Anchor Carehomes Limited

# Herries Lodge

## Inspection report

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Date of inspection visit:
07 September 2016

Date of publication:
17 October 2016

## 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? | Requires Improvement |

# Summary of findings

## Overall summary

This inspection took place on 7 September 2016 and was unannounced. This was the first inspection of Herries Lodge since the service was registered with Anchor Carehomes Limited.

The home is registered to provide accommodation and care for up to 47 older people, including people who are living with dementia. On the day of the inspection there were 46 people living at the home. The home is situated in Sheffield, in West Yorkshire. The premises had three floors and each floor had a large lounge / dining room and bedrooms. The ground floor accommodation had easy access to an enclosed garden. The first and second floors of the home were accessed by a passenger lift.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

Although some maintenance certificates were current, the maintenance certificates for the fire alarm system, emergency lighting and the emergency call bell expired in March or April 2016. This had not been identified when health and safety audits had been carried, and meant that there was a lack of assurance that people who lived and worked at the home were protected from the risk of fire, and that the emergency call bell system was fully operational.

This was a breach of Regulation 17 (2)(b) 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at Herries Lodge.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff told us that they were well supported by the registered manager and senior staff group. They confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We checked medication systems and saw that medicines were stored, recorded and administered safely. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home and relatives told us that staff were very caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff, and that staff had a good understanding of people's individual care and support needs. A variety of activities were provided to meet people's individual needs, and people were encouraged to take part. People's family and friends were made welcome at the home.

People told us that they were very happy with the food provided. We observed that people's nutritional needs had been assessed and individual food and drink requirements were met. However, some people told us that the food was, "Not as good as it used to be."

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

Staff, people who lived at the home and a relative told us that the home was well managed. Quality audits undertaken by the registered manager and senior managers were designed to identify that systems at the home were protecting people's safety and well-being. However, when quality audits had identified that improvements needed to be made, more care needed to be taken to record when actions had been completed.

## 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.

The premises had been maintained in a safe condition although some safety certificates had expired.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse. Staff had also received training on how to deal with behaviours that challenged the service.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following the home's policies and procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

### Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge they required to carry out their roles.

People's nutritional needs were assessed and we saw that different meals were prepared to meet people's individual needs. However, some people told us that the quality of the meals had recently deteriorated.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and their advice was followed by staff.

### Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff. Staff were kind, considerate and patient.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

## Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their individual care and support needs and their life history. This helped staff to have an in-depth knowledge of people's needs.

Activities were provided and were flexible to meet the needs of people who lived at the home.

People were encouraged to give feedback about the service they received. There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality audits were being carried out to monitor that staff were providing safe and effective care, although they had not always picked up safety issues.

There was a manager in post who was registered with the Care Quality Commission (CQC), and people told us that the home was well managed. Notifications were being submitted to CQC as required by legislation.

There were opportunities for people's family and friends and health and social care professionals to express their views about the quality of the service provided.

# Herries Lodge

**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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 September 2016 and was unannounced. The inspection was carried out by two adult social care (ASC) inspectors.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authorities who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with four people who lived at the home, one relative, two members of staff, one of the deputy managers and the registered manager. We also 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. Following the day of the inspection we spoke with a further two members of staff.

We looked around communal areas of the home and some bedrooms. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

# Is the service safe?

## Our findings

People who lived at the home told us they felt safe. One person said, "Yes, I feel really safe here and well looked after" and another told us, "I feel safe, I have no worries, and I have a key to my room." Staff described how they kept people safe. Comments included, "We rarely need to use hoists and slings, but if we use them, we check they are safe. We check that walking frames are in good order and that wheelchairs have the foot plates on", "If people are coughing, aspirating or choking we contact the speech and language therapy team, then make sure they have the right type of diet" and "People are safe within key coded doors."

Staff told us that they had completed training on safeguarding adults from abuse, and that they completed refresher training every twelve months. Staff were able to describe different types of abuse, and the action they would take if they became aware of an actual or potential incident of abuse. Staff told us that they would report any concerns to the registered manager or a senior member of staff and were also confident about using the whistle blowing procedure. They were certain they would be listened to and that appropriate action would be taken.

Information about safeguarding adults from abuse was also displayed on the home's notice board so it was available for people who lived at the home and visitors. We checked the folder that contained copies of safeguarding alerts submitted to the local authority and associated notifications submitted to CQC. There had been four safeguarding incidents recorded during 2016. The safeguarding folder included the home's policy and procedure; this was reviewed in April 2016. The forms needed to submit alerts and notifications were stored in the same folder.

We checked the recruitment records for three members of staff, including an apprentice. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. These checks meant that only people who were considered suitable to work with vulnerable adults had been employed at Herries Lodge. However, we discussed with the registered manager how start dates for new employees should be more easily accessible so that this information could be confirmed.

We noted that interview questions and responses had been retained with people's recruitment records. These evidenced that prospective employees were asked about their experience of working with people with a diagnosis of dementia. This gave the registered manager information about the applicant's level of understanding as well as their training needs.

We observed that there were sufficient staff members on duty to enable people's needs to be met. We noted that there was always a staff presence in communal areas of the home and that people did not have to wait for attention. The registered manager told us that the standard staffing levels on day shifts were two team leaders and six care workers. Overnight, there were two team leaders and two care workers on duty. In

addition to this, two care workers started work at 7.00 pm instead of 8.00 pm so that there was an overlap of day and night workers. There were two deputy managers employed at the home, and the registered manager and a deputy manager were on shift in addition to care staff. We checked the staff rotas and saw these staffing levels had been consistently maintained. Most staff absences were covered by permanent staff working additional hours, and the organisation also employed bank staff, so agency staff were not used.

In addition to care staff, there was a cook and an assistant cook on duty each day, two domestic assistants on duty from Monday to Friday, one domestic assistant on duty on Saturdays, a laundry assistant on duty each day and a maintenance person. This meant that care staff were able to concentrate on supporting people who lived at the home.

Staff told us that there were usually enough members of staff on duty. One member of staff said, "Nine times out of ten we have enough staff. We have bank staff and 'flexi' staff who can cover shifts." Staff also said that the registered manager always tried to cover shifts if people went off sick at short notice, and that the registered manager and deputy manager would help out 'on the floor' if it was needed. People who lived at the home said that there were always enough staff to assist them. Comments included, "They are always there when I need them, but I like to be independent", "They are there before you know it. I think they keep an eye out as sometimes I don't even have to press it [the call bell]" and "I never have to wait for attention." A relative told us, "Yes, there are usually enough staff around. I have seen them playing bingo with people this morning."

The registered manager told us that they used a dependency tool to determine staffing levels, as well as the level of risk involved in each person's care. We saw that dependency assessments identified whether people had high, medium or low care and support needs. Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for malnutrition, skin integrity, medication, mobility and the risk of falls. We noted that the falls assessment was scored to identify the person's level of risk and recorded, 'If score 2 or more then please complete the falls prevention plan'. Staff told us that risk assessments were reviewed every 12 months or following any incidents. The risk assessments we saw in care plans had been reviewed on a regular basis to ensure they remained relevant and up to date.

The registered manager told us that none of the people who currently lived at the home required a hoist to be used for transfers, but there was a hoist and slings available should they be needed.

We saw that care plans recorded possible behaviours that might challenge the service, and how staff should manage those behaviours to diffuse such situations. This information was recorded in a positive behaviour support management plan that contained details of the behaviour that could occur, any triggers to the behaviour, strategies for managing the behaviour and the people who should be involved in supporting the person.

Staff told us they had attended training on behaviours that could challenge the service. This was confirmed in the training records we saw, although we noted that some refresher training was overdue. Staff told us that they never used physical restraint at the home and were able to describe some of the diversion techniques they would use. Care plans recorded clear instructions for staff about the use of medication that was used to reduce a person's anxiety; these made it clear that all other ways of calming the person should be tried first, and medication only used as a last resort.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, the passenger lift,

mobility and bath hoists, gas equipment and fire extinguishers. However, there was no current service certificate in place for the fire alarm system, emergency lighting or the emergency call bell. The registered manager assured us that this would be addressed with the organisation's head office.

In-house checks were carried out on window opening restrictors, pressure mats, 'flushing' of water systems to test for the presence of Legionella, wheelchair safety, the emergency call system and pendants, portable electric appliances and thermostatic mixer valves (to check water at wash basins and baths was not too hot). These measures helped to monitor that the premises remained safe for the people who lived and worked at the home.

There was a fire risk assessment in place and this was audited as part of the monthly manager's audit to ensure it remained up to date. In addition to this, there was a daily fire safety checklist in use that monitored whether fire safety checks were up to date. The most recent fire drill had been undertaken in July 2016 and records showed that eight members of staff had been involved.

There was an emergency box in the reception area of the home. This included torches and high visibility vests as well as a 'missing person' form for each person who lived at the home to assist the emergency services should someone go missing from the home. The deputy manager showed us a sample of the organisations personal emergency evacuation plans (PEEP). They had been sent to the home from the organisations head office and were due to be completed on the day following the inspection. There would then be a record of the support each person needed to evacuate the premises in an emergency. The deputy manager told us that they planned to add a code to care plan files as a quick reference to indicate the person's level of risk.

There was a business continuity plan in place that provided staff with advice on the action to take in the event of an emergency such staff shortage, fuel shortage, utility failure and severe weather conditions. There was a checklist that recorded details of alternative accommodation and key contact numbers for staff, health care professionals, contractors and people who used the service. This meant that the service had plans in place to help deal with unexpected emergencies.

People told us that they received the right medication at the right time. One person told us, "They [the staff] are always spot on." We saw that people's care plans recorded a medication assessment, a list of the person's current prescribed medication, the reason the medication had been prescribed, how the person liked to take their medication and a pain assessment. When pain relief medication had been administered, there was a record of the reason it had been administered and a body map recorded where on the body the pain had occurred as well as any other action taken, such as 'Taken into garden for fresh air'.

We observed that medication was appropriately ordered, received, recorded, administered and returned when not used. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Blister packs and medication supplied in boxes or bottles were stored in the medication trolleys for each floor. The trolleys for the ground floor and middle floor were stored in the ground floor clinic room, and the trolley for the top floor was stored in the top floor clinic room. We saw a member of staff administering medication after lunch. They had water and beakers on the trolley so that they could give people a drink to take their medication, and we saw that they only signed the medication administration record (MAR) charts when they had seen people take their medication.

We saw that controlled drugs (CDs) were stored securely. CDs are medicines that require specific storage and recording arrangements. There was a suitable cabinet in place for the storage of CDs and a CD record

book. CDs for the ground and middle floors were stored in a CD cabinet in the ground floor clinic room, and CDs for the top floor were stored in the top floor clinic room. We checked a sample of entries in one of the CD books and the corresponding medication and saw that the records and medication held in the cabinet balanced. We also saw that CDs were audited (usually weekly) to ensure no recording or administration errors had been made.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. We saw that the temperature of the medication fridge and the clinic room was checked to ensure that medication was stored at the correct temperature, although this was not every day as required. Medication that needed to be returned to the pharmacy was stored securely and recorded in a returns book.

We looked at MAR charts and found that they were clear, complete and accurate, although we discussed that more care needed to be taken to ensure that hand written entries on MAR charts were signed by two people to reduce the risk of errors occurring. We also discussed that when medication had been stopped, the name of the person who had given this instruction and the date should be recorded on the MAR chart. There was a separate sheet included with MAR charts that recorded any known allergies, how the person liked to take their medication and 'alerts', such as the person's diagnosis of dementia. There were specific instructions for people who had been prescribed Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. Any protocols for 'as and when required' (PRN) medication were clearly recorded. Each cream was recorded on a separate topical administration chart; these were accompanied by body maps to show where on the body each cream should be applied.

A laminated sheet included details of people who required their medication to be administered at times other than the 'usual' times of medication rounds, and those people who required medication to be administered once a week. This acted as a good reminder for staff, as not everyone's medication was prescribed for the same day of the week.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. There were notices displayed in medication rooms that demonstrated good practice guidance, such as a list of common drugs and brand names, pressure ulcer classification, the use of pain relief patches and suggested expiry dates of products prescribed.

Only senior staff and staff who had completed medication training had responsibility for the administration of medication. The training records shown to us by the registered manager did not include information about medication training. However, evidence of this was sent to us on the day following the inspection. This showed that ten staff had completed Advanced Care of Medication training at Level 3. We did not see any records to evidence that medication competency checks were carried out with staff who administered medication.

We checked the accident records in place at the home. We saw that these recorded appropriate information about the accident or incident and that they were audited each month to identify whether any patterns were emerging or whether any further action needed to be taken. Accidents were also recorded in individual care plans.

The home was maintained in a clean and hygienic condition. We saw that the home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

# Is the service effective?

## Our findings

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 MCA 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the details of one DoLS application that had been authorised. The registered manager was still waiting for authorisation for other applications that had been submitted.

The training record showed that most staff had completed training on MCA / DoLS. This was confirmed by staff, who described this as 'basic' training. Staff who we spoke with understood the basic principles of the MCA and DoLS and told us, "We would be guided by the team leaders and deputies."

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that recorded people's consent to their care provision. In one instance a relative had signed this consent form on the person's behalf because they acted as the person's Power of Attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. However, we saw that not all consent forms had been completed and that some consent forms had been signed by a relative when there was no evidence they were the person's POA. The registered manager assured us that they would check with all relatives who had POA whether this was for health and welfare or finances, and record this information in the person's care plan. They said they would also ensure that only relatives who had POA for health and welfare were invited to sign consent forms.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "I keep things as simple as possible. I don't show people five outfits to choose from, just two. I show people different meals, not just give verbal explanations." Staff told us about best interest meetings that had been held or were planned to help people make a decision about permanent residential care. One person's care plan included information about a best interest decision; the person concerned, their GP and a relative had been consulted.

Staff carried out induction training when they were new in post. Staff told us they also shadowed an experienced member of staff (their 'buddy') for a week as part of their induction training. The registered manager told us that new members of care staff had commenced the Care Certificate; there were currently four members of staff working on this programme. The Care Certificate was introduced by Skills for Care,

and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

We checked the home's training record and this showed that the organisation considered essential training to be fire safety, food safety, moving and handling, falls awareness, emergency first aid, health and safety, safeguarding vulnerable adults from abuse, MCA / DoLS, dementia awareness and challenging behaviours. Records showed that most staff had completed this training, although some refresher training was overdue, including challenging behaviour, dementia awareness and first aid. Some of this training was booked for September and October 2016. The staff who we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. They told us they had attended "Lots of refresher training during the last year, including food safety and health and safety."

Some staff were 'learning coordinators' and others had completed a 'Train the Trainer' course and had a role in ensuring staff had completed the training that was considered to be essential by the organisation. In addition to this, 16 care staff had achieved a National Vocational Qualification (NVQ) at Level 2 and 11 staff had achieved this award at Level 3. The registered manager and one other member of staff had achieved a Level 4 award.

Staff told us that they had supervision meetings with the registered manager or deputy manager. They told us they felt well supported by the management team. One member of care staff told us, "I am listened to. My manager's door is open at all times."

Any contact with health care professionals was recorded in people's care plans, including the reason for the visit and the outcome. We saw that advice received from health care professionals had been incorporated into people's care plans. Any communication from NHS departments was retained with people's care records so that it was available for staff. We saw that some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms in place and that these had been signed appropriately by their GP.

A member of staff told us that the GP routinely visited the home each Wednesday, and this was when they saw people whose needs were not urgent. They would ring the GP outside of this time if they felt the person needed medical attention sooner. People told us that they could see their GP whenever they needed to. One person told us, "The GP is coming out today to see me." None of the people living at the home currently required assistance with pressure area care and none were being supported by a district nurse to administer insulin, although some people were being supported to have dressings renewed. One relative told us that their family member's health had improved greatly since they had moved into the home. They also said that staff had noticed that their family member was having difficulty swallowing and had contacted the relevant health care professionals, and that they were now on a soft diet.

We saw that people's nutritional requirements were recorded in their care plan; this included any special dietary requirements to meet health care needs and their likes and dislikes. However, they said that meals were not as good as they used to be. One person told us, "I have a cooked breakfast six mornings a week. I don't have one on a Sunday as we have a roast dinner." Another person said they were "Getting fed up of sandwiches at tea time". This was acknowledged by the registered manager who told us that they were currently working with reduced catering hours and other staff were helping to cover these shifts.

We observed the serving of lunch in two of the three dining rooms. Heated trolleys were brought to the lounge / dining areas from the home's kitchen. We noted that staff created a pleasant atmosphere and encouraged people to chat to each other. When everyone's meal had been served, staff prepared themselves a meal and sat with people in the dining room, chatting to them. They all sat with a different

group of people. Tables were set with cutlery, napkins, condiments and a glass. People were given a choice of orange or blackcurrant juice; one person asked for lemonade instead and this was provided. People were also given a choice of main course; one person was uncertain about both of the choices on offer and we saw that staff offered them a choice of an omelette or jacket potato. Another person asked for toast and this was provided. People were asked about portion sizes and which vegetables they would like. Meals were described to people rather than being shown to them. We discussed with the registered manager how it might have been easier for people to understand the choices if the meal had been shown to them, and this was acknowledged. The registered manager told us that a new menu system was due to be introduced that included a printed A5 menu, a smaller menu to be placed on each table and a sample of each meal that could be shown to people to help them make a decision about which choice to make.

We saw that people were able to eat at their own pace and when they had finished their meal, staff asked them if they had enjoyed their meal and if they would like any more. Staff gently encouraged people who were reluctant to eat. However, we also noted in one dining room that some people were eating their meal for a long time due to their frailty and that it was probably cold and unappetising. We discussed with the registered manager that they needed to consider ways of ensuring people's meals remained at the right temperature to eat.

People were accommodated in single rooms, and each room had an en-suite toilet and shower. In addition to this, there were one or two bathrooms on each floor. People living with dementia were accommodated on the ground floor, meaning they had easy access to a secure garden area. The garden included various seating areas so that people could rest whilst they were using the garden. Bedroom doors were painted in different colours to look like 'front' doors, and there was a picture board that included the person's name. This was to help people locate their own room. Carpets and walls were plain and handrails were easy to identify, and corridors were wide and easy to negotiate.

Staff had received training on working with people who were living with dementia. As part of this training it had been recognised that structural changes were needed to the lounge area on the middle floor, as the current layout created a barrier to free movement. This showed that consideration had been given to the suitability of the premises for people who were living with dementia.

Good

# Is the service caring?

## Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Comments included, "Staff are marvellous. Everything is thought about", "Staff are kind and considerate", "They [the staff] are all lovely" and "They are a lovely bunch of people." One relative told us, "Staff genuinely care – some more than others. They try to do the right thing" and "Staff seem to be the right kind of people to do the job." They mentioned one member of staff in particular who they described as "A joy." They told us they had seen this staff member walking and singing with a person who was anxious and said that the person's demeanour changed as a result.

People who lived at the home told us that staff were kind, patient and compassionate. We noted that when staff asked people questions, they were patient when waiting for a response. We saw positive interactions between people who lived at the home and staff on the day of the inspection, and this was confirmed by the Short Observational Framework for Inspection (SOFI) that we carried out. We noted that people were comfortable in the presence of staff, and that staff were polite and sensitive to people's needs.

Staff told us that they believed care workers and other staff genuinely cared about people who lived at the home. One member of staff said, "It would soon be picked up if someone was not right for the job. New staff do the Care Certificate and they have a mentor. We have a yearly assessment that looks at our person-centred approach." Another member of staff told us, "We are a good team. Staff give 100% - we know what we are here for."

The registered manager told us that they had previously appointed dignity champions but that this role had now been changed to dementia champion. A dementia champion's role is to take a special interest in the topic of dementia and to promote good practice within the staff group. Staff had recently won an award from Anchor for the use of dementia / dignity champions, training on dementia awareness and improvements that had been made to the environment to make it more suitable for people who were living with dementia.

There were areas of the home where people could see their visitors in private. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. Staff told us that they respected people's privacy when they were assisting them with personal care, such as making sure doors were closed, leaving people alone for a short while to have some privacy and by covering people up when they were undressed. One member of staff said, "I put a towel around them as soon as they get out of the bath. I chat to them to make it informal. It's always on a one to one basis." Care plans recorded the person's preferred name and whether or not the person preferred to be assisted with personal care by a care worker of the same gender.

There were two leaflets on display about advocacy. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. One leaflet informed people about the NHS Complaints Advocacy service for Sheffield and another informed people about the Independent Mental Capacity Advocacy (IMCA) service. IMCA's offer an advocacy service

for people who lack capacity to make decisions for themselves. There was also information displayed on notice boards to inform people about the home's policies on privacy, complaints and safeguarding adults from abuse, and information welcoming feedback from people who lived at the home and their visitors.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve. One person told us, "I like using my own shower. I can have one whenever I like although staff help me if I need it." Another person said, "I am getting forgetful. The staff help me remember and prompt me when I flag." A relative told us that their family member had previously lived in another care home, and that a wheelchair had been used to move them around the home. Since moving to Herries Lodge, staff had spent time with their family member encouraging independence, and their mobility had improved. They added that their relative was also encouraged to take part in social activities such as coffee mornings.

We asked people if there were any restrictions on their life and they all told us there were none. One person said, "Staff encourage me to be independent. I can't go out alone but I don't wish to. I can go where I like within the home" and "The only restrictions are those caused by my health condition."

Good

# Is the service responsive?

## Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included mobility, nutrition, maintaining independence, continence, sleep / rest, communication, medication and emotional / psychological care. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, a MCA assessment and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

Care plans were very person-centred. Each person's care records included information about their GP, their medical conditions, their current medication and any current physical or mental health care concerns. Care records also included a document called 'My Life Story' which contained the headings 'All about my life', 'My life now' and 'My life going forward'. We noted that some of these documents had not been fully completed. Care plans were written in the first person. For example, 'I can eat independently with a knife and fork and I can make my needs known if I am hungry or thirsty' and 'I can say if I am worried or don't feel safe'. GPs had provided medical care plans to be included in the home's care plan.

The mobility section of people's care plans recorded any equipment that needed to be used to move the person safely, and the number of staff that needed to be involved in any transfers. We also noted that people's mobility was linked to their health conditions, to their prescribed medication and to their diagnosis of dementia, demonstrating that staff did not look at a person's mobility in isolation. One person's care plan recorded that they liked to remain in bed until lunchtime. However, staff were advised to encourage this person to get up earlier, as it was recognised that staying in bed late had an impact on the person's nutrition that could lead to weight loss. Staff told us that these changes were introduced gradually and with the person's consent.

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information, and more formal reviews were held six monthly. Records evidenced that the person and their relatives were invited to the care plan review and that any changes in the person's care needs were discussed and recorded. A relative told us that they had been invited to care plan reviews. They told us that they were able to review the plan and give some feedback on the content.

We asked staff how they got to know about people's individual needs. They told us that they were encouraged to read care plans, especially if they were the person's key worker. One member of staff said, "We try to have a good relationship with families as this helps us to get to know the person well." Another member of staff told us, "We try to get groups of residents together to chat. We would add any new information we found out about to the person's care plan. We also ask families." Some relatives had completed a family history (including photographs) of their family member and these provided excellent information for staff about the person's previous life history and lifestyle. We were told that, although care workers tended to 'move around', team leaders usually worked on the same floor of the home. This helped

them to get to know people and provided consistency for people who lived at the home.

We saw that people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some women were wearing makeup and jewellery. One person told us, "I have done this all my life so I don't want to change now."

We saw the 'handover' sheet that was used by staff to pass information from one shift to the next. This included the names of staff working on each floor of the home, domestic / laundry staff on duty, details of any hospital or GP visits and any accidents or incidents that had occurred during the day or night.

A relative who we spoke with confirmed they felt there was good communication between themselves and staff at the home. They said they were always kept informed about any events that involved their family member. They also told us that they could visit the home at any time and were made to feel welcome. This was confirmed by the people who lived at the home who we spoke with. One person who lived at the home told us, "I get lots of visitors."

We saw that people had a social activities care plan in place that recorded their hobbies and interests, past and present. This meant that staff knew how people might like to spend their day. There were pleasant gardens for people to use and we saw that some people sat outside for part of the day. There was a cinema room where film nights were held, and there was a hairdressing salon; a hairdresser visited the home on Mondays and Fridays.

There was no activities coordinator working at the home; the registered manager told us that activities were part of a care workers role. On the day of the inspection we saw that some people were playing card games, some people were watching TV and some people attended an in-house coffee morning and sing-along organised by the staff on duty. Twiddle muffs had been provided for people who were living with dementia to help keep them occupied. People living with dementia can find comfort in repetitive sensory stimulation and twiddle muffs provide 'entertainment for restless hands'. We saw that people were able to walk around the home uninterrupted and go to their bedrooms to relax if that is what they preferred.

The complaints policy and procedure was displayed around the home and we noted this was also available in large print so that it was easier for people to read. Complaints were recorded in the quality assurance folder. There were two complaints recorded in July 2016. One complaint was about the quality of the food and the registered manager had recorded that a new menu had been introduced. The other complaint was about cleanliness of the home and this had been passed to the housekeeping team to deal with. On the day of this inspection we saw that the home was clean and had been maintained in a hygienic condition. In August 2016 a complaint had been received from a relative who wished their family member to spend more time outdoors. The person's care plan had been updated and we were told that this person now spent time outdoors. We saw several people using the outside space on the day of the inspection. There was a record indicating that a response had been sent to the complainant, but there was no copy of a response letter to evidence this. However, we felt that complaints had been listened to and that on occasions they had led to improvements in the service.

People who lived at the home told us that they felt able to express their concerns. One person said, "You can talk to any of them" and another told us, "Yes, any of them would help me sort things out." Staff told us that, if someone complained to them, they would try to rectify the situation. However, if the complaint was more serious they would pass it to the registered manager, or even to the safeguarding adult's team. They were confident people's complaints were listened to and dealt with.

We saw that meetings were held for people who lived at the home and relatives; the most recent meeting had been in April 2016. Topics discussed included meal times; it was decided that these should be 1.00 pm and 5.00 pm and on the day of the inspection we saw that this had been introduced. Menu changes were also discussed. These meetings gave people and their relatives an opportunity to express their views, make suggestions and ask questions about care provision. Relatives told us that there was a relatives committee that they were invited to, and that they were also invited to social events and 'fund raisers'.

Requires Improvement

# Is the service well-led?

## Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

A monthly safety checklist recorded the regular checks that were made to monitor the home's safety; this included accidents, falls, bed rails, pressure areas, infections control, weight loss and safeguarding. The weight audit carried out in August 2016 had resulted in one person being referred to the speech and language therapy (SALT) team. Their advice was for snacks to be encouraged and supplements to be prescribed. However, there was no current service certificate in place for the fire alarm system, emergency lighting or the emergency call bell. The previous service certificates for the emergency call bell and emergency lighting expired in March 2016 and the service certificate for the fire alarm system expired in April 2016. this had not been identified when health and safety audits had been carried out. This meant that there was a lack of assurance that these systems were working effectively to protect the safety of the people who lived and worked at the home.

This was a breach of Regulation 17 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff described the culture of the home as "Friendly", "Open", "Inclusive and not cliquey", "One of the best", "Caring" and "One big family." They told us that staff would learn from any accidents, complaints or incidents as they would talk about the issues and how they could make sure they did not occur again. One member of staff said, "We would talk about this at handovers etc."

People who lived at the home and a relative knew who the registered manager was and told us they could approach them to talk about any problems they might have. We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that they all responded well. One relative said, "The manager is good at 'banter' and she sees the real person." Staff told us that there was good management and leadership at the home. Comments included, "We have a good manager, and a good team of deputies / team leaders", "Everyone knows what needs to be done – the home runs smoothly" and "I believe the home is well-led. I am confident in the abilities of the manager."

We saw that there was a quality assurance system in place that included surveys, audits and meetings. Audits were carried out in-house and also by a manager from the organisation's head office. We saw details of the management audit that was carried out in July 2016. This recorded areas that had been identified as requiring improvement with target dates in place. We saw that the registered manager had recorded when these actions had been completed.

A medication audit had been carried out in August 2016 on the top floor of the home. This recorded some action points, such as the lack of self-medication audits, missing signatures and a missing MAR chart for one medication. Although the registered manager was able to tell us about the action taken following this audit, there was no written record. However, further training had been booked on 20 September 2016 for staff who administered medication. The medication audit undertaken on the ground floor in August 2016 had not identified any errors. Care plan audits were also taking place. The audit for August 2016 recorded some missing information but there was no record of the action that had been taken to bring the care plans up to date. Other areas audited included mattresses and pillows, safeguarding and the 'dementia environment'. This meant that there was insufficient evidence to demonstrate that identified shortfalls had been actioned.

There was a feedback form on display within the home that stated 'We welcome your feedback'. This invited people to share their views about the care home and included a 'freepost' envelope so that it could either be handed to staff or posted to the organisation. There was a notice displayed in the passenger lift and on a notice board in the reception area that stated, 'Meet our resident committee board'. This showed that people who lived at the home were involved in decision making about how the home was operated.

A satisfaction survey had been distributed to staff by the organisation's headquarters during 2016 and the responses had been collated. The outcome had been recorded as 'Three things that are working well' (New care plans, supporting in respect of the company changing and more activities for residents) and 'Things we need to focus on' (Marketing, training and development and staff performance). The document recorded that improvements would be achieved by 'sending leaflets to local areas', 'paying staff to attend e-learning' and 'planning training for staff'.

Staff meetings were held on a regular basis. There were meetings for the full staff group and meetings for specific groups of staff such as senior staff, night staff and kitchen staff. Following the recent staff meeting the management team had produced a "What you said / what we did" document. This informed staff what action could and could not be taken. For example, staff had suggested that shifts could change from 8am until 8pm to 7am until 7pm. The management team explained this could not be changed, as staff were contracted to work from 8am until 8pm. Other suggestions had been acted on, such as introducing 'food stations' and action in respect of the cleanliness of the home. The minutes of these meetings showed that the topics of documentation, training, a recent quality assurance visit and a pharmacy inspection were discussed. Staff were informed of the improvements that had been suggested by the pharmacist. Most staff told us that these were 'two-way' meetings where they could express their views, make suggestions and discuss issues. However, some staff expressed concerns about confidentiality and information 'spreading amongst the staff group'. This was also raised as a concern in a satisfaction survey.

The most recent kitchen staff meeting was held in May 2016. Topics discussed included food safety e-learning, complaints about food provision and that the standard of meals provided for people on a soft diet were not acceptable. Topics discussed at the night staff meeting in April 2016 included deployment of staff, cleaning schedules, giving pain relief creams on time and missing signatures on MAR charts. The most recent senior staff meeting was in May 2016. Staff discussed new menus, a food and hydration station, care plans, safeguarding and annual leave. The manager had also visited the home during the night as a 'spot

check' as they did not usually see staff working during the 8pm to 8am shift.

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 17 HSCA RA Regulations 2014 Good governance<br><br>Quality audits undertaken by the registered provider had not highlighted that some safety certificates had expired, so not all risks had been mitigated.<br>Regulation 17 (2)(b). |