Care Quality Commission

Runwood Homes Limited

Humfrey Lodge

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 3 February 2016 and was unannounced.

Humfrey Lodge provides accommodation and personal care support to 48 people including people living with dementia. On the day of our inspection there were 48 people living at the service.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had systems in place and staff trained in identifying acts of abuse and steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern.

There was ineffective systems in place to audit, risk assess and protect people from the risk of cross infection. The provider failed to maintain standards of hygiene

Summary of findings

appropriate for the purposes for which the premises were being used in line with current legislation as described in the Department of Health prevention and control of infections in residential care settings.

The provider had established and operated effective procedures for the management of people's medicines.

The provider had followed staff recruitment processes to reduce the risk of employing unsuitable staff. Staff were supported with regular supervision and staff meetings. Staff worked well as a team, and had a good relationship with the manager, who worked hands on shift alongside staff. However, there were insufficient numbers of staff employed and available at all times to meet people's needs. This put people at risk of not having their care and treatment needs met.

The provider did not act in accordance with the Mental Capacity Act 2005 and associated code of practice in failing to take steps where people lacked capacity to make an informed decision, or give consent to their care and treatment.

Further work was needed to ensure people were involved in the planning and review of their care. Care plans did not include assessment of individual's wishes and preferences regarding their preferred day and night time routines. Staff did not have easy access to risk assessments and this meant they were not provided with recorded guidance to refer to with details of action they should take to mitigate risks to people's health, welfare and safety.

Steps had not been taken by the provider to make sure that people were supported to receive adequate nutrition and hydration, and that people at risk were monitored and had access to specialist advice.

Staff received training, supervision and support to provide them with the knowledge and skills they needed to meet the needs of people living at the service. However, e-learning training to support staff with the required knowledge in understanding the needs of and supporting people living with dementia was insufficient.

During this inspection we identified a number of breaches 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe because there was ineffective systems in place to audit, risk assess and protect people from the risk of cross infection. The provider failed to maintain standards of hygiene appropriate for the purposes for which the premises were being used in line with current legislation.

Risks to people's safety had been assessed, however these were not easily available for staff to access and risks to people were not effectively managed and reviewed.

The provider had established and operated effective procedures for the recruitment of staff and the management of people's medicines.

Is the service effective?

Requires improvement

The service was not consistently effective. Although the registered manager knew how to make an application for consideration to the local safeguarding authority to deprive a person of their liberty, they had not always followed the requirements of the law in considering the protection of people's human rights.

Steps had not been taken by the provider to make sure that people were supported to receive adequate nutrition and hydration and that people at risk of losing weight were monitored and had access to specialist advice.

Is the service caring?

Requires improvement

The service was not consistently caring as interactions between staff and people were in the main task focused.

People's personal property had not always been protected, respected and stored appropriately.

People's privacy and dignity was maintained in supporting people with their personal care.

Is the service responsive?

Requires improvement

The service was not consistently responsive. People and their relative's told us that they had been involved in the initial assessment of their care and support needs. However, they also told us they had not been involved in any review of their care plan and had never seen a copy of their care plan.

Staff did not have easy access to care plans including risk assessments in order to deliver people's care and treatment in a way that met their needs and kept them safe.

Summary of findings

Is the service well-led?

The service was not consistently well led because there were ineffective governance systems in place to regularly assess, monitor and mitigate risks relating to the health, welfare and safety of service users.

Staff were in the main positive about the manager but did not have confidence in the overall leadership of the service. They were provided with regular supervision and annual appraisals.

Requires improvement

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

This inspection took place on the 3 February 2016 and was unannounced.

This inspection was carried out by two inspectors 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. The Expert by Experience had experience of providing care and support for an older person.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During and following our inspection we spoke with health and social care professionals. We also reviewed information available to us about the service, such as statutory notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information of concern received prior to our inspection regarding staffing levels provided and concerns regarding the cleanliness of the service.

We spoke with eight people who were able to verbally express their views about the quality of the service they received and ten people's relatives and friends. We observed the care and support provided to people and the interactions between staff and people throughout our inspection. We carried out observations of the interactions between staff and the people who lived at the service. We also used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six members of care staff, the cook, maintenance staff, one domestic staff, the activities coordinator, deputy manager, the visiting dementia care manager, the registered manager and the regional director.

We reviewed care records for five people and examined daily care records for a further four people. We also reviewed records in relation to medicines management, staff rotas, staff training, staff recruitment and other care records related to the quality and safety monitoring of the service.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information of concern that staffing levels were insufficient to meet the needs of people. Our findings at this inspection did not reassure us that there were sufficient numbers of skilled staff, available to provide the care and support that people needed.

People told us, "There are not enough staff around when you need help. I can't move myself and there are not enough staff to help me when I need them. I don't like to ask and be a nuisance", "The staff are all very kind but they have a lot to do" and "The lack of staff is the biggest problem here. There are not enough staff and the young people they recruit don't stay."

Visiting relatives expressed their concerns to us that staffing levels did not always provide the care they wanted for their family member. One relative said, "Sometimes [my relative] has had to wait for 15 to 20 minutes for someone to come when they call for help. Although once you point it out to them they come straight away but we are not always here to do that." Another said, "Sometimes you can see the home is low on staff. They come promptly when we have made them aware our [relative] needs help, but staff need to check up on people more often to check they are OK especially when they are in bed for a long time."

Staff told us there was not enough staff available and this had been an ongoing problem for some time. They told us, "There is not enough staff. We work hard but do not have the time to spend with people as they would like us to. We cannot always answer the buzzers when people want help to the toilet. You can't be in more than one place at a time", "We have had new staff start and leave in the same week. They say it's too hard here and complained about the level of care needed and the lack of staff. We are a good caring team and we just do the best we can" and "There should be at least six care staff on duty and we only had four people one day last week, you have no choice but just have to do your best. We regularly work short of staff. The owners don't like us to use agency staff as it is too expensive, but it's just not fair on people who live here." The shortages of staff on the days staff told us about were confirmed from discussions with senior staff and the staffing rotas we reviewed.

We observed staffing levels during our inspection to see if there was sufficient staff to keep people safe and to meet their care and support needs. We asked staff about people's dependency levels and were told there was 18 people who required two care staff members at any one time to support them with mobilising and personal care. There were six members of care staff and staffing levels dropped to five for late shifts and three for the night shift.

We saw that staff were busy and sometimes rushed throughout the day and that care was not always delivered in a timely manner and not always according to individual's needs and preference. We observed call bells were not responded to in a timely manner and were left to ring on several occasions.

During the meal time we observed people, who needed support to eat, were left with their meal in their room untouched until staff were able to support them. One person was left with their meal which had gone cold and was untouched. We informed staff of this. They told us they were supporting another person and unable to attend. Visiting health professionals told us that, on occasion, they had observed people crying out for staff to support them with their personal care for significant periods of time, without a response from staff. No help was forthcoming until the health staff managed to locate staff to alert them to people's request for support.

We asked the manager and the regional director how staffing levels were determined to meet the assessed needs of people who used the service. They told us that the provider used a nationally recognised dependency tool. This tool did not take into account the number of people who required two staff at any one time to double to support people in the use of a hoist when mobilising and also the layout of the building which consisted of four individual units. This presented a challenge given the staffing numbers allocated to each unit. The current allocation of staff for the morning shift was five care staff with one additional staff member to support across all the units. The afternoon shift consisted of one less member of staff. It was evident that with the current staffing levels and the dependency needs of people it was not possible to ensure that staff were available as and when people needed their support on each unit. The registered manager told us they had recently assessed a need to increase staffing levels to at least seven staff on the morning shift and although this increase had been agreed by the provider it had not been implemented.

Inadequate

Is the service safe?

The registered manager told us that they and the deputy manager regularly had to work shifts to cover shortages on the rota. This impacted on their ability to carry out their management delegated tasks. They also said they had experienced difficulties in trying to recruit and retain permanent staff with currently a vacancy of 114 staffing hours. They also told us that four staff recently recruited had stayed for only one week. Interviews had been planned to fill staff vacancies within the next month.

As well as providing care to people, we saw that staff were required to carry out additional tasks such as washing up by hand on their unit after each meal as well as being required to serve the tea time meal. Staff told us they had repeatedly requested the provision of dishwashers on each unit to enable them to have more time to provide people with care rather than spending their time with domestic tasks.

The manager told us that domestic staff took responsibility to wash up after meals. However, it was evident from our observations that there was insufficient numbers of domestic staff available to support on each unit and we saw that care staff carried out the washing up tasks.

We were not assured that the provider had taken action to do all that is reasonably practicable to ensure they employed sufficient numbers of suitably qualified staff to be available at all times to meet people's care and treatment needs. We discussed our concerns with the registered manager and the regional director. They told us they would review our findings.

This demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety had been assessed. Risk assessments had been personalised to each individual and covered areas such as moving and handling, management of people's medicines as well as the assessment of environmental risks to prevent falls. However, care plans including risk assessments were locked away in a room which staff did not have access to unless they asked the manager to unlock the door.

None of the staff we spoke with had seen any of the care plans, including risk assessments for the people whose care plans we reviewed. We noted that for one person where staff had referred in their daily notes to their presenting behaviour as, 'violent' and 'aggressive' staff told us they had not been provided with any written guidance in how to respond to this person when they presented with distressed reactions to situations and others. As care plans were not easily accessible to staff, including agency staff who were not familiar with people's care needs. This had the potential to put people who used the service and others at risk. We discussed this with the manager who told us that staff could ask to see care plans should they wish to do so. However, it is the manager and providers that are responsible for ensuring staff are familiar with people's care plans. We were not assured that the provider had taken steps to provide staff with easy access to written guidance with actions they should take to mitigate risks to people's health, welfare and safety.

This demonstrated a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received information from a variety of sources who told us that the premises and equipment were not kept clean and the environment free from odours. Concerns included a lack of cleaning of the environment, care staff having to hand wash crockery and cutlery after meals due to a lack of dishwashers and inadequate numbers of domestic staff available to support staff in carrying out these tasks.

We found during our inspection that there was personal protective equipment available for staff use, and cleaning schedules in place for staff to record when they had carried out specific cleaning tasks. The main kitchen was clean and systems were in place to evidence health and safety checks had been carried out to prevent the risk of infection and to help keep people free from harm. However, we found standards of cleanliness throughout the rest of the environment woefully lacking. Although staff had signed to say they had cleaned designated areas of the service, we found these areas in an unhygienic condition. There was a strong odour throughout the service, in some areas worse than others. Unit fridges were found to be dirty and it was evident they had not been cleaned for some time. Food and drink stored in fridges was not all dated when opened. Microwaves, cupboards and drawers where food, cutlery and crockery were stored, including food and drink containers, were found to be unclean. One microwave had a plate of food left in it. When asked, staff did not know how long this plate of food had been there. Draining board

Inadequate

Is the service safe?

crockery holders on every one of the units were found to be encrusted with lime scale and grime which presented as a hoarding place for bacteria to develop and put people at risk of cross infection.

Bathrooms were found with vinyl flooring which was stained and difficult to clean in some areas as the flooring was in a state of disrepair. Carpets and soft furniture were found to be soiled and stained throughout and some furniture in need of replacement. Staff and the manager told us there was an ongoing problem with roof sky lights leaking and we saw that flooring and baths had been stained as a result. We discussed our concerns with the registered manager and the regional care director.

This demonstrated a breach of Regulation 15 (1)(a)(c)(d)(e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place and staff were trained in identifying acts of abuse and what steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern.

Alongside senior staff, we looked at systems and processes in place for the management of people's medicines. We checked medicine administration records (MAR) and checked balances of stock against these records. We found that the provider operated an effective system which monitored the management of people's medicines on a daily, weekly and monthly basis which included an audit of medication stocks and records of people's medicines. This meant that there was a system in place to identify any medication administration errors in a timely manner.

Staff told us they had received training in the management and handling of people's medicines via e-learning.

We looked at the staff recruitment records for four staff appointed within the last 12 months. Recruitment records showed that the provider had carried out a number of checks on staff before they were employed. These included checking their identification, health, conduct during previous employment and checks to make sure that they were safe to work with older adults. We were therefore satisfied that the provider had established and operated recruitment procedures effectively to ensure that staff employed were competent and had the skills necessary for the work they were employed to perform.

Requires improvement

Is the service effective?

Our findings

Staff told us that they had good access to e-learning training and we saw that the manager used a spreadsheet to monitor overall attendance on the training in key areas. A newly appointed member of staff told us about their induction training, which included opportunities to shadow more experienced staff for three days so that they could get to know the care and support needs of the people who used the service.

Despite staff attending training, some people's needs were not always consistently met by skilled staff, and training was not always put into practice. For example, some staff demonstrated a lack of understanding about the needs of people with dementia who presented with distressed reactions to situations or others. Neither were they familiar with what strategies could be used to de-escalate incidents we saw described in daily care notes. Care plans did not always provide staff with guidance including de-escalation techniques describing actions they should take to support people safely. All the staff we spoke with told us they had not read any care plans as they did not have easy access to them as they were locked away.

Staff told us that although they had been provided with e-learning training in supporting people living with dementia, they found this limited. They said they would value more interactive training which would enable them to discuss case scenarios and ideas for supporting people appropriately. For example, with demonstrated de-escalation techniques to diffuse situations and protect people from the risk of harm.

Visiting relatives told us, "The less experienced carers do not always recognise the signs that [my relative] with dementia has needed to go to the toilet until more experienced staff have intervened." Another told us, "There are some staff who I believe would not know if [my relative] was in pain and there is a signal which tells you when they need to go to the bathroom, I'm not sure that all the staff would know to respond to this."

We observed a high number of people's rooms had a gate in place within their door way. We asked the registered manager why these were in situ. They told us that they had been in place since before they came to work at the service but believed that for some people they had been placed at the request of relatives to stop other people entering rooms uninvited. We noted that where in use, people's care plans did not evidence any assessment of risk and neither that people had been consulted as to their wishes and choices regarding their use. We were not assured that the informed consent of individuals had been obtained, and neither if any consideration as to a potential deprivation of a person's liberty to move around the service freely was considered and regularly reviewed.

The manager had a good understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and demonstrated an awareness of the requirement to assess people's capacity to consent to their care and treatment and to consider people's best interests when supporting them to make decisions. However, staff were less clear. They had been provided with e-learning training on the subject, but did not feel fully confident with regard to understanding their roles and responsibilities and were in some cases confused as to what action they should take to comply with the law if they believed a person had been deprived of their liberty in relation to compliance with the Deprivation of Liberty Safeguards (DoLS).

Although the registered manager knew how to make an application for consideration to the local safeguarding authority to deprive a person of their liberty, we found that the provider had not always followed the requirements of the law in considering the protection of people's human rights. For example, one person we observed to be isolated in their room, appeared restless, trying to sit up to eat their meal with bed rails in situ. When we asked staff to support this person to sit up to eat their meal, they told us they could not raise the head of the bed as this person would try to climb out of bed over the bed rails. Staff also confirmed this person received 24 hour bed care and did not get up out of bed. When asked why this person was in bed all the time, given that they did not require palliative care or have any other medical need requiring bed care, care staff and the registered manager told us this person was at risk of falls and to protect them from harm a decision had been made to support them with bed care. We reviewed this person's care plan and noted that there was no evidence that this person's capacity to consent to the use of bed rails and to their confinement to bed had been considered. The registered manager confirmed that this person did not have capacity to consent to their care and treatment and that no action had been taken to refer to the local safeguarding authority any urgent request for authorisation

to deprive this person of their liberty. This meant that this person's best interests had not been established and acted on in accordance with the requirements of the MCA 2005 and associated code of practice.

This demonstrated a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments in relation to the quality of the food provided was positive. Comments included, "The food is lovely", "I think the food is very good indeed" and "The chef is great they come and ask you what you like and if you have enjoyed your meal." Our observations were that people were offered regular drinks and the midday meal served looked appetising. Comments from relatives were less positive., Comments included, "What is on the menu is not always what is provided and they don't tell you it has changed." and "There is a lack of choice for the tea time meal. It is always soup and sandwiches." This was confirmed by staff who told us, "The majority of tea time meals are soup and sandwiches. They can also have beans but there is no one to cook a meal at tea time. It is up to staff to serve the meal. We don't have time to cook as well."

We observed the midday meal. The menus placed on tables did not reflect what was actually served. One person asked what was for pudding. They were told by staff that it was Bakewell pudding when in fact apple sponge was served.

The cook had a good knowledge of people who required specialised diets. For example, people diagnosed with diabetes and food intolerances.

We observed people who were supported by staff to eat their meal in a sensitive manner. Staff sat at eye level and chatted to the person throughout the meal. Whilst other people were left with their meal to go cold without assistance from staff in a timely manner. In response to concerns regarding one person without assistance staff told us, I am too busy to attend to more than one person at a time."

People who had risks associated with poor fluid and food intake had 'food and fluid' charts completed to monitor their daily intake with daily fluid intake totalled up at the end of the day. However, where people had not received sufficient fluid intake for the day there was no record of what action had been taken in response to this. Records did not accurately reflect what people at risk had consumed. We found staff completed food and fluid charts later in the day and

records we looked at showed people had eaten meals that we knew they had not eaten.

Malnutrition screening assessments were not always completed on a monthly basis as per the provider's policy. We found that there was insufficient assessment and planning to meet the needs of people at risk of an inadequate nutritional intake. Nutrition screening tools were used to assess people who may be at risk of inadequate nutrition and fluid intake and to monitor their weight. We noted that in response to these assessments where risk had been identified. Not all care plans contained actions for staff to take in mitigating risks. Where two people had been assessed as at risk of losing weight and consequently at risk of malnutrition staff had recorded that these people required weekly weighs. We found that weekly weighs had not been actioned and no weights had been redcorded for everyone since December 2015. We also noted for one person who had been losing weight, staff ha recorded in their care plan to refer this person for specialist advice from a dietician. We asked senior staff if this had been actioned and we were told this had not. We were not assured that action had been taken to regularly review people's nutrition and hydration needs and that action would be taken without delay to address these concerns and mitigate risks to people from inadequate nutrition and fluid intake.

This demonstrated a breach of Regulation 14 (1)(2)(4)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they saw other healthcare professionals when required. Records showed that GP's and community nursing staff were contacted when people required support or advice. Staff told us that the GP visited the service on a weekly basis to monitor people's health and wellbeing, and completed medicines reviews to make sure people had the most appropriate medicine for their health conditions.

Requires improvement

Is the service caring?

Our findings

The majority of people we spoke with were complementary about staff and were satisfied with the service they received. One person told us, "I'm quite happy, it's like being at home." Another said, "Before I came here I did not expect them to be so friendly." A relative told us, "[my relative] is treated with respect." Another said, "The staff are kind and understanding. If I wet the bed they say it doesn't matter, you can't help it."

During the midday meal we observed interactions between staff and people were, in the main, task focused. For example one person's care plan identified them as having communication difficulties. Staff showed them both meal options on plates for them to choose from. They responded 'no' and the plates were taken away without them being given the time to show their preference and a meal was then placed in front of them without being given the choice again.

We also observed that when people came to sit in the lounge area attached to the dining room they were not always acknowledged by staff who were busy providing assistance elsewhere.

Staff did not always take time to promote people's independence. For example, we saw that one person was able to reach for their own drink and feed themselves but when staff walked past they picked up their glass and held it to their mouth for them to drink from.

People's continence aids were individually assessed and allocated to individuals according to needs and remained the property of the individual. We noted that once received into the service these were stored in a cupboard as there was insufficient room to store in people's rooms. However, the boxes had not been individually labelled and staff told us they would not be able to tell which aids belonged to which individuals. This meant that people's personal property had not been protected, respected and stored appropriately.

People's privacy and dignity was maintained in supporting people with their personal care.

One person said, "The staff treat you with respect." Another person told us, "When I have a bath I feel comfortable." We observed staff treating people with dignity and respect and being discreet in relation to personal care needs. For example, we saw staff knocked on people's door and waited for a response before entering.

People told us that they were supported to maintain contact with their relatives and friends. We observed a steady stream of visitors throughout the day. All of the relatives we spoke with were positive about the care and support their relative received but all said that there was a lack of staff which impacted on the care staff's ability to spend time with people and in meeting their social and emotional care needs.

Requires improvement

Is the service responsive?

Our findings

People and their relative's told us that they had been involved in the initial assessment of their care and support needs before they came to stay at the service. They also told us they had not been involved in any review of their care plan and all of the people we spoke told us they had never seen a copy of their care plan. Some care plans were informative and included details of people's backgrounds and interests but others did not. Other sections of some individual's plans were blank and did not provide guidance to staff, for example in people's end of life wishes and preferences, the use of gates across people's bedroom door and updates in response to people assessed as at risk of losing weight.

Staff did not have easy access to care plans including risk assessments in order to deliver people's care and treatment in a way that met their needs and kept them safe. Although care plans were held securely, they were kept locked in an office which care staff did not have access to without having to ask the manager to unlock this room. One care staff told us, "We do not review care plans and we do not have access to them without having to ask the manager to get them for us. They are not always here to unlock the room where they are kept. Senior staff and the manager look after the care plans and they are the only ones to write in them." Staff also told us that as they did not all have access to risk assessments and, they were unable to tell us what guidance was available to them in mitigating risks to people's safety. However, staff did tell us that they received some verbal information with updates on people's care needs through handovers from senior staff on a daily basis.

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

We noted a weekly programme of activities was published and displayed on notice boards throughout the service. People told us they enjoyed the group activities provided by designated staff responsible for planning and providing group and one to one activities. They also told us they very rarely had opportunities to enjoy trips out into the community. One person told us, "We have activities like coffee mornings, dominoes, snakes and ladders and the hairdresser visits weekly." Another person told us, "It would be nice to go out more. You never know what time of year it is if you don't feel the air on your face do you." People told us that staff respected their wishes when they wanted to be alone and encouraged those who enjoyed the company of others to participate in group activities. We observed during our inspection that only the more independent, active people took part in activities.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had asked the provider within this document, What do you do to ensure the service you provide is responsive? They told us, 'We have a robust complaints system in place to deal with comments and complaints from service users or others involved in their care. This includes a public display of the complaints procedure and the steps that we should take to assist the complaint, also information regarding the process and where else the complainant could take their concerns. We encourage people to tell us their concerns either verbally or in writing, either way all complaints will be taken seriously. We look upon complaints in a positive way and try to learn from them'.

When also asked what improvements have you identified that will make your service more responsive? The registered manager wrote, 'The service hopes the Friends of Humfrey Lodge will be able to give us some new ideas, contacts to the community and time for fundraising; For cooking to be incorporated into the activity programme each week; for people to be provided with the opportunity to peel and prepare the vegetables, salad and fruit to be consumed with their meals as they believed that cooking would support a sense of community and aid reminiscence'.

A newly appointed activities coordinator had been employed within the last week. They told us they were finding their feet and hoped to achieve the provider's aim to improve the quality of the activities provided to people as described within their PIR.

People said that they were supported to voice any concerns at resident's meetings. We reviewed meeting minutes and saw that people had been asked their views regarding the food provided and in the planning of group activities. One relative told us, "We are always kept informed by the home of any event affecting [our relative] and can always speak with the manager if we have any

Requires improvement

Is the service responsive?

concerns." Another told us, "We were concerned that [our relative] was isolated in their room. The staff have been helpful in supporting the installation of a phone in our [relative's] room. This helps us to keep in more regular contact with them."

We looked at the provider's concerns, suggestions and complaints log. We noted that all concerns and complaints had been responded to in a timely manner.

Requires improvement

Is the service well-led?

Our findings

People in the main told us that they were mostly happy at the service and that the registered manager was approachable and was often seen around the service. One told us, "The manager will always stop and talk to you." One relative said, "The manager is approachable and works hard. If you have concerns or worries they support you as best they can." Another told us, "The manager is approachable and runs a tight ship. I just wish they could keep their staff without this chopping and changing."

Staff told us they were provided with regular supervision and annual appraisals. We noted supervision planning documents demonstrated that supervision and appraisals had been planned. Staff also told us that regular staff meetings were held where a variety of subjects were discussed, including staff performance, policies and procedures and training. This meant that staff had been provided with opportunities to meet with their manager to discuss their work performance and plan their training and development needs.

The registered manager acknowledged that while there had been progress in some areas since their appointment 18 months ago, further work was required to ensure continuous improvement of the service. When asked what these challenges were they said, improvement of the environment and maintenance issues with leaking roofs and replacement of flooring, staff recruitment and retaining sufficient numbers of skilled staff to meet people's needs. The manager told us that they were in the process of recruiting further staff.

Staff were in the main positive about the manager of the service but less so in relation to the overall leadership of the service. Comments included, "The manager is straight down the line and they have supported me with personal issues when I needed it", "This is a chilled place, it's quite organised, staff are friendly and everybody seems to know what they are doing," "The manager works hands on to help us out when there are not enough staff but I don't trust the organisation to look out for the needs of people and staff, they don't seem to care we are struggling to cope with not enough staff. When we have needed agency staff this has been ignored, until recently. We were told they are too expensive. That doesn't help when you are running short of staff and not fair on people who live here."

The service had a number of systems in place to evidence its aim to provide quality and safe care. Records showed that the manager and provider carried out a range of audits and where shortfalls were identified an action plans with timescales developed. However, these audits had failed to identify the shortfalls we found at this inspection in relation to the cleanliness of the environment, staff access to care plans, the monitoring of people's nutrition and hydration needs and the impact on people's care from inadequate staffing levels provided. Recent management audits recorded the environment had been assessed as clean and safe with no concerns.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had asked the provider within this document, what improvements have you identified that will make your service better led? They told us, 'To ensure improved communication and a clear understanding of everyone's roles by providing better systems for improving communication with health professionals. However, the provider's PIR did not identify planning for improvement within the areas where shortfalls had been identified at this inspection.

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

The service had arrangements in place for people who lived at the service, their representatives and staff to provide their views about the care and quality of the service delivered. Quality assurance questionnaires were sent to relatives and people who used the service to gather

their views and opinions. The information received back had been analysed and suggestions subject of a brief action plan. However, it was not evident when action planned in response to people's feedback had been undertaken.

The service had a compliment folder and this had a number of cards from relatives with positive comments about the care their relative had received when living at the service. People had access to regular residents meetings.

Requires improvement

Is the service well-led?

However, attendance at these meetings was small in comparison to the number of people who lived at the service and people's capacity limited in enabling them to contribute their views through this format.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Safe care and treatment Risks to the health, welfare and safety of people were not adequately assessed and reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 (1)(2)(4)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Meeting nutritional and hydration needs** Steps had not been taken by the provider to make sure that people were supported to receive adequate nutrition and hydration or that people at risk were monitored and had access to specialist advice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (1)(a)(c)(d)(e) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Premises and equipment**

This section is primarily information for the provider

Action we have told the provider to take

The provider failed to maintain standards of hygiene appropriate for the purposes for which the premises were being used in line with current legislation as described in the Department of Health prevention and control of infections in residential care settings.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Need for consent** The provider did not act in accordance with the Mental Capacity Act 2005 and associated code of practice by failing to take steps where a person lacks capacity to make an informed decision, or give consent to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Good Governance** There were ineffective systems in place to regularly assess, monitor and mitigate risks relating to the health, welfare and safety of service users.