAR charts until medicines had been taken by the person. Staff were knowledgeable about the medicines they were giving. The provider undertook regular audits of medicines management and also facilitated a yearly audit from an external provider. We noted issues identified as a result of these audits were addressed in order to maintain the safe and effective management of medicines. All medicines were delivered and disposed of by a pharmacist. We noted the management of this was safe and effective. There was no dedicated lockable room for the storage of medicines; however, all trollies, fridges and cupboards were securely locked. Medicines requiring refrigeration were stored in a fridge, which was not used for any other purpose. The temperature of the fridge and the room which housed it was monitored daily to ensure the safety of medicines. No-one at the home managed their own medication and no-one received their medication covertly, that is, without their knowledge or permission.

The provider employed a 'handy–man' who was responsible for undertaking regular checks on environmental risks and carrying out day to day repairs. There was a recent fire risk assessment in place and weekly fire alarm tests were recorded. People had small coloured stickers on their doors to enable quick identification of those people who would need additional assistance if it should be necessary to evacuate the building

We looked at recording of incidents and accidents and found that reports were consistently completed and corresponded with information in individuals personal files. The person in charge told us that accident and incident reports were monitored by the registered manager and appropriate action was taken to prevent or reduce the risk of the incident or accident occurring again. She gave an example of how patterns are identified and used to improve the support for someone who began to fall regularly. She described how the registered manager had contacted the GP and the falls clinic for advice, and this resulted in an increased level of support from staff at times when the individual was at higher risk of falls due to issues with her blood pressure.

The Provider also had oversight of incidents and accidents through the auditing process and this included ensuring that notifications of serious incidents were completed.

Requires improvement

Is the service effective?

Our findings

People, health care professionals and visitors told us that the staff had the skills and knowledge to meet people's needs. We found that the service was not consistently effective as consent to care and treatment was not always sought in line with legislation and guidance.

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

We found that people were asked to give their consent to their care, treatment and support and there were signed consent forms on peoples' care files. However consideration of people's capacity to give consent was not considered consistently and mental capacity assessments were not always recorded for people who appeared to lack capacity. We found that bed rails were in use and although risk assessments were in place it could not be evidenced that consideration had been given to capacity in relation to consenting to their use or evidence of a best interest decision regarding their use. It appeared that two people may have been deprived of their liberty and the registered manager had not given consideration to undertaking a DoLS assessment to determine if this was the most appropriate action .

Following the inspection the provider confirmed that she had contacted the local authority for advice and that DoLS authorisations were being sought for the two people we had identified as potentially being deprived of their liberty. The MCA was not being adhered to and peoples consent was not sought in line with relevant legislation. This meant that people's right to consent to treatment was not being considered and documented in full. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about issues of consent and about their understanding of the MCA. Most of the staff we spoke with had undertaken recent training in this area. They had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Some staff could tell us the implications of DoLS for the people they were supporting. One staff member told us, "We've had training on this recently. We need to make sure the residents are safe but we don't take their rights away". Another staff member told us, "Sometimes we have to make decisions for residents but they can still make other decisions, like what they eat or what they wear". We saw information displayed in the lounge about advocacy services for people who lack capacity and staff were aware that a DoLS authorisation was in place for one person.

Staff were skilled and knowledgeable about the needs of people living with dementia and how to care for them effectively. Some staff had undertaken training in how to care for people with dementia and we saw examples of how they put this into practice for example talking to people about the food on their plate so that they were aware of what they were eating.

One person said, "I've noticed a lot of training goes on," another said, "The staff are excellent" and a third person commented that "Considering it's a care home not a nursing home, I think the staff are very well trained." A visiting relative said "From what we have seen staff know what they are doing." We spoke with staff about the training opportunities on offer. One staff member said, "It's one of the best places I've worked for that," another staff member told us, "There's the usual mandatory stuff but if there's something else you want to do, as long as it benefits the residents, the manager will provide it". We examined the 2015 training plan and looked at staff files. We noted all staff were able to access training in subjects relevant to the care needs of the people they were supporting. Several staff were undertaking National Vocational Qualifications (NVQ) at various levels. We were told that all new staff members were expected to undertake the Skills for Life Care Certificate, one new staff member had completed the 15 modules in September 2015 and another had recently

Requires improvement

Is the service effective?

started. The Care Certificate is a training tool devised by Skills for Care that provides a benchmark for the training of staff in health and social care. It covers 15 standards of health and social care.

All of the staff we spoke with had received recent, formal supervision and a yearly appraisal or had one planned. One staff member said, “Yes, that’s okay. I feel that I can speak to my line manager though, if I have a problem. We have staff meetings too”. Another staff member told us, “We fill out a self-appraisal form before we go into our appraisals so we feel involved”. We looked at the supervision planner and we noted that supervision sessions and yearly staff appraisals for all staff had been undertaken or planned, in line with the provider’s policy.

Staff communicated effectively to ensure that the health and well-being of people was maintained. We observed the afternoon handover, led by the deputy manager and attended by staff coming on duty. Each person was discussed and information was given about how they had been that morning, what was planned for later in the day and anything of concern that staff should be aware of. This included informing staff that one person had been found to have an infection , the GP would be called and staff should be monitoring and encouraging fluids. Staff were engaged with the process and asked appropriate questions that demonstrated they had a good understanding and knowledge of individuals. A visiting GP told us that “Staff are very thorough and aware of issues, they communicate really well with us and follow instructions.”

Everyone we spoke to told us that the food was good and they had enough to eat. We saw recording in care plans included information about dietary needs and preferences, involvement of a dietician, and monitoring and recording of people’s weight. The menus were planned over four weeks and the chef was able to talk in detail about the individual dietary needs and preferences of people including those who had diabetes, those who required a soft diet and people’s individual preferences. He explained that there were two choices of main meal available but people could choose something different if they wanted to, they said ” If they ask for something I make it. If the residents are happy, that’s the main thing.” The chef had a list of dietary requirements and preferences as well as evidence of consultation on menus in the minutes of the residents’ meeting. At lunchtime we observed that staff were gentle and supportive in their approach, offering choices and supporting people with cutting up food and feeding if needed. One person told us “The food is very nice, they try all sorts of things to encourage me to eat, ” another said, “The food is excellent, 10/10 for that, you get a choice and he’s a bloody good cook.”

Support and involvement of other health care professionals was evident throughout the inspection. People told us that they receive on-going health care support, one person said “ The nurses come every three weeks,” a visiting family member told us when their family member had been unwell,

"They called for medical attention immediately and the hospital staff commented on the quality of the paper work.” We also saw evidence of visits from a chiropodist, the falls team, optician and audiologist as well as speaking to a visiting GP and someone from the community neurological team. Staff told us that they accompany people to hospital appointments as part of their key working role and there was evidence of this in the main diary showing planned visits for individuals.

Good

Is the service caring?

Our findings

The person in charge told us that the staff knew the people who lived at St George's Lodge really well. She said "Continuity, that's what we do really well here, we all cover the different shifts and we don't use agency staff, that means we get to know the people who live here really well and we can maintain the homely feel." People spoke highly of the staff, they told us that they were kind and caring. One person said, "Staff are very caring, always cheerful and obliging" another said,

"The carers are very good, they are there for you all the time". We observed staff interacting with people in a kind and gentle way, when helping someone with their meal a staff member explained the different food that was on their plate, offered choice of drinks and gave people time to decide what they wanted. One member of staff said "It's about putting the residents at the centre of what we do, if someone wants a pyjama day why shouldn't they?"

Staff told us that they knew people well and that there was a key worker system in place to support positive relationships, recording in the keyworker file showed that staff spent time talking to people whom they key-worked, sorted out clothes with them and attended hospital appointments with them. All the staff we spoke to had worked at the service for between three and eight years we observed that they had a good knowledge of individuals living at St Georges Lodge. The person in charge told us that "We always include shadowing as part of the induction process for new staff, we want to ensure that all our staff are kind and caring. Because the managers are hands on we are working alongside staff on a regular basis and so we can observe what is going on."

People were able to express their views and were actively involved in making decisions about their care and support. One person said "I'm always being given choices, sometimes I eat in the dining room, sometimes in my own room, they always ask what I want." Someone else said" I'm encouraged to do what I can within my scope, they help me with what I can't manage. I always have my door closed because I like my own privacy". We observed staff using communication effectively to enable people who were living with dementia to make choices and used equipment such as coloured crockery to help people to distinguish between different food options. People had signed an agreement to their care plans and that their views and preferences were included, such as "[the person]will pick her own clothes in the morning" and "[the person]doesn't like stair lift- always use passenger lift ", another stated "[the person] prefers a bath only, doesn't like shower." This showed that people had been involved in developing their care plans. Notes from residents meetings showed that people were able to express their views for example when planning future events people had said they would like children to come and sing Christmas songs in December- the Provider said that she would be arranging this and that where people didn't attend meetings she would visit them in their rooms to ask for their opinions.

People's confidentiality, dignity and privacy were maintained. People considered staff to be respectful and said that they felt they were treated with dignity. One person said " People always knock on the door," another said " My eyesight is poor, the staff always tell me what they are doing and the reason why", a third person said "When you have a shower the girls are there all the time looking after you so you don't fall, we have a laugh and a joke." We asked staff how they supported people to maintain their dignity and privacy, one staff member told us, "Some of the people here need a lot of personal care so we need to make sure we protect them when we do it." Another staff member said "I always knock before I go into someone's room." Our observations on the day of the inspection confirmed this. We saw that people were dressed appropriately and according to their personal choice, their clothes were clean and some women had chosen to wear jewellery and carried handbags.

The provider had reviewed their policy on confidentiality earlier this year, all confidential records were kept in a locked cabinet and staff have received training in maintaining confidentiality as part of their induction or NVQ training. During the inspection it was noted that a white board was being used to aid communication but people's confidentiality was maintained as no names were included on the board.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans were reviewed regularly and signed by the person or a family member, they contained detailed information about people's care needs such as the management of risk associated with mobility and the management of medicines. People or their representatives had been formally involved in planning their care and risk assessment reviews on an annual basis.

We looked at a care plan for someone who had a complex range of care needs including some behaviour that people needed support with. There was a risk assessment in place that described how staff should act to minimise the impact of a potentially hazardous situation whilst ensuring the safety of both the people and the staff. The Registered Manager had sought a specialist assessment from the Dementia Crisis Team to support this work. Another person's care plan described a high level of risk concerning the development of pressure sores. We noted action had been taken to minimise this risk through the use of equipment, regular assessment of dietary need and frequent repositioning of the individual, who was unable to get out of bed. We noted that the person had developed a pressure sore the previous year. The Registered Manager had correctly involved external agencies such as community nurses and followed their advice. The pressure sore fully healed earlier this year and had not reoccurred.

The care records also contained information about personal histories, one noted that a person had been a tailor in the past, and she still enjoyed knitting. Personal preferences were included within care plans "Likes to eat breakfast and supper in her room, prefers hot chocolate at bedtime," Another stated " [the person]likes to keep door closed, enjoys own company," and we saw that this was the case. During our visit people told us that these preferences were respected by staff. The person in charge told us that " Where ever possible we try and respect people's choices, if people have particular religious or cultural needs we will do all we can to support them, for example we have made arrangements for a pastoral team to come in and provide holy communion for a couple who can no longer attend their Church."

Personal preferences in relation to food were noted in care plans and the information was provided to the chef. He was able to talk in detail about individual dietary needs including who didn't eat pork, who didn't like green beans and those who preferred small portions or had a vegetarian diet. A family member told us " As soon as they knew she likes crunchy nut cornflakes they bought them immediately"

Relatives visiting on the day of the inspection told us that they were welcomed in the home, one person said "Staff are very friendly and attentive." The person in charge told us "We like to keep people up to date, we use emails and phone calls to keep family informed. Visitors are always welcome and if they want to come at meal times we can arrange for them to have a family meal together." People told us they were happy with the way staff communicated to families. One person told us " The manager keeps in touch with my son, he's in Saudi Arabia" a visiting daughter said " If I phone up I always get the details – it's a consistent staff team and they are all really friendly and very caring."

A newsletter was sent to people and their relatives every three months and residents meetings were planned and advertised in advance to encourage people to attend. Minutes of the last two meetings, showed that one was attended by around 14 people and had details of planned events and evidence of consultation with people living at St Georges Lodge about forthcoming events and activities. The Provider told us that if people don't come to the residents meeting she goes and talks to them in their room to gather their views too.

There was a current activities plan for the month and an activities file that included an evaluation section for each event where feedback was recorded. We noted that families and friends were welcomed to these events. We spoke to the provider who had a role in organising activities, she explained that they had a staff member who led on activities twice a week including, arts and crafts, bingo, quizzes and reminiscence. In addition to this the staff arranged visits from local musicians and recently had the rotary club choir to entertain people. She said " In the afternoon staff are encouraged to play board games or spend time with people chatting. I go and talk to people to check they are happy and if they want to go out I arrange it, we go on shopping trips or walks in the local area." Some organised outings were arranged, including trips to the garden centre, in response to feedback from people at a residents meeting.

On the day of the inspection there were no planned activities in place, most people were in their bedrooms and

Good

Is the service responsive?

a few people were watching television in the lounge after lunch. People we spoke to had mixed views about the level of social engagement and activities on offer. Most people told us that they enjoyed the activities that were arranged, especially the musical events that happened about once a week. One person said “They had a girl here singing with a saxophone, she was really good,” someone else said “Someone came in with a piano-accordion, I really enjoyed it!” Some people we spoke to told us that they would like to have more to do, one person said

“There’s not many activities here, the singers are very good, I’m not one for joining in” someone else said “They do take us out, which they could do more often, I would like to do more walking.”

We gave this feedback to the provider who confirmed their commitment to enabling people to follow their interests.

She told us about a number of recent occasions when people had been supported to go out shopping or just for a walk and said that she would continue to ensure that people’s views regarding activities were supported.

A complaints procedure was on display in the lounge and had been recently reviewed. People told us they knew who to speak to if they wanted to make a complaint. One person said “ I would approach the owner, “ another said “I would tell a manager or a carer if I wasn’t happy,” a third person said, “There’s plenty of ways to complain, just go to the office, I would go and complain quickly if I needed to.” The Provider told us that she undertook monthly interviews with people and family members to gather their feedback. We saw that someone had commented that their room was cold in the morning and an additional heater was provided as a result. The owner had gone back a few days later to check that this had solved the problem. This demonstrated that the provider was using information that was fed back to them to improve the service.

Good

Is the service well-led?

Our findings

People told us that they felt St Georges Lodge was well-led, one person said, "Yes, I think it's well managed, consideration is always given to the residents and they take great care of everyone" another person told us "I think (the manager) runs the home with care and knowledge and love." We saw positive feedback reviews that had been completed by residents or family members during the autumn and were published on the provider's website.

There was an open culture and people and staff spoke highly of the management and owners of the home saying that they were approachable and visible. Staff told us that they were well supported, one staff member said "The manager is really nice and you can say things in confidence. It's the best home I've worked in", another staff member said "Everybody (staff) gets on really well and I think that's down to the owners and the manager". Staff were aware of the lines of accountability and who to speak to if they had any concerns. The person in charge said that it was important to the managers to lead by example and to be accessible to the team so they regularly worked on shifts with the care workers. They said that the provider was supportive to the managers and very visible to staff and residents. The provider was actively involved in driving continuous improvement and sought feedback on the service through a variety of methods including through residents' meetings, questionnaires, reviews and individual meetings. During the inspection it was clear that the provider knew the staff and people well and that they took great pride in the service.

We asked staff the question, "What is the purpose of the home and what does it offer to people?" One staff member said, "It's to be a home from home, which it is". Another staff member told us, "It's about the person, not the illness they might be suffering. This place is very family oriented. The residents know us and we're part of their lives". A third staff member said, "It's to put the residents at the centre of what we do. If someone wants a 'pyjama day', why shouldn't they?" This demonstrated consistency with the prime objective set out in the homes statement of purpose "to provide a relaxed, homely and happy environment." The Provider checked that people's experience matched up to the homes objectives through regular feedback processes.

The Provider told us that the Registered Manager and deputy attended a local forum where they had the opportunity to meet other local managers. We spoke to professionals visiting the home who told us that partnership working with St Georges Lodge was good, a visiting GP told us that communication with the staff was very good and that they were good at seeking clinical help in a timely way. A member of the neurological team visiting to assess a resident told us that "Staff always know what's going on, they are really compliant with anything that we suggest and refer to services when needed. Staff treated people as individuals and the managers are really good."

Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with people and other 'relevant persons' (people acting lawfully on behalf of others) when things go wrong with care and treatment,giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents .The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. None of the care staff members we spoke with were aware of this regulation and they were unable to describe its relevance and application. There were no notifiable safety incidents identified that warranted the duty of candour. Since our visit, the registered manager confirmed the actions they are taking to ensure that should such an event occur staff are confident to know their responsibilities under duty of candour.

There was a comprehensive auditing system in place and this was overseen by the provider who undertook quality assurance checks on a monthly basis. This enabled the registered manager and the provider to measure and review care delivery and to use this information to drive continuous improvements to the service provided. We saw that they did this by using the information from quality monitoring to develop and implement improvement plans. For example to ensure the suitability of the premises for people living there, bathrooms had been refurbished to provide better access.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users had not always been provided with lawful consent of the relevant person because the provider had not always acted in accordance with the 2005 Act. Regulation 11(1)(2)(3).