

Embrace (UK) Limited

High Peak Lodge

Inspection report

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Date of inspection visit:
19 October 2016
20 October 2016

Date of publication:
13 December 2016

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

We carried out an unannounced inspection of High Peak Lodge on 19 and 20 October 2016.

High Peak Lodge is registered to provide personal and nursing care for up to 39 people. It is situated close to Leigh town centre. All the rooms are for single occupancy and have en-suite facilities. There are gardens to the front and rear of the home and car parking is available. At the time of our inspection there were 27 people living at the home.

The home was last inspected on 18 and 19 February 2016, when we rated the service as 'inadequate' overall and identified six breaches of four of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing; safe care and treatment; person-centred care and good governance.

Prior to the last inspection in February 2016 we became aware of serious concerns with how the service was managing the needs of people at risk of pressure sores. During the inspection we saw that whilst the home had taken steps to address these concerns, there were still issues with the monitoring and documentation around pressure care and use of specialist equipment.

In June 2016, the Police commenced an investigation into concerns about the care and support received by a person using the service up to their death; this investigation remains on-going.

At this inspection we found the service had made improvements and was now meeting all regulatory requirements. We did not identify any current concerns with the care provided to people living at the home.

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

We saw the home was clean and had appropriate infection control processes in place. Five housekeepers were employed, one of whom was a supervisor who oversaw completion of the daily and weekly cleaning schedules.

People we spoke with told us they felt safe. Similarly relatives had no concerns about the safety of their family members and were positive about the level of care provided. The home had appropriate safeguarding policies and procedures in place, with detailed instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

Staff and people using the service commented on the improvements in staffing levels and felt that the home

had enough staff to meet people's needs. The service was continuing to recruit additional staff, particularly nurses in order to remove the need for any agency staff on night shifts.

Both the registered manager and staff we spoke to demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We saw the service was working within the principles of the MCA and had followed the correct procedures when making DoLS applications. Although the majority of applications made were still awaiting assessment, the service had ensured on-going contact with the local authority had taken place, to request feedback on when these would occur.

We saw medicines were stored, handled and administered safely and effectively. All necessary documentation was in place and was completed consistently. Staff responsible for administering medicines were trained and had their competency assessed annually. Sterile water used for Percutaneous Endoscopic Gastrostomy (PEG) flushes along with thickening agents, which are used to thicken fluids, were stored securely in a locked cupboard in the dining area.

Staff spoke positively about the training available and confirmed that statutory sessions were refreshed on an annual basis. We saw all the staff had completed an induction programme, new staff had been enrolled on the care certificate and on-going training was provided to ensure skills and knowledge were up to date.

Staff confirmed they received regular supervision and annual appraisals, which along with the completion of monthly team meetings, meant they were supported in their roles. Staff were actively involved in the supervision process and the home had recently introduced out of session tasks linked to the supervision process. These focussed on challenging poor practice.

Observation of meal times showed these to be a positive experience, with people being able to make choices about where they sat and what they ate. Staff encouraged people to use the dining room, in order to promote engagement and involvement but abided by people's wishes. Drinks and snacks, including fortified foods, were available in the lounge throughout the day and people were supported and encouraged to drink on a regular basis, with detailed monitoring in place.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. Both people who used the service and their relatives were complimentary about the attitudes of the staff and the standard of care received.

We looked at six care files which contained detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, which helped ensure their needs were being met and their safety maintained.

The home employed an activity co-ordinator and had sourced specific training for other staff to enable them to provide activity support. Everyone we spoke with was positive about the activity options available. We saw the activity schedule catered for all interests and abilities and people were actively encouraged to participate in any way they could.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily and monthly basis and covered a wide range of areas including medication, care files, infection control, health needs and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe living at High Peak Lodge

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed on a regular basis.

Is the service effective?

Good ●

The service was effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in the care plans.

The dining experience was positive with nutritional needs being assessed and appropriate care plans in place.

The service worked closely with other professional and agencies to ensure people's health needs were being met.

Is the service caring?

Good ●

The service was caring.

Both people living at the home and their relatives were positive about the care and support provided.

Regular meetings were held so that people could be provided with information and offer their opinions on the care being provided.

Throughout the inspection we observed positive interactions between staff and people. Staff members were friendly, kind and respectful and took time to listen to what people had to say.

Is the service responsive?

Good ●

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed and signed off, with involvement from the person themselves, their family or other representative.

People we spoke with were positive about the type and choice of activities available. People were encouraged to take part and could make suggestions about new things they wanted to do.

Is the service well-led?

Good ●

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Both the people living at the home and staff working there felt that the home was well-led and managed and they felt supported by management.

Team meetings were held to ensure that all staff had input into the running of the home and made aware of all necessary information.

High Peak 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.

The inspection took place on 19 and 20 October 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also spoke to the quality assurance team at Wigan Council.

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 the course of the inspection we spoke to the registered manager, clinical lead, a nurse, five staff members, activity coordinator and head cook. We also spoke to six people who lived at the home and two visiting relatives.

We looked around the home and viewed a variety of documentation and records. This included six staff files, eight care plans, Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at High Peak Lodge. The six people we spoke with all told us they did, with five saying, "Yes, I do." We asked relatives visiting the home for their opinion, one told us, "Yes, [relative] is very safe here and well looked after, this gives me great peace of mind." Another said, "Definitely safe here, she's looked after very well."

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file which contained a copy of the company policy along with local authority guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully. A matrix was also in place to monitor and log all referrals; we saw that all necessary forms had been submitted with confirmation of receipt attached to each one.

We asked all staff we spoke with about safeguarding adults. Each member of staff confirmed they had received training in this area and that this was refreshed every year. The staff all demonstrated a good understanding of what to look out for and how to report concerns. One staff member told us, "We do this on e-learning; it's an on-going thing that has to be refreshed every year." Another said, "Yes, this is done on e-learning, we get an expiry date sent through to us and we have to renew before this date." A third staff member said to us, "I would report any concerns to the manager or senior nurse in charge and document it." A fourth explained, "It depends on the abuse and who it's about, if a nurse is suspected I would go to the manager, otherwise I would report it to the nurse."

We looked at six staff files to check if safe recruitment procedures were in place and saw evidence that Disclosure and Barring Service (DBS) check information had been sought for all staff and was logged on each file. Staff also had a completed application form, at least two references as well as a full work or educational history documented.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. There was signage clearly visible throughout the home detailing infection control practices for staff and visitors to follow, to reduce the risk of spreading infections. We saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. The home was in the process of completing refurbishment work, part of which had included installing two new bath and shower rooms on the ground floor. We noted that these were well lit, clean and clutter free. The registered manager told us that plans were in place to carry out the same work in all bath/shower rooms throughout the home.

The home completed dependency assessments for all the people who used the service and used a dependency screening tool to determine the number of staff needed to meet people's needs. We asked the registered manager about staffing levels and were told that during the day the home ran with at least one nurse and six carers and at night with one nurse and three carers; although on occasions they would only have two carers on all night with the third working until midnight.

During the previous inspection in February 2016, despite having a dependency tool in place which indicated staffing levels were sufficient, staff and people we had spoken with did not believe there were sufficient staff at the time to meet people's needs.. As part of this inspection, we asked people who used the service for their views on staffing levels. One told us, "Yes, there's enough." A second said, "Yes, they can't watch everybody all the time, but there's enough." A third stated, "By and large I'd say there are enough. Obviously in a morning and the evening, we may have to wait a bit longer, but they always let you know." Another person had a different view telling us, "Not really. I need to go to the toilet regularly but need two staff for this. It can be up to a 15 minute wait at times."

We asked staff for their current views on staffing levels and ability to meet people's needs in a timely manner. One told us, "We did have problems before but this has improved. Obviously not much you can do if someone doesn't turn up for their shift, but overall the staffing levels we have now are fine. Staff are better allocated now, there's more structure and organisation to how we are deployed." Another said, "Got enough staff to meet people's needs. People don't have to wait long for support, it's much better than it used to be." Whilst a third told us, "Staffing is alright at the minute, with the numbers we have, we are busy but we can meet people's needs."

The registered manager monitored and reviewed the alarm call system data every week. We looked at a random four week sample and noted that the average wait times had been between 30 and 60 seconds. We asked people who used the service for their experiences. One told us, "At present I don't have to wait long for assistance." Another said, "There doesn't look like there's many staff about, but you don't have to wait long for things though." We asked staff how long people had to wait for assistance. One told us, "Not long, a few minutes at most." Another said, "It can vary but I'd say a couple of minutes maximum." Whilst a third said, "Can depend on time of day, I don't like doing personal care at suppertime when I'm responsible for giving out food, as this increases infection risks. So at this time I may ask people if they are okay waiting a little longer."

Our observations over two days indicated that wait times were not an issue. The home had 24 out of 27 people needing two staff to complete transfers which resulted in some people waiting if several people requested assistance at once, but the time people waited wasn't excessive.

We looked at how accidents and incidents were managed at the home. Accidents and incidents were recorded correctly and historical records were held in an accidents/incidents file. The registered manager analysed accidents and incidents monthly. We looked at the audits for the past two months which showed the majority of accidents and incidents related to bruises and skin tears people had sustained. We discussed this with the registered manager who told us they had identified this issue and were investigating why these were happening. They told us they had taken action by reviewing moving and handling practices and staffing and were continuing to monitor the situation.

We found there were safe systems in place to manage medicines and shortfalls identified at the previous inspection had been addressed. For example, we saw thickening agents and the sterile water and syringes used for PEG flushes were kept in a locked cupboard in the dining room so they were accessible to staff yet stored securely. We saw a detailed risk assessment and support plan was in place for the person who self-administered nicotine lozenges. Staff told us there were no other people who self-administered their medicines.

Medicines were stored safely and securely and there were records which accounted for all medicines ordered, received, disposed of or returned. We looked at a sample of medicine administration records (MAR) and found these were generally well completed with no gaps. Detailed information about each individual

was kept with the MARs which included the person's photograph, allergies and any special instructions about how the person liked to take their medicines. Arrangements were in place to make sure people who required their medicines to be given at set times received them correctly. Similarly protocols were in place for PRN, 'as required' medicines showing in what circumstances these should be administered and the minimum time between doses. We saw when staff were administering medicines they asked people if they had any pain and offered pain relief. Some people were prescribed topical creams for application by care staff. MARs for these were well completed and showed people received these creams as prescribed. We saw records were maintained when thickening agents were used.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely and records were completed correctly. We checked the stock balance of three people's CDs which were correct.

Staff told us they had received training in medicines and had their competency assessed both of which were updated annually to make sure they had the required skills and knowledge. We found staff monitored how people were taking their medicines and addressed any issues promptly. For example, the night nurse reported one person was struggling to take their pain relief medicine in tablet form and the day nurse contacted the person's GP to arrange for this medicine to be changed to liquid.

Staff told us two people received their medicine covertly. We looked at the care records for both these people and saw mental capacity assessments and best interest decisions recorded and letters from both people's GPs which stated they wished for medicines to be administered covertly to ensure good health was maintained. However, although both people's records referred to pharmacist advice there was no evidence to show what this advice was or that a pharmacist had been consulted. We also found, apart from the GP letters, there was no information with or on the MARs to indicate these people had their medicines covertly or any special instructions to guide staff about administration. We discussed these issues with the clinical lead nurse who assured us these matters would be addressed straightaway. When we returned on the second day, we saw evidence that all of these areas had been addressed.

Is the service effective?

Our findings

Prior to and during the last inspection in February 2016, we identified concerns with the home's management of pressure care. At this inspection we looked at this area in detail due to the previous failings. Care records we reviewed provided detailed information about people's pressure care needs and detailed the care and support required to meet these needs. For example, we saw care plans showed how often people needed to be repositioned and the positional charts we reviewed showed this was happening. Similarly we checked the settings on two people's airflow mattresses and these correlated with the settings detailed in their care plans. We saw a person sat in the lounge whose care plan stated they should sit on a pressure relieving cushion and this was in place. We found wound and pressure ulcer management plans detailed the treatment required and records showed this was being provided. The clinical lead nurse told us they carried out a weekly audit of pressure ulcers to monitor and review the treatment regime and we saw a recent record of these audits showed the pressure ulcers were either static or improving.

People living at the home told us they enjoyed the food and got enough to eat and drink. One said, "The food is excellent. Definitely get enough, the portions are very big." Another told us, "The food is very good, you get enough and there is a good choice." A third stated, "I get enough to eat and drink, the foods good here."

The meal time experience was monitored by both the registered manager and area manager to ensure it was positive for people using the service. People were asked for their opinions of the food and service they received, along with what improvement they would like to see. Prior to each meal we saw the dining tables had been set properly with each one containing napkins, cutlery, condiments, a daily menu and a vase of flowers. A larger weekly menu was located on the door to the dining room. Staff encouraged people to eat their meal in the dining room, in order to promote group interactions, however respected people's wishes when they asked to remain in their room or the lounge. Upon arriving in the dining room, people were supported to sit at the table of their choice and asked if they would like a drink. We saw that everyone was served in a timely manner and dishes were emptied and removed promptly.

We spoke with the head cook who had a good understanding of people's special dietary needs, fortified meals and drinks. They told us they added butter, cream, milk powder and full fat milk to foods to boost people's calorie intake. High calorie snacks and drinks were also available which included smoothies, chocolate bars, crisps, biscuits and cake. We saw these available, along with juice and water on a trolley which was located in the lounge throughout the day.

We found there were effective systems in place for monitoring people's food and fluid intake and making sure people received sufficient amounts to eat and drink. People's care plans provided detailed information about their dietary requirements as well as any food or drink preferences. The food and fluid charts we reviewed were fully completed and showed what was offered to the person along with the amount taken. Daily fluid targets were included and there was evidence in people's care plans to show these totals had been discussed and agreed with people's GPs.

The clinical lead nurse told us they reviewed the food and fluid charts daily to ensure people were having an adequate intake. This was evidenced on the charts we looked at which recorded the previous day's intake and advised staff if more snacks or drinks were needed. For example, we saw one person's chart showed the previous day's input had been poor and instructed staff to provide hourly fluids. The clinical lead nurse told us they carried out a weekly review of the food and fluid charts. Our review of these records showed people's food and fluid intake was assessed across the week, their weight was compared with the previous week's and the action being taken was recorded. The most recent weight records showed people had either gained weight or were stable.

Our review of people's care records showed the service worked closely with other professionals and agencies to meet people's health needs, these included general practitioners (GP's), speech and language therapists (SALT), dieticians and advanced nurse practitioners (ANP's).

We looked at how the home sought consent from people who lived there. One person told us, "Staff always seek my consent." Another said, "They always knock and always explain what they are going to do." We asked staff how they gained people's consent. One replied, "Even if they only nod, by asking them first you know that they have consented." Another told us, "A lot of people here are able to tell you, so I ask them if it is okay. We also have consent forms in the files, however things change, so it's best to constantly ask and check." Each care plan contained consent forms, which had been signed by either the person themselves or their representative. During the inspection we saw staff seeking consent before providing care and support, including knocking on doors and seeking agreement before commencing any manual handling task.

We looked at the home's staff training documentation which was stored electronically. Staff training was monitored via a matrix with each staff member's record detailing what training sessions had been completed, the date of completion and date of expiry. The computer system also identified which staff were due to attend training sessions and a letter was then generated and sent out informing them of when and where the training was to be held. The home provided a comprehensive induction programme and further training in moving and handling, safeguarding and infection control. We saw copies of the care assistant, kitchen assistant and registered nurse's induction programmes, all of which had been designed to ensure they received all the information they needed to successfully carry out each role.

We asked staff for their opinions on the training provided. One told us, "Training here is really good. Some people don't like e-learning, but I do." Another said, "Training is good, I'm happy with it." A third stated, "It's good, I feel more comfortable doing it on my own on the computer, rather than have someone read a presentation at me." However one person told us, "For some things, I would like more hands-on training, like we do for manual handling. I don't always feel confident unless someone has actually seen me do it."

We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015. We noted that the care certificate had been incorporated into the home's induction training programme and any staff commencing employment after April 2015 had completed this.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of providing this. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One told us, "We do e-learning on these, DoLS are usually left to the nurses, they do the applications but if we think someone may be being deprived we report this." Another said, Yes, we do

DoLS training. I think we have a couple of DoLS in place at the moment, but are waiting for all the others to be assessed."

At the time of inspection, only one person had a DoLS in place with a further 20 people awaiting assessment following submission of the necessary documentation. We saw that the registered manager completed a tracking document for each application and we saw copies of emails which evidenced that action had been taken to pursue outstanding applications. Within people's care files we saw that any potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention being utilised.

The staff we spoke with said they received regular supervision from their line manager. One told us, "We have supervision regularly, plus if there are any concerns we will do them more often." Whilst another said, "We have supervisions three monthly." Staff members also told us that appraisals were "done yearly". We viewed staff supervision and appraisal documentation. We saw that the home had a supervision file in place with sections for each category of staff. A standardised supervision form was used for each person with tick boxes to indicate which areas had been covered during the meeting. We saw that exercises on the challenging of poor practice had recently been incorporated into the supervision process. Staff were asked to complete this exercise outside of the meeting and return upon completion. A matrix was in place to monitor staff completion of both supervision and appraisal. The company policy indicated that all staff should receive three supervisions per year and one annual appraisal, however we noted that some staff had already completed in excess of this.

When inspected on 18 and 19 February 2016, it was noted that the home was not very 'dementia friendly' with only limited adaptations in place. During this inspection we observed the home had been proactive by improving the overall décor, introducing plain walls with contrasting hand rails, and wooden flooring throughout. Large text and pictorial signage had been fitted on all the bathrooms, toilets and offices and reminiscence items were on display around the home and in the dining room. People had also been asked about the introduction of themed rooms, with plans to decorate the dining room with historical images of Leigh. Display boards had been fitted outside each person's room and relatives had been asked for their support in supplying images to decorate these, although all were still empty during the inspection. We also noted that whilst the new bathrooms contained contrasting coloured hand rails, which made them easier to identify, all the toilet seats were white. We raised this with the registered manager who immediately made a request for these to be replaced.

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be caring. One told us, "Oh yes, they are very kind. They are happy to do anything for you." Another said, "The rapport I have with the staff is second to none, they are neither lewd, crude nor demeaning." A third added, "I like it here, you can have a bit of a laugh." We spoke to visiting relatives to get their views, one said to us, "Although the staff are busy, they are still alert to people's needs. When you watch how they are with people, you get the feeling they are looking after one of their own relatives."

We asked people who lived at the home if staff treated them with dignity and respect. All confirmed that they did, with one telling us, "Yes, they always ask first." Another said, "Yes, all the time. I like the fact I have never heard any of them use facetious language." A third told us, "They are very good with this, respect works two ways and they understand this." The home had a dignity champion. A dignity champion is a designated person who is passionate about maintaining people's human rights; person centred care and provides support to the team to achieve this.

We asked staff how well they knew the people they cared for and how they knew what they wanted. One told us, "When they first come in they complete the 'this is me' and 'my day' documents which tell us all about them and how they lived at home, we try to replicate this here." Another said, "I sit and chat with them to find out their preferences, can also look in care plans as it's all documented in there." One of the relatives we spoke with told us that staff "asked me for loads of information about [relative], so they knew how she would want to be supported".

Over the course of the inspection we spent time observing the care provided in all areas of the home. People looked clean, appropriately dressed and well groomed. There was a calm, friendly atmosphere and people were relaxed and comfortable around staff. An observation from the inspection on the 18 and 19 February was that interactions tended to be task based and staff were not observed sitting and chatting to people. During the course of this inspection, despite being busy, staff still found time to chat with people about a range of topics including their families, holidays and things they enjoyed doing. We observed staff singing with people and holding their hands. People were smiling back at staff, clearly appreciative of the physical contact and attention.

Prior to engaging in an activity or providing care, staff explained what they intended to do. For example, after supporting a person into the lounge after breakfast, the staff member asked if the person wanted to sit in a lounge chair. After they confirmed they did, the staff explained that they would need support to transition them from the wheelchair and what this process would look like. They went on to explain that [carers name] was helping another staff member and when they were free they would be right over to help.

People using the service told us that when they asked staff questions or had any concerns they felt listened to. One said to us, "They are very good, they will either sort things for me, or happily take me to the office if needed, so I can speak to the manager directly." Another told us, "What I like is if I ask staff a question, I get a straight answer." Whilst a third said, "They always listen to me, I am quite content in this regard."

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "If someone can feed themselves, then promote and encourage this. If they can hold a cup, get them to do this, if necessary get them a cup with a lid. Ask if they would like to wash their own hands and face." Another said, "We have one lady who needs support to eat, however when we are doing this she sometimes moves her hand towards the spoon, so we encourage this and try to get her to feed herself, even if it's just one or two spoonful's." We spoke to the relative of this person, who was very appreciative of the staff's efforts and told us that they were very patient, giving their relative as much time as they needed to try and feed themselves.

We asked people who use the service for their views, one told us, "The staff will push you to do things for yourself. I can do a lot more for myself than I could before. I am really chuffed with the way I am being looked after."

Resident meetings were held on a regular basis, with minutes taken and stored on file, as well as displayed on the notice board. We looked at the minutes from the meeting on 16 September 2016 and saw that 10 people had attended. The agenda had included an update on the refurbishments and a request for people's continued input moving forwards. The meeting also covered the new menus and people's views on overall practice. People asked if meetings could be held monthly, to ensure they were kept up to date with any news and changes, this was agreed and implemented. We saw from previous minutes, that people had been involved in choosing both the paint and bathroom tiles for the refurbishment.

At the time of the inspection nobody using the service was in receipt of end of life care, however the staff members we spoke with told us they had all received training in this area. We saw that where they had been open to discussing this, people's care files contained end of life care plans, which documented their wishes when they were at this stage of their life. We saw evidence that the home had utilised an advocacy service to discuss end of life wishes with one person. However when the advocate began to talk about this, the person became upset and refused to discuss further. It was agreed to put on hold until a later date and try again.

Is the service responsive?

Our findings

We saw that the service provided care which was personalised and responsive to people's individual needs and preferences. Prior to admission a nine page pre-admission assessment was carried out with the involvement of the person and/or their relative(s). This covered a number of areas including reason for assessment; particularly the aims, purpose and specific outcomes the person was looking for, personalised information; including background, life history, hobbies, interests and aspirations and more specific information about a person's well-being and abilities, such as medical issues, communication skills, personal hygiene and continence. The assessment also looked at important things about the person, including what they enjoyed, how they liked to spend their day, what made them happy or sad, what support they required and what they wanted from the service. People's needs and wishes were then carefully described on their care plans so that staff knew exactly what the person wanted and how to go about providing this.

To compliment the pre-admission information, the service also used other methods to ensure they were person centred in their approach. Each person was supported to complete a 'My Day' document, which detailed what they liked to do, and what support they wanted/needed throughout the day. Each person also had a 'This is Me' document in place, which was reviewed every six months. This document was split into three sections, with section one including information about any medical aids the person required such as glasses or hearing aids, along with their description and serial number. This would help identify items if they got misplaced. This section also provided information about eating and drinking, activities, communication, mobility and important things staff needed to know. The remaining two sections covered activities and communication in more detail, looking at what the person likes and is able to do and what support they would like in each area. For people with limited verbal communication skills, this identified ways in which the person communicates their needs, so that staff would know if they were hungry, thirsty or in pain.

People we spoke with confirmed they had been involved in planning their care. One told us, "Yes, they asked me about what I could and couldn't do and what I would like." Another said, "Yes, I was involved, I'm quite happy with everything." A third told us, "The do discuss this with you, things are done here in a sensible way." We asked relatives if they had been involved, one said to us, "Yes, I was involved initially and had another meeting about this a few weeks ago."

We asked staff how they ensured the care they provided was person centred. One told us, "Not everyone likes the same things, so give people choice and do what they want to do. We don't care for everyone the same way." Another stated, "By getting to know people, reading their 'My Day' and 'This is Me' documents and respecting their wishes." A third said, "Read the care plan as this tells you how each person wants to be cared for."

Staff members reviewed each person's care plan on a six weekly basis, documenting if any changes or amendments had occurred. We saw some records of family or advocate involvement in both initial care planning and reviews of care plans, which were scheduled to take place every six months. The registered manager told us that this was an area they had looked at improving, as not all families were involved,

however the home did not have records evidencing their wishes. As a result a letter had been sent to all family members asking if they wished to be involved in care reviews, and if so, how often they wished to have involvement, either not at all, as and when a change occurred, every three, six or 12 months. The responses received would help shape the review process moving forwards.

The service also had a 'resident of the day' programme in place; this involved completing a full review of all aspects of that person's care. As well as reviewing the care plan, the person was met with by a range of staff including the manager, activities coordinator, cook and maintenance person, so they could provide feedback on each area and make requests for what they would like. Each person's room was also given a 'spring clean' by one of the domestic staff. This process ran on a rota basis, starting with bedroom one and continuing each day until everyone had been completed, before commencing again from the beginning.

During the inspection we observed staff members being responsive to people's needs and choices. On one occasion, we saw two people only come through for breakfast at 10.30am, after choosing to have a lie in. They were offered the same breakfast choice as everyone else, despite the kitchen being in the process of preparing lunch. Another person had indicated in their care plan that they liked their own company and being in quiet surroundings, so preferred to spend time in their room, however they also liked to 'people watch' on occasion. Staff were aware of this and after encouraging the person to sit in the lounge, ensured they were sat in a quiet spot where they could take in what was going on.

The service had introduced a 'you said...we did' board onto which they documented what had been done to address any suggestions or concerns raised by people who lived there. This could be via resident meetings or suggestion / complaints slips which were accessible to all. We saw that people had asked for a quiet area to meet family and friends and as a result the conservatory had been made into a dedicated visitor's area.

Care records we reviewed provided detailed information about people's pressure care needs and detailed the care and support required to meet these needs. For example, we saw care plans showed how often people needed to be repositioned and the positional charts we reviewed showed this was happening. Similarly we checked the settings on two people's airflow mattresses and these correlated with the settings detailed in their care plans. We saw a person sat in the lounge whose care plan stated they should sit on a pressure relieving cushion and this was in place. We found wound and pressure ulcer management plans detailed the treatment required and records showed this was being provided. The clinical lead nurse told us they carried out a weekly audit of pressure ulcers to monitor and review the treatment regime and we saw a recent record of these audits showed the pressure ulcers were either static or improving.

We looked at what activities were carried out in the home. Since the last inspection, the service had introduced regular 'Oomph' sessions into their activity schedule. The aims of 'Oomph' are to enhance mental, physical and emotional well-being through mental stimulation and fun, physical activity. We observed an 'Oomph' session being facilitated in the lounge by the activity coordinator and a care assistant, both of whom were qualified to do so after attending an external training course. Music was being played and people were being encouraged to participate in gentle activity, including shaking pom poms and playing hand held instruments such as tambourines. During the afternoon a singer visited the home, performing in the lounge for over an hour. Staff encouraged people to sing along and to get up and dance, holding hands and joining in with those that chose to. During both activities we observed all those taking part smiling and laughing and interacting with both staff and people sat near to them.

An activities board was located in the dining room which contained a list of what was on offer for the next four weeks. An activities newsletter was also produced and circulated each week which listed each day's

activities. We looked at the newsletter for week commencing 10 October 2016, activities that week ranged from 'Oomph' and bingo through to a reminiscence session and cake decorating.

We asked people who used the service for their opinions on activities at the home. One told us, "There's plenty going on every day." Another said, "Yes, enough going on, you can discuss what you would like to do." A third stated, "We play bingo, do exercise, I am happy with what there is." We spoke to visiting relatives, one told us, "There's lot's going on, lots of activities. [Relative] has vascular dementia but they still encourage her to take part." Another said, "The activities are good, [activity coordinator] is very enthusiastic."

During the previous inspection in February 2016, staff said the home did not provide enough activities for people. At this inspection we again asked them for their views. One told us, "It's much better now than it used to be, more going on." Another said, "It's not bad, they do like 'Oomph' and the other day we had the giant dominoes out." A third told us, "Activities here are a struggle, a lot of people just want to watch TV in the lounge and we have a number of people who stay in their rooms, so need to do 1:1 sessions with them. We offer as much as we can and encourage people to take part."

We looked at how complaints were handled. The home had a complaints file in place, which included the policy and procedure for dealing with any concerns received, we noted that an 'easy read' copy was also available. There were three complaints in the file, two of which were from 2016. Each complaint had been fully investigated with a written responses and action plans provided to the complainant, both of whom were relatives of people using the service. We asked people using the service if they knew what to do, should they have a complaint. All stated that they would speak to a staff member or the manager, but stated they had nothing to complain about. One told us, "I'm happy with everything, definitely improved here over the last few months." Another said, "I know how, but not needed to as yet." Whilst a third stated, "I'm very happy, no complaints at all."

The home displayed thank you cards and letters as well as logging compliments on file. We saw that positive feedback had been received from both relatives and visiting professionals. One professional from Wigan Hospital had provided positive feedback about the treatment provided to a person with a pressure ulcer and the improvements that had been noted as a result. A relative had thanked the home for all the help and support provided, stating that their relative had 'felt like part of a family, rather than a patient.'

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 home had a clear management structure in place, with the registered manager being supported by a clinical lead. Both had been in post since June 2016. Throughout the inspection, people who used the service, relatives and staff members all commented on the positive impact these appointments had had on the way the service was run. Both the registered manager and clinical lead were visible on the floor and people who used the service that we spoke with, knew who they were and could identify them. Staff were also complimentary, with one telling us, "They are on the floor a lot, which is good. We have not really had that before." Another said, "You see them a lot. I have noticed lots of positive changes over the past few months."

The staff we spoke with felt the home was well-led and managed and they felt supported. One told us, "Before [registered manager] came here, we didn't have anyone we could go to; there is much better support in place now." Another said, "[Registered manager] says their door is always open. I regularly go in to speak to them and they've always been happy to listen." A third stated, "It's much better than it was. We have had a lot of management changes in the past. Currently there are a lot of changes to practice being brought in and as a result the home is running much more smoothly now." Staff also identified a change in the atmosphere within the home as a result of the new management structure. One told us, "A couple of months ago, morale was very low, but this has been completely turned around." Another said to us, "The atmosphere is getting better and better because people can see an improvement. We are getting the things and support we need to do our jobs."

We spoke with the registered manager who told us, "The biggest challenge has been breaking the culture of negativity, which I believe we have done. We have plans to provide additional training and opportunities for staff, such as introducing nursing assistant positions. My overall aim is to make High Peak Lodge a centre of excellence."

We saw that team meetings were completed on a monthly basis. Minutes were taken and action plans generated. We looked at the minutes from the last four months and saw that as well as the manager discussing operational matters and provision of care, staff were able to add to the agenda items they wished to cover. It was noted that the times of the meetings were not suitable for all of the staff, with night staff generally not attending. One staff member told us, "They have meetings every month but they are usually held in the afternoon, which is an awkward time for night staff, so they don't attend."

The home held regular meetings for relatives, which people using the service were invited to attend. The last meeting in September had been attended by seven relatives and one person using the service. Minutes showed that all relatives in attendance were happy with the care and service being provided and an

agreement was made to hold these meetings quarterly. Dates for relatives meetings had been identified for the year and the next meeting was scheduled for 22 December. Minutes of meetings were made available to people and their families and a list of attendees at each meeting was kept. Due to recent attendance issues, the registered manager had introduced a confirmation slip on the invite, which they hoped would help increase numbers.

The home's policies and procedures were stored both on file and electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copy were always available. All staff had signed an agreement to confirm that they had read and understood the key policies.

We saw there was a range of systems in place to monitor the quality of the service. The registered manager completed daily 'walk rounds' which allowed them to observe the provision of care. Each 'walk round' was documented and looked at a number of areas including infection control, dining experience and overall care practices. Action points were generated then signed and dated upon completion.

Provider level audits were completed by the area manager; these covered all areas from provision of care and staff training through to the safety and suitability of the environment. The audit forms contained a description of any actions required, level of priority, who responsible for actioning along with sections to detail date of completion and an update on what had been done. Every six months a 'quality development tool audit' was completed which looked at the home's management of the following areas; involvement and engagement, MCA, DoLS, provision of care, nutrition, safeguarding, medication, safety of premises/equipment, staffing levels, staff training and supervision, complaints and overall record keeping. Audits were stored electronically at provider level to enable progress to be monitored on an ongoing basis

Internally, the registered manager completed a number of other daily, weekly and monthly audits in areas such as catering and kitchen management, food/mealtime experience and laundry management. Again action points and a section for reporting on progress were included on the documentation, along with comments made by people using the service.

We found accidents; incidents and safeguarding had been appropriately reported as required. We saw that the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and that copies of all notifications submitted were kept on file.