The New Lodge Nursing Care Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
The New Lodge Nursing Care Ltd., is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The New Lodge Nursing Care Ltd., accommodates up to 33 people in one adapted building. At the time of the inspection there were 29 people in residence who had complex health needs.

People's experience of using this service:
● People's safety was promoted. We found there were sufficient staff to meet people's needs who had undergone a robust recruitment process. Staff had a clear understanding as to how people's safety was to be promoted as they had received and continued to receive training and guidance.
●Staff followed the information within people's records to reduce potential risk, promoting people's health and wellbeing. People's medicines were managed safely, and prescribed medicines were regularly reviewed by a health care professional.
● People lived within a clean and well-maintained environment which met their needs. The service was homely and welcoming and provided opportunities for people to socialise, both within the service and the garden. Equipment to promote people's independence and meet their personal and health care needs was provided.
● People's needs were regularly reviewed with their involvement or that of a family member and changes were acted upon. People had access to a range of health care professional who visited them at the service. Health care professionals stated people's clinical and health care needs were met.
● People's dietary and nutritional needs were met, which included the provision of specialist diets which met people's specific health requirements. Meals and foods were homemade and food and drinks were in plentiful supply and were served throughout the day.
● People's rights and choices were promoted on an ongoing basis. Where people were not able to make informed decisions, then decisions were made in their best interest. Family members were consulted about their relative's health as part of best interest decisions and were involved in the development of care plans.
● People were supported by staff who had access to training reflective of people's needs. People stated recently recruited staff were not always familiar with their needs, however acknowledge they worked alongside experienced staff.
● People spoke positively about the caring approach of staff and they confirmed their privacy, dignity and independence was promoted by staff.
● People had opportunities to take part in activities within the service, however the management team had identified this to be an area for improvement to promote a holistic approach to care and to improve people's quality of life. An action plan was in place for how this was to be achieved, which included working with existing external organisations.
● People's needs were met, which included end of life care. The service had attained an end of life award

and staff had access to training specific to meet people's needs.
● People's views and that of their family members were sought through meetings and the sending out of questionnaires, however not everyone was aware of the meetings held.
● Staff, people and family members were familiar with members of the management team, and found them to be supportive and approachable and all were confident to raise concerns.
● The registered person met their legal obligations, which included The Duty of Candour and the General Data Protection Regulation. The provider shared information with people and family members as required.
● The provider had developed its systems to monitor the quality of the service, which included regular auditing in key areas. Action plans to bring about improvement were in place when audits identified areas for improvement. The action plan was monitored by the registered manager and the management team to ensure identified improvements were actioned.

Rating at last inspection:
This is the first inspection of this service since it re-registered with the Care Quality Commission (CQC) on 4 April 2018 as a result of changes made by the provider to the organisations legal entity.

Why we inspected:
This was a planned comprehensive inspection.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

The New Lodge Nursing Care Ltd

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was carried out by one inspector, a Specialist Advisor (the Specialist Advisor had experience working and caring for people who require general nursing care) and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
The New Lodge Nursing Care Ltd is a care home, which provides nursing care.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
Inspection site visit activity took place on 3 April 2019 and was unannounced. We returned on 4 April 2019 announced.

What we did:
We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Our planning took into account information we held about the service. This included information about incidents the provider must notify us about, such as abuse; and we looked at issues raised in complaints and how the service responded to them. We obtained information from the local authority commissioners.

We spoke with five people and three family members/visiting friends.

We spoke with the registered manager, a nurse, three members of care staff, an activity co-ordinator, a chef, the registered person and the business development and operations manager. We spoke with two visiting health care professionals and a health care professional via the telephone. The health care professionals were involved with some of the people who used the service.

We looked at the care plans and records of four people. We looked at three staff records, which included their recruitment, induction and on-going monitoring. We looked at staff training matrix. We looked at the minutes of staff meetings and records related to the quality monitoring of the service, which included minutes of meetings involving people using the service and their family members.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
- People we spoke with considered themselves to be safe due the care and approach of staff and because of the friendly environment in which they lived. People shared their views as to why they felt safe. One person said, "The atmosphere feels safe. I have a walking trolley. Staff don't bully me at all."
- There were safeguarding and whistleblowing policies and procedures to guide staff on what action to take should they have any concerns. These are laws that protect whistle-blowers from being unfairly treated for reporting misconduct.
- Staff were clear in their discussions with us that they would have no hesitation in alerting the registered manager or a nurse should they have any concerns about a person's welfare.
- The registered manager referred safeguarding concerns to safeguarding teams and informed other relevant organisations such as the CQC.
- Information about safeguarding was displayed on a notice board within the service.

Assessing risk, safety monitoring and management:
- People were aware of the equipment that was available to promote their safety. People's views about the use of equipment to promote their safety was listened to and respected. One person told us, "I did have a fall and got a bruise on my face but I refused to go to the hospital. I don't want that. I have bedrails but I don't want to use them."
- Equipment to meet people's health needs and keep them safe was provided, this included equipment to support people to have a bath or shower and move about the service independently. Family members were aware of equipment used, a family member told us. "He has a suction machine to clear his airway. Staff check him hourly. He has to sit up in bed and is kept propped up. His bed is kept mechanically inflated to avoid any sores."
- Potential risks to people were assessed and regularly reviewed. For example; falls, skin integrity, nutrition, mobility and eating and drinking.
- An individual risk assessment had been undertaken which identified the level of risk to the person should they be required to evacuate the service in an emergency. PEEPs were stored in a central location so they could be easily accessed in an emergency.
- People's capacity was assessed when decisions were made about potential risks. Where people were found not to have capacity to make decisions, best interest decisions were made involving family members and health care professionals.
- Systems were in place to ensure equipment within the service was maintained. For example, fire systems, moving and handling equipment and utilities such as electrical appliances and installation, gas and water.

Staffing and recruitment:

● Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people, which included a completed application form, a full work history, references and a record of their interview.
● Prior to commencing work, staff had a Disclosure and Barring Service check (DBS). The DBS assists employer to make safe recruitment decisions by ensuring the suitability of individuals to care for people. Records were in place to evidence nursing staff were registered with Nursing and Midwifery Council (NMC), which meant they were registered to provide nursing care safely.
● The registered manager had oversight of staffing levels to ensure people's needs were met in a safe and timely way. The registered manager reviewed staffing levels which were linked to people's needs as identified within their assessments and care plans.
● People spoken with and family members stated there were sufficient staff to meet their needs. One person told us, "There are plenty of staff. It's never short and we don't have to wait long." A family member said, "Absolutely enough staff. I always see at least 2-3 nurses and plenty of care staff. The response to call alarms is almost immediate or pretty quick." We observed that staff responded in a timely manner when people required assistance.

Using medicines safely:
● People and family members had confidence in the management of medicines and were aware of the medicines prescribed. A person told us. "I get my tablets, morning, lunch and in the evening. I don't take them until I've asked what they are for." Family members were knowledgeable about the medicine their relative was prescribed and had in some instances had spoken with health care professionals when medicines were reviewed. A family member told us, "My son gets his medicines as liquids through a tube. The doctor comes to see him regularly and has discussed his medicines with me."
● People's medicine was managed safely and records we viewed confirmed this. There were clear protocols for the management and administration of medicine which were adhered to. People's health care records reflected their health was monitored in response to medicines prescribed. People's records detailed the frequency and dosage of their medicine and how it was to be administered.
● There were clear protocols in place for people who were prescribed medicine to be taken as and when required. Nurses were observed administered medicines safely, people were asked if they required medicine to alleviate pain and information was given to people about the medicine they were taking. Where people could not make an informed decision about their medicine or were unable to verbally express their views, records detailed how the person may express pain for example, through changes in their behaviour or by facial expressions.
● A medicine policy and procedure was in place, which was linked with good practice guidance and legislation. This included guidance on the action the service was to take when people did not have the capacity to make an informed decision about the administration of their medicine.

Preventing and controlling infection:
● People spoke positively about the cleanliness of the service. One person told us, "My room is cleaned three times a day. They (staff) are very efficient at that. Bedlinen is changed every two days."
● Anti-bacterial gel dispensers were sited throughout the service for staff and visitors to use.
● Staff were seen to wear personal protective equipment (PPE) including gloves and aprons when they supported people with personal care, during clinical interventions and when serving meals and drinks.
● Audits were undertaken to ensure infection control measures were effective, which included a visual check on equipment such as mattresses to ensure they were in good working order and free from stains.
● Policies and procedures on preventing and controlling the spread of infection were in place.
● Staff underwent training on the prevention and controlling of infection.
● The food standards agency had visited in May 2018 and awarded the kitchen a 5-star rating of very good.

(The ratings go from 0-5 with the top rating being '5').

Learning lessons when things go wrong:
● The provider had made changes following an incident which had occurred the previous year. This had included the development of a new role within the management team to drive improvement and quality. Specific changes relating to the incident had taken place, which included a review of policies, procedures and processes which had been supported through training for staff.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
- People's needs were assessed by commissioners who fund people's care and by the registered manager. Assessment had been carried out consistent with the Equality Act to ensure there was no discrimination when making decisions as to people's suitability to move to the service. The assessment process covered all aspects of people's health, care and well-being to ensure that the service could provide the support and care the person required.
- Assessments included seeking information about a person's life. We saw people's records contained information about their family life, working life, hobbies and interests, pets and anecdotal stories which were of significance to them.

Staff support: induction, training, skills and experience:
- People and family members commented positively on experienced staff skills and knowledge. A few people told us staff had recently been recruited, which meant they did not always fully understand people's needs. However, they told us new staff worked alongside an experienced member of staff who provided guidance. A family member said, "A lot of the new ones (staff) don't understand. The regular ones do know. The new ones are still learning."
- Staff undertook training to promote and maintain the health, safety and welfare of people. Staff who had not previously worked in care studied to gain the Care Certificate. The Care Certificate covers an identified set of standards which health and social care workers are expected to implement to enable them to provide safe and effective care. Staff also worked towards attaining vocational qualifications in care.
- Staff received regular monitoring through supervision and observed practice. Staff supervision and appraisals enabled staff to review the objectives set by the provider and to develop personal performance objectives to enhance their skills in meeting the provider's visions and values of the service.
- Staff spoke of training they had undertaken to meet people's need, which included catheter care management and the management of percutaneous endoscopic gastrostomy (PEG) feed, which is where people's nutritional needs are met directly via a tube into their stomach.
- Nursing staff evidenced their continued professional development to maintain their registration with the Nursing and Midwifery Council (NMC). Nurses told us of the training they had received, which included the use of equipment to administer people's medicine. Nursing staff were assessed as being competent to verify an expected death. Nursing staff spoke of planned training, which included 'mentorship training', along with other staff. Nursing staff underwent regular clinical supervision.
- A nurse spoke of their induction when they had commenced their employment. They told us, "I shadowed an experienced member of staff for three days, until I learned the routine and procedures. I had to have everything signed in a booklet to say I was competent before I could work alone."

Supporting people to eat and drink enough to maintain a balanced diet:
● People and family members were complimentary about the meals.
● The menu for the day was displayed on a chalk board on the wall of the dining room. Tables were set with a table cloths and napkins. Condiments were available. People in some instances ate in the dining room, whilst others ate their meal in their bedroom. Staff were seen taking meals to people in their rooms and provided help where required.
● The chef was provided with information as to people's dietary requirements and preferences. The chef told us that all meals and foods, such as cakes were homemade. Seasonal menus were in place, and menus were discussed at 'The Friends of the New Lodge' meetings.
● Food and drink was accessible to people and visitors. Staff were seen to regularly serve refreshments throughout the day.
● Assessments identified people's needs with regards to food and drink. Specialist diets to meet people's needs were provided. For example, diets to support medical conditions such as diabetes. Where people received their nutritional needs via an alternative method, for example a PEG feed, (this is where nutrition is given directly into the stomach via tube a tube.) We found clear guidance to be in place with a copy of the guidance kept in a person's room so it was readily accessible to staff.
● Risk assessments identified people at risk in relation to eating and drinking so that measures could be put into place to ensure people had enough to eat and drink. For example, those at risk of poor food intake and who were noted to have lost weight were provided with a high calorie diet. People at risk of choking were given a soft diet and thickened fluids as recommended by a Speech and Language Therapist to minimise the risk of choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
● People spoke of their access to healthcare services. One person said, "The doctor came last week to see me and I see the chiropodist. I also went for a dental inspection but not for treatment." Family members spoke of health care support, provided by external healthcare professionals. A family member told us, "The epilepsy nurse comes every week and we receive weekly visits from staff from [a hospice]. The home contacts the SALT (speech and language therapist) team if there are any problems with his PEG tube."
● Staff were provided with information in a timely manner where people's needs changed. A member of staff said, "The daily charts (recording people's care and well-being) are excellent here, always updated, and we are informed of any changes in care requirements."
● People's views and that of their family members were discussed when planning their future care needs and where people had expressed their wishes these were recorded within an advanced care plan, setting out the circumstances in which they wished to receive medical treatment.
● Staff were both effective and responsive in responding to people's health. We saw first-hand how staff monitored the health of a person who was unwell. Staff kept a detailed record of their observations throughout the day and liaised with the person's GP and implemented the persons care plan by administering medicine to be taken as and when required.
● Health care professionals from a range of specialisms visited people to review their needs. A doctor from a local GP practice visited weekly and when requested. Visiting health care professionals, we spoke with had confidence that people's clinical care needs were being met and staff were professional and knowledgeable about people's needs. They went onto to say staff received good training to enable the care of people and that staff contacted them and other health care professionals appropriately and in a timely manner.
● Records detailed health care professional visits along with people's access to hospital appointments to monitor health conditions such as diabetes.

Adapting service, design, decoration to meet people's needs:

● The New Lodge Nursing Care operates from an adapted building, which has been extended and was well maintained. Communal rooms were located on the ground floor. Bathing, showering and toilet facilities and bedrooms were located on the ground and first floor. The garden provided a safe place for people to sit and relax.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● People's capacity to make informed decisions about their health, care and welfare were assessed. Where assessments had identified people did not have the capacity to make an informed decision, then a best interest decision was made on their behalf. Best interest decision meetings involved health care professionals and family members.
● A number of people at the service, who did not have the capacity to make an informed decision had an authorised DoLS in place, which placed restrictions on them, for example leaving the service without being accompanied, as this would place the person at risk.
● Staff had received training on the MCA and our observations showed that staff always sought people's consent before providing care and support.
● We found staff to be knowledgeable about people's individual capacity to make day to day decisions. We saw staff offered people a choice for example as to what they wished to eat or drink, where they wanted to sit or whether they wished to take part in an activity.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect:

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care:

- People spoken with considered staff to be friendly, caring and helpful. A family member told us, "Staff are very friendly and helpful. I get endless offers of tea and coffee. If I had to live in a home, I'd be happy to live in this one."
- People, did not express any concerns or worries about staff seeking consent or explaining what they were doing to support them in a way that respected their privacy and dignity. A person told us, "I'm fairly independently minded. You can't impose things on me. Staff always ask me first." A family member said, "Staff always explain what they are doing."
- People, or a family member were aware of care plans and had been consulted in their writing and review. A family member told us, "The home talked to us about her [relative's] needs and she was able to have a say in that." A second family member said, "Staff talk with me about any improvements or if he [relative] needs different medication."
- People's spoke of how their diverse needs were met. One person told us, "I am not religious. I prefer a woman to care for me and that happens." A family member told us, "We are not very religious, a Vicar did call to see if we wanted to talk but we're not bothered." A local Vicar held monthly Communion at the service.
- Staff spoke passionately about their role and told us how they enjoyed providing support and care to people. Staff told us they were often busy as many people had high dependency needs, they felt however that they were able to provide the standard of care they wanted to.
- Staff had completed training in equality and diversity and we observed staff supported people in a non-discriminatory way.

Respecting and promoting people's privacy, dignity and independence:

- People and family members stated privacy, dignity and independence were respected. A person told us, "Staff always knock on my door before coming in." A second person told us, "Staff will close the door when helping me to have a wash and closed the curtains too. They will ask if I want any help to dress but I can do a lot for myself." Signs were placed on people's door when personal care was being provided to ensure people did not enter the room. A family member told us, "When he gets a bed wash the door is closed and they explain what they are doing. He can't reply most of the time but they [staff] still speak with kindness and are very clear."
- Our observations showed staff promoted people's privacy and dignity. Staff were seen to always knock on people's doors and preserved people's modesty by ensuring sheets or towels were used to when providing personal care.
- People were supported to maintain relationships; family members and friends were encouraged to visit.

● Family members and friends were made welcome when they visited the service and were offered refreshments. Visitors could join their family member or friend for a meal if they wished.

● Respect and dignity towards people extended to include their death. The provider offered to hold gatherings at the service when a person died, for family members and others to celebrate a person's life. When a person had died, staff provided a 'guard of honour' as the person left the service and transferred into the hearse. A member of staff said there wasn't a condolences book, and that was something they were going to suggest. An event referred to as 'Stars on the Tree' is held annually at Christmas. Each person who has died at the service is remembered, by having a personalised star, hung from the Christmas Tree. A local Vicar presides over a service held at the New Lodge Nursing Care Limited, where all those whose names appear on a star are remembered.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People we spoke with and their family members considered they were offered a service in line with their preferences and were cared for. Assessments of people's needs were used to develop care plans, which included family members where appropriate. People told us they were able to contribute to decisions about their care and that family members were involved. A person told us, "My son and wife have Power of Attorney (POA) and the home will let them know how I'm doing and give them updates." A second person told us, "Waking and sleeping and what I do is entirely up to me. I have freedom of choice and action."
● Experienced staff involved in people's care and welfare had a comprehensive understanding of people's needs, which enabled them to note and therefore respond to any changes in people's wellbeing.
● To enable staff to provide care based on people's needs, key information about specific aspects of their care were displayed pictorially. For example, people who required to be positioned in a specific way either when in bed or a wheelchair, with the use of equipment was made easier to reference.
● People's care plans were in the process of being reviewed to better support person centred care; focusing on individual preferences and choices for how a person they spent their day. The registered manager spoke of their commitment to provide opportunities for people with complex health care needs to be able to leave their bed or bedroom to access communal areas within the service. A family member told us, "He's [relative] been out of the room in a chair for a couple of hours. Its recent. He smiled to show he had enjoyed it." A person told us, "I prefer to stay in my room, I go to the dining room if I want for dinner. I'm offered activities but prefer not to join in."
● People were supported to take part in activities with the support of an activity co-ordinators. An activity co-ordinator told us they recorded the activities people participated in and that they were in the process of developing plans to reflect people's ideas, hobbies and interests. Small groups of people were seen to be encouraged in an activity of throwing a bean bag at cans. Whilst two people were being supported in a game of dominoes.
● People we spoke with said they did not have an activity plan and family members spoke of their relative's frustration at not being able to do take part in things they used to enjoy. A family member told us, "He [relative] has always been active and his inability has greatly limited him. It frustrates him that he is unable to access his prior interests." A second family said, "Recently one of the girls [staff] has come in to chat to him. He watches the T.V and listens to music. He is not asked much to go into the lounge. I would like him to get out of his room more often."
● The registered person and registered manager were receptive to the idea that the activity co-ordinators access training to enable them to better support people to engage in activities reflective of their hobbies and interests with a view to identifying any therapeutic benefits.
● The provider information return (PIR) had included information as to planned improvements, which included the promotion of holistic care. To achieve this, they had identified improvements were needed to ensure people had the opportunity to take part in activities, which were meaningful to them. The provider

had recognised how the use of technology could be used to support people and through establishing links with partner agencies.

● The providers understanding of communication and its importance to those who used the service was an area for improvement to fully meet the requirements of the Accessible Information Standard (AIS), by ensuring people's individual communication needs were fully understood by staff and recorded throughout people's care records. A person we spoke with had identified how staff's lack of awareness of their specific needs impacted on them. This was shared with the registered manager who confirmed they would act. We found positive examples of where information was available to support people's specific communication needs. For example, signs and symbols in Makaton were displayed in a person's room.

● The displaying of information to promote people's understanding had been considered. For example, information about daily activities, the weather and menu were displayed both in writing, supported by pictures or symbols. An area for improvement would be signage to support people's orientation around the service, for example signs and directions to communal rooms.

End of life care and support:

● We spoke with a family member whose relative had received end of life care at the service. They told us, "Staff were always courteous and very respectful of my wife. She and I felt that she was very much cared for." The family member went onto tell us how staff responded to changes in their relative's care. "As her pain worsened the treatment responded to that. We were involved in those discussions. Her end of life care was handled first class."

● Opportunities for people and family members to talk about their wishes should they became unwell were provided. People's wishes were recorded and any actions as a result of their comments was actioned. For example, some people had in place a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). People's capacity to make informed decisions about DNACPR's were documented.

● Care plans were in place for those people who were receiving end of life care and were reflective of the Gold Standards Framework. The plans included information about any medicines prescribed to help support people with any pain or symptoms and staff liaised with the palliative care team to ensure people's needs were met.

● Staff said they were supported to provide good end of life care and felt they were able to go 'above and beyond' and could attend the funerals of those who had died.

Improving care quality in response to complaints or concerns:

● People and family members were confident in raising concerns. Where people had raised a concern or complaint they told us it had been dealt with to their satisfaction. A family member said, I have never had any complaints. If I did I would go to the owner." A second family member said, "I did raise some complaints with the manager and they were sorted."

● The provider had a complaints procedure, which was displayed on a notice board. The complaints procedure included information about external agencies which could support people with complaints.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

● People spoken with considered the service to be well led and run well overall. They thought the registered manager and provider were approachable and came to say hello and ask how they were. A family member said, "The matron [registered person] and the registered manager make sure everything is alright." People were asked how they would score the home on a scale of ten. People scored it highly. A family member said, "I don't think it can improve on anything." A person told us, "On the whole the service is good."

● The registered manager and the management team provided staff with constructive feedback through team meetings, supervision and appraisal. A member of staff told us, "I feel this is a well-run home and very rewarding working here. I receive feedback and feel valued, praised and I am allowed to contribute and am listened too."

● Staff stated they were confident to discuss any issues with the nurse in charge or the registered manager and felt that staff worked well as a team. A member of staff said. "Staff are friendly here and there is good team working, management are brilliant." A second member of staff said, "It's a lovely atmosphere to work in."

● The provider had developed a new role of 'business development and operations manager' within the management team. We spoke with the business and development and operations manager who told us as part of their role they had spoken with care staff individually. Group meetings had also been held for staff employed to carry out other duties, which included catering, laundry and domestic duties. The discussions had been held to seek their views about the service, including specific issues dependent upon staffs' role within the service.

● The business development and operations manager, in conjunction with the registered person and registered manager had developed a plan for improvement. It had been identified that records reflecting people's care and welfare were not consistently being completed in a timely manner. As a result, a 'triple lock' system had been developed, the purpose of the system was to minimise the risk of human error by ensuring records were completed well and in a timely manner.

● The registered manager, along with others within the provider's organisation supported staff through ongoing training, supervision and meetings to ensure staff were motivated and caring. And meetings were held at all levels to review the quality of the service.

●The day to day running of the service was well organised, staff were clear about their collective and individual duties and worked together as a team to provide good quality care. A system of auditing was in place covering topics related to the environment, staffing and people's care to ensure any shortfalls identified were actioned for improvement.

● The provider and registered manager met their legal obligations in line with the Duty of Candour. The Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that require registered persons to act in an open and transparent way with people in relation to the care and treatment they receive. For example, following an incident at the service the management team had used the forum of the 'Friends of The Lodge' meetings, to inform people of an incident in the service and the steps taken as a result of the incident to put systems in place to prevent reoccurrence. The registered person had also provided an explanation to people about The Duty of Candour.
● The registered manager had completed an on-line tool registered with the NHS regarding General Data Protection Regulation (GDPR). This would facilitate the sharing of information about people's health care needs in a safe way, to comply with GDPR legislation. Family members had been sent GDPR forms, of which a majority had been signed, and GDPR had been discussed with people at a 'Friends of The Lodge' meeting.
●The provider had a Certificate of Assurance confirming the safety and security of the electronic system.
● The registered manager informed relevant agencies, such as the local authority and the Care Quality Commission (CQC) when a person sustained an injury as a result of an accident or incident. For example, from a fall.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● The registered person (matron) and the registered manager had an open and transparent approach to sharing information; this included a forum made up of people using the service and their family members referred to as 'The Friends of the New Lodge'. However, not everyone was aware of the group. A family member said, "I don't know about residents' meetings. They are doing 'Friends of The New Lodge meetings'." A second family member said, "I'm now aware of resident's meetings or Friends of The New Lodge meetings." Minutes of these meetings showed the most recent meeting had been held November 2018.
● People's views were sought through the sending out of questionnaires. A number of questionnaires had been returned, which were in the main positive. However, the information from questionnaires had yet to be collated, analysed and the outcome shared with people. Staff had the opportunity to complete questionnaires. The business development and operations manager were committed to using information gathered from questionnaires to continually develop the service based on people's experiences and comments.

Continuous learning and improving care; Working in partnership with others:
● The registered manager accessed information from external organisations to keep up to date with good practice. The service had attained the Derbyshire end of life care quality award in May 2018. The provider was currently working towards attaining the Derbyshire Dignity Award, to attain this all staff had to be Dignity Champions, which a majority of staff were.
● The provider had developed and continues to develop links with organisations to improve the quality of life for people. Members of the management team spoke of contacts they had made with the British Legion, a hospice providing support to young people with life limiting conditions and organisations who help those with a life limiting condition to achieve a specific aspiration or wish.
● Clinical governance meeting for nurses were used to reflect and discuss updates on the codes of conduct for nurses, and to review NICE (National Institute for Health and Care Excellence) guidance. For example, recent guidance regarding how named drugs had been re-classified, which had meant changes had been introduced as to how these medicines were stored and accounted for.
● Publications, such as 'community care' and 'the nursing standard' were available for staff to read, which provided guidance and information about changing themes within care.