Uniquehelp Limited

Harbledown Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 18, 19 and 20 April 2017 and was unannounced.

Harbledown Lodge is registered to provide personal care and accommodation for up to 56 older people. There were 42 people using the service during our inspection; some of whom were living with dementia and conditions such as diabetes or impaired mobility.

Accommodation is set over three floors and upstairs bedrooms can be accessed by a passenger lift. There is a communal lounge, activities room, dining room and quiet room on the first floor and a lounge on the second floor. The home has extensive grounds and a part of the garden is accessible and secure, with a seating area. An onsite activity centre and hydrotherapy pool facility was being refurbished and nearing completion.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives gave mainly positive feedback about the service. We found some aspects that were not safe and required improvement to address them.

Some risks to people had not been properly reduced. The risk of falls was not always proactively managed and incidents and accidents were not always managed appropriately to avoid recurrences. Some pressure relieving air flow mattresses were not on the correct settings to provide people with appropriate relief from pressure on their skin. Statutory safety certificates were not present for all equipment used at the service and oxygen cylinders were not safely stored.

Records of people's care and treatment were not always up to date or meaningfully completed and, although audits were regularly undertaken, they did not always identify shortfalls they were intended to.

A survey of people living in the service found they felt safe. Assessments had been made about environmental risks to people and actions had been taken to minimise them. Staff knew how to recognise signs of abuse and how to report it.

There were enough staff on duty to support people, and proper pre-employment checks had taken place to ensure that staff were suitable for their roles.

Staff had received training in a wide range of topics and this had been regularly refreshed. Supervisions and appraisals had taken place to make sure staff were performing to the required standard and to identify developmental needs.

People's rights had been protected by assessments made under the Mental Capacity Act (MCA). Staff understood about restrictions and applications had been made to deprive people of their liberty when this was deemed necessary.

Healthcare needs had been assessed and addressed. People had regular appointments with GPs, health and social care specialists, opticians, dentists, chiropodists and podiatrists to help them maintain their health and well-being. Medicines were well managed and people received them when needed.

Staff treated people with kindness and respect. Staff knew people well and remembered the things that were important to them so that they received person-centred care.

People had been involved in their care planning and care plans recorded the ways in which they liked their support to be given. Bedrooms were personalised and people's preferences were respected. Independence was encouraged so that people were able to help themselves as much as possible.

Staff felt that there was a culture or openness and honesty in the service and said that they enjoyed working there. This created a comfortable and relaxed environment for people to live in.

Systems were in place to encourage feedback from people, relatives and staff and were subject to continuous review.

People's safety had been protected through cleanliness and robust maintenance of the premises. Fire safety checks had been routinely undertaken and equipment had been serviced regularly.

People enjoyed their meals; any risks of malnutrition had been adequately addressed. There were a range of activities.

The registered manager was widely praised by people, relatives and staff for their commitment to improving the service. There was an open, transparent culture amongst staff and management.

People knew how to complain if they needed to; most complaints were addressed in line with the services' policy.

We found a number of breaches of Regulation. You can see what action we told the provider to take at the back of the full version of the report.

We have also made the following recommendations:

We have made a recommendation about the frequency of review for high risk skin care concerns and the review of the continuing clinical need for catheters following admission from hospital.

We have made a recommendation about practice and facilities to ensure dignity and privacy is promoted at all times.

We have made a recommendation about handling of verbal concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Risk assessments did not always record suitable measures required to keep
people safe and incidents and accidents did not receive suitable oversight or promote learning to reduce the risk of them happening again.

Some equipment was not safety inspected when needed and other equipment was not safely stored.

Medicines were safely managed, people felt safe and staff knew how to recognise and report abuse.

There was a safe recruitment process in operation.

Is the service effective?

Good

The service was effective.

Staff understood how to protect people's rights in line with the Mental Capacity Act (MCA) 2005.

New staff received an induction and all staff received training to enable them to support people effectively.

Staff were supported and had one to one meetings with the registered manager to support them in their learning and development.

People received care and support from a team of staff who knew them well.

Is the service caring?

Good

The service was caring.

People spoke positively of the care they received and staff were kind and caring.

Staff spoke with people and supported them in a caring,

respectful and friendly manner.

People were relaxed in the company of staff and people were listened to by staff who acted on what they said.

Relatives and people's friends told us they were made to feel welcome when they visited the home.

Is the service responsive?

Good

The service was responsive.

The service involved people and their families or advocates in planning and reviewing care.

Care plans were individual and person centred.

There was a variety of activities, functions and outings on offer.

An accessible complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Regular audits and checks were undertaken to make sure the service was safe and effectively run. However, not all audits identified the shortfalls they were intended to.

Policies and procedures were available.

People and staff were positive about the leadership at the service. Staff told us that they felt supported.

Harbledown 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 18, 19 and 20 April 2017 and was unannounced. The inspection was carried out by one inspector and a specialist nurse advisor with nursing experience of older people.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 19 people who lived at Harbledown lodge and observed their care, including the lunchtime meal, some medicine administration and some activities. We spoke with five people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with one nurse, one senior team leader, three care assistants, the kitchen and housekeeping staff as well as the deputy manager, registered manager, area quality assurance manager and provider.

We 'pathway tracked' four of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for six other people. To help us collect evidence about the experience of people who were not able to fully describe their experiences of the service for themselves because of cognitive or other problems, we used a Short Observational Framework for Inspection (SOFI) to observe people's responses to daily events, their interaction with each other and with staff.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and

policies and procedures.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Requires Improvement

Is the service safe?

Our findings

People told us they liked living at the service and felt safe. One person said, "I feel completely safe, the staff good, I feel reassured". Another person told us "I feel cared for and safe, I am glad to have found Harbledown Lodge". A visitor commented, "I visit a lot, there always seems to be a fair number of staff about, the home smells fresh and is clean, I would probably recommend it". However, another visitor commented while they did not have concerns about their relative's safety, they did not feel assured that all aspects of personal care were carried out daily and without fail. We spoke with the registered manager about this, they agreed to discuss and address this issue directly with the people concerned. We found after speaking with people and staff and making observations that there were enough staff on duty to meet people's needs.

Our last inspection in December 2015 found the service was not always safe; this was because wound and skin pressure area management and prevention plans had not always been put in place or followed. During this inspection, although improvements had been made, other improvements were required to ensure falls were managed proactively, incident and accidents were reviewed effectively to reduce the risk of further events and equipment was safely stored and correctly safety inspected.

One person had experienced a series of falls and, although their falls were becoming less frequent and a crash mat had been placed next to their bed to reduce the risk of injury, active measures to reduce the risk of falls were not effectively managed. For example, a referral to the falls clinic and a portable pressure mat, designed to alert staff when the person left their seat, were only put in place following our discussion with staff after the person had fallen again. Given their history of falls prior to admission and frequency of falls since their recent admission, staff had not done all that was reasonably possible to reduce the risk of falls.

People were at risk of unsafe care because risk assessments did not always record sufficient measures required to keep people safe and were not always effectively reviewed following an accident. For example, a risk assessment identified one person may fall when trying to mobilise unsupervised; the risk assessment stated staff should be aware of the person's whereabouts and assist when needed. On the first day of our inspection, the person fell while unsupervised in a communal lounge; in the days preceding this, the person had fallen twice unsupported in their bedroom. Effective review of accident records should have identified the person was falling while unsupervised; the risk could have been mitigated by use of pressure sensing pads or other measures for example, increased staff supervision. This would have alerted staff to the person's movement, allowing them to intervene and therefore reducing their high risk of falls. People were at risk of continuing injury and therefore, poor care, because investigation of accidents and incidents did not reflect learning to minimise the risk to people of incidents happening again.

Where people were at risk of skin breakdown and development of pressure sores, special air flow mattresses and pressure relieving cushions were provided. However, for the mattresses to work to its best effect, it is essential they are inflated to the correct pressure; this is determined by a person's weight and should be correspondingly set on the mattress air pump. At this inspection some air pumps were correctly set but others were not. Two mattresses were overinflated and therefore did not provide the intended protective or

therapeutic effect. When pointed out, the deputy manager instigated an immediate audit, adjusting pump settings where needed.

Although processes were in place together with a designated area for the safe storage of oxygen cylinders, two oxygen cylinders stored in a bedroom were not secured to prevent them from being accidently knocked over. Additionally since they were not stored within the designated area, statutory British Standard signage, to alert the emergency fire service to the storage of oxygen, was not displayed. Servicing of most gas appliances, such as boilers and the cooker range, took place regularly together with the issue of statutory safety certificates. However, the service's two gas tumble driers, although serviced, had not been issued with required gas safety certificates. Systems and processes did not assure a safe environment, compliance with statutory requirements or national guidelines. When identified, immediate action was undertaken during the inspection to address these shortfalls.

The provider had failed to ensure risk assessments recorded sufficient measures to keep people safe; that they were appropriately reviewed; reflective of people's changing needs and did all that was reasonably possible to mitigate risks. People were at risk associated with the premises because the provider ensured they were used in a safe way. This was a breach of Regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate systems were in place for the management and treatment of wounds and skin integrity concerns. Case tracking of some people demonstrated an established pattern of successful treatment and healing of their skin. However, some records for the management of wounds, such as dressing changes, wound evaluation, repositioning charts and the application of some skin creams were not always completed. Some people wore protective boots to help protect foot pressure areas, no records were kept of when they were last washed; one was observed as being dirty during the inspection. Although all staff were aware of the risks of dehydration to people and actively encouraged people to drink, records of fluid intake did not meaningfully support staff to understand if people had drunk enough. This was because records did not always record the quantity drunk or inform staff what daily amount a person should drink; staff were therefore unaware if a person was on target to meet their daily hydration need or if further encouragement was needed.

The failure to maintain accurate records, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided is a breach of Regulation 17 (1) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We assessed procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. People received their medicines safely and when they needed them. There were policies and procedures in place to make sure that people received their medicines safely and on time. Medicines were stored securely, properly labelled, prescribed to individuals and in-date. Stock was well managed so that people were not left without medicines they needed. Medicine administration records had been completed neatly and showed people had received their medication consistently. There were directions for staff about giving medicines people could take as and when they were needed; which ensured people were regularly offered pain relief or laxatives, with proper time gaps between doses. Medicine records contained photos to help staff ensure the right person received their medicines. Regular medicine audits were carried out by the registered manager; we saw clear records of the checks that had taken place. Competency checks were completed for staff responsible for administering medicines as well as ad hoc observations. Staff we spoke with knew what medicines were for and were clear about procedures, such as what to do if a person refused their medicines, diabetes management and administration of time critical medicines for Parkinson's disease and Osteoporosis (brittle bones).

The service had adopted a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medicines for people who were approaching the end of their life. People often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods, by anticipating symptom control needs and enabling immediate availability of key medicines within the service.

There were clear policy and procedures in place for safeguarding adults from harm and abuse, this gave staff information about preventing abuse, recognising signs of abuse and how to report it. Staff had received training on safeguarding people and were able to identify the correct procedures to follow should they suspect abuse. Staff understood the importance of keeping people safe. Staff told us they were confident any concerns raised would be taken seriously and investigated to ensure people were protected. Staff were aware of the whistle blowing policy and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with properly.

Recruitment files showed that the required checks had been made to make sure that staff were right for their roles. Full employment histories and references from previous employers had been taken, along with checks to ensure that staff were of good character. Documents to prove identity had been seen and copied. All nursing staff had been checked to ensure they had a current and valid registration with the Nursing and Midwifery Council.

There were enough staff to meet people's needs. People told us that call bells were answered promptly and, although busy at times, we observed staff attended people's needs efficiently throughout the inspection. Four to five care staff and a nurse were on duty each day as well as the registered and deputy managers, who were also registered nurses. Overnight there were four care staff as well as a nurse. The registered and deputy managers provided weekend support to the nurse on duty although a further nurse was being recruited to fulfil this role. There were also kitchen, domestic and maintenance staff working each day. Rotas' showed that staffing had been consistent in the weeks prior to our inspection. Any gaps were either covered by the staff team or, if needed, regular agency staff were used. The registered manager explained that the rotas were flexible, for example, when needed they would arrange for an extra member of staff if people's needs changed. Staff told us they were able to tell management if people's needs changed and they would respond accordingly. Call bell monitoring checks found they were usually answered between one and four minutes.

The premises were clean and well maintained. An on going maintenance plan was in place; during the inspection an activity centre and hydrotherapy centre were approaching completion following refurbishment. This was intended to provide a facility for people at Harbledown lodge as well as people visiting the service. Checks took place to help ensure the safety of people, staff and visitors. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been reported. Records showed that portable electrical appliances and fire fighting equipment were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Records showed Health and Safety audits were completed monthly and that these were reviewed by management to see if any action was required. Fire risks had been thoroughly assessed and people had individual emergency evacuation plans. They gave details of the assistance each person would need in an urgent situation. Staff had regular fire safety training and could accurately describe the way in which people would be helped. Appropriate testing and monitoring of water temperatures ensured people were safe from risks of scalding; variations in water temperatures were addressed when identified. These checks enabled people to live in a safe and suitably maintained environment.

Good

Is the service effective?

Our findings

People told us staff looked after them well; one person told us "All the staff are always kind, cheerful and helpful". A relative commented, "Mum has well settled, she is happy and that makes me happy". Everyone we spoke to commented on the team work and friendly, homely atmosphere at Harbledown Lodge. Throughout the inspection we observed people and staff relaxed in each other's company. Staff communicated clearly with each other and handovers between each shift made sure that they were kept up to date with any changes in people's needs.

Our last inspection in December 2015 found the service was not always effective; this was because staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA) and some training was not up to date. During this inspection it was evident there was an embedded understanding and application of the MCA and on-going training was up to date.

People's health was monitored to help maintain their well-being. Physiotherapists, speech and language therapists, occupational health practitioners, opticians, chiropodists and GPs all visited the service to assess people and contribute to their care and support on a regular basis.
Where people had particular healthcare needs; such as diabetes, skin integrity concerns or catheters, care plans had been put in place. These informed staff of the actions they should take to support people. However, where identified as at very high risk of skin damage, no differential was made of the frequency a person should be reassessed when compared to a person at moderate or low risk. This did not promote the best possible opportunity for intervention at the earliest possible stage. In addition, when people were discharged from hospital and admitted to the service with a catheter in situ, no review was completed to consider its continuing clinical need within the new care setting.

We recommend the service consider current guidance on the frequency of reassessment for high risk skin care concerns and the continuing clinical need for catheters following admission from hospital and take action to update their practice accordingly.

The Mental Capacity Act 2005 MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

Applications had been made for deprivation of liberty safeguards (DoLS) authorisations for people who needed them, 14 authorisations were granted with the remainder being processed. These authorisations were applied for when it was necessary to restrict people for their own safety. The service was responsible for making applications and the relevant supervisory body (local authority) considered each application, issuing authorisations as needed. These helped to ensure any restrictions on people's liberty were warranted and as least restrictive as possible. A review of granted authorisations found one had recently expired, however, it had been granted for an unusually short period of time; upon discovery a new application was immediately made to the local authority.

Records showed people's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. The management and staff had knowledge of and had completed training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff showed good knowledge and understanding of the MCA. We observed staff offering people choices and they told us about people who needed more help to make their own decisions. For example; one person needed support to choose what to wear. Staff described how they would pick out alternatives to show the person to assist them in making their choice.

The management and staff were aware of the need to involve relevant people if someone was unable to make a decision for themselves. If a person was unable to make a decision about medical treatment or any other big decisions then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest.

Staff told us they had an induction when they started working at the service, this involved office time with a manager where they spent time reading people's care records, policies and procedures and getting to know the service. They also spent several shifts shadowing experienced colleagues to get to know people and their individual routines. New staff received a comprehensive programme of training before they started working with people. New staff were completing the Care Certificate; a set of standards that social care workers follow in their daily working lives. Staff were supported through their induction, monitored and assessed to check that they had attained the right skills and knowledge to be able to care for, support and meet people's needs effectively. Staff told us they supported each other and could ask their colleagues for help or advice if they needed to.

Staff completed a mixture of e learning and face to face training in a range of subjects to perform their roles safely and to provide the right care and support to meet people's needs. Training in all mandatory subjects was up to date for all staff. Our observations found that staff were both competent and confident in delivering personalised care. Staff had also undertaken extra training in subjects such as challenging behaviour, diabetes and dementia awareness. Competency checks were completed after each training session to check staff knowledge and understanding. One member of staff told us, "The training is good, it's regular training and helps with our job." Many staff had achieved at least a level two National Vocational Qualification (NVQ) in health and social care; with a number of staff having or studying towards NVQ three or higher. NVQ's are work based qualifications which recognise the skills and knowledge staff need to do their job. Staff have to demonstrate their competency to be awarded each level.

Staff had individual supervision meetings and an annual appraisal with either the registered or deputy manager. This gave staff the opportunity to discuss any issues or concerns that they had about caring for and supporting people, and gave them the support that they needed to do their jobs more effectively. Good training and supervision helped to ensure that people were cared for by staff who were confident, competent and supported by the management in their development.

Staff were aware of what people liked and disliked and gave people the food they wanted to eat. During the inspection we observed staff discussing with people what was on the menu and recording their preferred meal choices. Staff respected people's choices about what they did eat. People were supported and encouraged to eat a healthy and nutritious diet. Where needed plate guards were used to help people eat independently. Where one person was not able to see their food, staff described the food on their plate and its position using a numbers on a clock format. Throughout the inspection regular drinks and snacks were offered by staff. We observed and some people and visitors commented that the smaller dining room could become overcrowded making it uncomfortable and difficult to navigate. A second, much larger dining area was available but not used on a daily basis. Discussion with the provider established the large dining room

should be used and this was communicated to staff.

Harbledown Lodge provides accommodation and support for older people, many of them living with dementia. The registered manager had due regard to guidance of best practice for a dementia care setting. For example, there were handrails in corridors to aid mobility. Signage to toilets and lounge areas were easily visible and in written and pictorial forms; toilet doors were painted in contrasting colours to help people to more easily distinguish them. This helped to aid people's awareness of their surroundings. The service was clean, tidy and free from odours. People's bedrooms were personalised with their own possessions, photographs and pictures. They were decorated as the person wished and were well maintained. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use. The building was well maintained. Lounge areas were suitable for people to take part in social, therapeutic, cultural and daily living activities. There was a relaxed and friendly atmosphere at the service.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. A visitor described the service as "Kind, caring and safe". They said that there was a "Caring culture" and this had been their criteria when looking for a home for their relative. They felt Harbledown Lodge had met this criterion when they chose the service and it continued to do so. People felt valued and recognised as individuals, telling us they were happy and content in the service. More than one person told us, "I wouldn't want to live anywhere else". Another person told us "All of the staff are wonderful." One person commented "I was expecting Harbledown Lodge to be good, I'm not disappointed or wished I'd gone somewhere else. I'm very happy here". Most relatives confirmed they found staff knowledgeable about the support their relative needed. However, one relative told us of their frustration that some staff needed reminding about some aspects of care and they were not confident that all care was delivered consistently all of the time. They however felt the situation had improved, but questioned, based on previous experience, whether it would be maintained. We raised these concerns with the registered manager who readily agreed to discuss and resolve the concerns raised.

Staff were clear about how to treat people with dignity, kindness and respect. All of our observations were positive, staff used effective communication skills which demonstrated knowledge of people and showed them they were valued and thought of as individual. For example, staff spoke with people at the same level so it was easier to communicate with them or to understand what was being said. They made eye contact and listened to what people were saying, and responded according to people's wishes and choices. Staff told people what they were doing when they supported them. They gave some people a narrative, such as your lunch has arrived, tell me what you would like to drink and would you like me to assist you. This respectfully helped people to make decisions and introduced orientation to any support they might need within normal conversation. Staff were courteous and polite when speaking to people in private. They gave people time to respond and spoke in a way that was friendly and encouraged conversation.

We discussed with staff the dignity of giving some people medicines in communal areas, such as an insulin injection in the dining room. Although the person told us they did not mind and staff 'shielded' them when administering it, it did not promote the person's privacy or dignity and did not take into account the feelings of other people or visitors present. A brief discussion with staff resulted in their suggestion that a screen could be used to preserve people's modesty.

We recommend that the service review their practice and facilities to ensure dignity and privacy is promoted at all times.

Staff knocked on people's doors and otherwise tended to people who required support with personal care in a dignified manner. People were encouraged to be as independent as possible. Staff explained how they supported people to wash their own hands and face, for example, and to choose their clothing. Staff told us how important it was for people to retain their independence. Staff described how they supported people with their personal care; explaining to people what they were doing before they carried out each personal care task. People, who needed it, were given support with washing and dressing.

Staff showed attention to the details of care, people's hair was brushed; they were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. This level of care helped to demonstrate that staff valued and respected the people they supported. Relatives commented whenever they visited, people seemed well cared for and happy. People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit the service, they were always made welcome and invited to events, such as a recent Easter Fair. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us how staff contacted them if they had any concerns about their family members.

Staff knew people well and demonstrated a high regard for each person. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about specific individual needs and provided us with a good background about people's lives prior to living at the service; including what was important to people. People were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, one person frequently became agitated. Staff spoke calmly and slowly with the person, encouraging them to speak and help them understand why they were unhappy. Staff knew how to encourage the person to remember a time when they were happier. They chatted with the person about this which helped to calm the person. Staff knew about people individually and chatted about things that were relevant to them. For example, previous jobs, pets, where people used to live and what they did during the war.

People's care plans showed that discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had happened. Some people who could not easily express their wishes, or did not have family and friends to support them to make decisions about their care, were supported by staff and a local advocacy service.

Care records were stored securely and information kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this. Care plans contained specific information about people's wishes for end of life care.

Good

Is the service responsive?

Our findings

People told us they felt staff were responsive and supportive of their needs and were offered choice in all parts of their care. They felt confident about raising any concerns with the registered manager and were involved in discussions about their care plans if they wanted to be. One person told us, "It's my own daily routine." Another person commented, "They know I like to stay in my room and keep my own company, that's my choice". A relative told us they were kept informed about their relatives' care needs and were actively involved in the development of their care plan. They told us, "Any blips in care were dealt with and resolved efficiently". People said they were happy with the range of activities. Some relatives acknowledged the difficulty in trying to engage people in activities.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts, and also encouraged people to raise any concerns or complaints with staff or the registered manager. The registered manager had an 'open door' policy and made herself available to people and their relatives, this was evident during our inspection. A suggestions box was available for anyone at or visiting the service to use.

There was a system for people to write down any concerns and staff told us how they would support people doing this. Documentation showed that all complaints were taken seriously, investigated, and responded to in a timely way. People were confident they could raise any concerns with the staff or the registered manager and said they would not hesitate to complain if they needed to. Since our last inspection, the service had dealt with three complaints. Although there was evidence that some verbal concerns were recorded and progressed as per the service's policy, we found this did not always happen.

We recommend that the service record, action and address all verbal concerns as set out in their policy.

Each person had a pre-admission assessment to ensure that the service would be able to meet their individual needs. The assessment included consideration of the current resident group and how the potential new person would adapt to living in the service, with the people already there. Admission assessments and resulting care plans captured an inclusive approach to care and included the support people required for their physical, emotional and social well-being. These included all aspects of care, and formed the basis for care planning after they moved to the service.

Care plans included people's personal hygiene care, moving and handling, nutritional needs, continence, sleeping, skin care, and pain management. A section contained details about people's lives, this included their work, family, hobbies holidays as well as more personal information about if people preferred a bath or a shower; if they needed help with dressing and undressing; when they liked to get up and go to bed, and preferences about their food, their clothes, and their social activities. People's care plans were discussed with them and their family members if this was their wish. Care reviews were carried out each month and were up to date. One person told us, "My care is right for me" and told us how they had improved mentally and physically since moving there. The service operated a resident of the day system, families were notified

in advance and all care records to do with that person were checked, reviewed and updated. The person received one to one activities and their room was deep cleaned. This helped to ensure information remained current and care was person centred.

Contact details of family members and other important people were recorded in care files and people were supported to keep in touch. Some people went out with their families, and families also visited the service. Relatives and friends were encouraged to visit and participate in activities and events, for example; a recent garden party provided an occasion for all to come together and celebrate.

Changes in health or social needs were responded to. Short term care plans were written for people with acute conditions, for example, chest and urinary infections. Care plans identified if people could communicate their needs clearly and recognised how people living with dementia could suffer from confusion. Staff realised that if people presented a behaviour that may challenge, it may be that they were trying to communicate their needs. For example, one person sometimes banged on the table and shouted. There was information for staff on how to best communicate with the person detailing simple instructions and short sentences to maximise communication. Staff spoke about the importance of understanding body language, posture and facial expression in communicating effectively with people with dementia. Throughout the inspection our observations and people's daily notes showed they were cared for and supported in accordance with their individual wishes.

An activities coordinator had recently been appointed and people told us they enjoyed the activities provided. The activity coordinator was enthusiastic and spoke positively of their role in providing for people's social needs. They were aware of people's specific interests, for example, one person's particular enjoyment of games and reading, both of which had been supported and encouraged. Activities and interaction logs recorded people's activities, engagement and enjoyment of activities. This enabled staff to make meaningful evaluations and suggest changes if needed.

Some activities were delivered on a one to one basis where this was more suited to these people's needs. Other activities were carried out with small groups of people. There was a good recognition of people's needs and ability to benefit or otherwise from group activities. A visitor told us their relative was not an activities person and did not like to join in with group activity sessions. Other people told us the location worked well and they enjoyed looking out of the window at the tranquillity of the countryside and birds. Activities included music, chair exercise as well as visits from PAT dogs (a certified Pets As Therapy dog which visits the home with its owner). People also enjoyed watching period films and listening to music of their era. Staff and visiting health care professional had identified the benefit to one person's mental health and general wellbeing if they were able to keep a pet. They arranged for the person to have a cat, ensuring all associated risk assessments, vet requirements and day to day care of it took place. We spoke with the person who expressed the enjoyment having a cat gave them. The service planned to provide a mini bus to assist with activities; however, it was not clear when this would happen.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they felt the service was well led, they were positive about the registered manager, the staff team and how the service was run. People were happy with the care provided at Harbledown Lodge and enjoyed living there. The registered manager was supported by a committed and conscientious team including a deputy manager, nursing staff, care supervisors and care workers along with ancillary staff. Staff morale was high and the atmosphere within the service was warm, happy and supportive. One staff member told us, "The manager is supportive, if we bring anything up about staff or residents they sort it out straight away. They are nice, supportive and listen". All staff demonstrated they knew people well and had a clear knowledge of people's needs. During the inspection we observed that people engaged well with the registered and deputy managers who were open and approachable. Staff were clear about their role and responsibilities and were confident throughout the inspection. The culture of the service was open, honest and caring and focused on people's individual needs.

Our last inspection in December 2015 found the service was not always well led; this was because people's choices and preferences were not always recorded and care plans did not always fully record health care professional's instructions. At this inspection we found improvement had been made, however, other areas required improvement.

The quality assurance framework in place was not fully effective; although audits were regularly undertaken, they focussed on completion of the audit processes and did not always identify failings within those processes. For example reviews of accidents did not ensure all steps were taken to reasonably and practicably mitigate the reoccurrence of risks and did not routinely lead to reviews of risk assessments. Audits of mattresses had not ensured all were in a serviceable condition, checks of pressure relieving equipment had not identified incorrect settings, which are crucial to its correct operation. Audits of repositioning charts, topical cream application records, dressing changes and wound evaluation had not ensured correct and continuous completion. Fluid hydration records were not identified as not being fully completed or meaningfully guiding care staff about people's hydration needs. Safety processes such as the correct storage of oxygen cylinders and statutory safety checks of all equipment were not embedded in practice.

This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services is a breach Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Established systems sought the views of people, relatives, staff and health and social care professionals and were due to be undertaken for the current year. People had completed questionnaires about their opinions of the service. Questions covered staffing, choices, feeling safe and being listened to, and the responses were positive overall.

The service had a variety of methods by which to measure the standard of care and people's experiences of

it, including one to one meetings and discussions with people's families, a comments box and monitoring feedback given on an online care home survey site. All feedback was evaluated and, where needed, action plans ensured points raised were addressed. This was particularly evident around menu planning.

Harbledown Lodge had engaged widely with the local community and organisations such as, Skills for Care Managers Network and local network groups. The service are Dementia Champions through the Alzheimer's society and deliver the Dementia awareness sessions for the local community and school as well as supporting the placement of student nurses within the service. They have participated in an initiative, Measuring Outcomes of Care Homes (MOOCH) in partnership with the local university to review and improve care practice.

The provider has also set out their commitment for the service to undertake the National Gold Standard Framework for End of Life Care (GSF) in 2017. The GSF End of Life Care is intended to enable those providing end of life care to ensure better lives for people by providing recognised standards of care identifying levels of need and bespoke care for people nearing the end of their lives.

Staff told us and records confirmed the culture within the service was supportive and enabled staff to feel able to raise issues and comment about the service or work practices; staff felt they would be supported by the registered manager. The values and commitment of the service were embedded in the expected behaviours of staff and were discussed with staff and linked to supervisions and appraisals. Staff recognised and understood how their behaviour and engagement with people affected their experiences living at the service. Staff displayed these values during our inspection, particularly in their commitment to care and support and the respectful ways in which it was delivered.

Observations of staff interaction with each other showed they felt comfortable with each other and there was a good supportive relationship between them. Staff felt they worked together to achieve positive outcomes for people, for example, discussing changes in wellbeing and ensuring appropriate action was taken. Policy and procedure information was available within the service and, in discussion; staff knew where to access this information and told us they were kept informed of any changes made.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way and had done so consistently.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risk assessments recorded sufficient measures to keep people safe; that they were appropriately reviewed; reflective of people's changing needs and did all that was reasonably possible to mitigate risks. People were at risk associated with the premises because the provider ensured they were used in a safe way. Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and failed to maintain accurate records, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment. Regulation 17 (1) (2) (a) (b) (c)