

Runwood Homes Limited

# Loganberry 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?

**Requires Improvement** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection took place on 12 and 13 December 2017 and was unannounced.

Loganberry Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Loganberry Lodge is registered to provide care and support for up to 138 people, some of whom live with a diagnosis of dementia. Care is provided across four units in the main building and a separate unit called Huckleberry located adjacent to the main building. There were 133 people in residence when we inspected.

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 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.

At our last inspection of the service on 1 June 2017, we rated the service as "Requires Improvement" overall but as inadequate in the key question of Safe. This was because we found deficiencies in the way medicines and staffing were managed. We found that the provider was in breach of a number of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was placed in special measures as the service had been rated 'Inadequate' in Safe over two consecutive comprehensive inspections. We took enforcement action and issued warning notices setting out our concerns and the actions the provider needed to take to improve. Following the inspection the registered provider sent us an action plan setting out the steps they would take to address the concerns. At this inspection we found that improvements had been made and as a result were no longer in special measures, although the overall rating remains 'Requires improvement.'

Medicines were managed in a safer way. Medicines were stored securely in clean and tidy treatment rooms, and the temperatures of the storage areas were recorded regularly. Our observations and a review of the records showed that medicines were administered as prescribed. We have however recommended that the provider review medicine procedures and protocols to further protect people. This should include the management of diabetes and distressed behaviours, as well as the guidance available to staff on supporting people at the end of their life.

At this inspection we found that there had been improvements to staffing. The service was fully staffed and was no longer dependent on agency staff which meant that people were supported by a consistent team of people who knew them. However the feedback from people was not consistently positive and some people continued to express concerns about the availability of staff. The registered manager provided assurances that they closely monitored staffing levels and told us that they intended to make further changes to deployment to take account of the comments made at the inspection. We have recommended that the

provider keep staffing levels under close review to take account of peoples changing needs.

Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. The registered manager had made appropriate referrals to the local authority when they had concerns about people's wellbeing. They were aware of their responsibilities under their duty of candour.

Risks were identified and management plans were in place to guide staff on how to reduce the likelihood of harm. The management plans were informative but staff did not always recognise potential risks or consistently follow the plan. The environment was regularly monitored and checks were undertaken on equipment to reduce the likelihood of equipment failure. Staff understood the need to report safety incidents and any concerns. Staff received training in infection control and protecting people from infection but did not always implement their training.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The registered manager understood their responsibilities but staff were less clear. People had capacity but key documents had been signed by family members who did not have the legal authority to consent on their behalf. It was agreed that the registered manager would review the records and guide staff appropriately.

There were systems to check on staff suitability prior to them starting work at the service which included references and disclosure and barring checks. There was an induction, training and development programme, which supported staff to gain relevant knowledge and skills. However, further efforts were needed to consolidate learning and best practice in key areas such as dementia care, infection control and moving and handling people. We received assurances from the registered manager that they were accessing additional training and reviewing staff competency across the service.

People received regular and on-going health checks and support to attend appointments. The registered manager was looking at ways to improve communication with health professionals to drive improvements at the service.

People were offered choice and supported to eat and drink. The service was in process of piloting a change to meal delivery but people raised issues with us about how this was working and the impact on them. We observed that the organisation, presentation and delivery of meals could be improved in some parts of the service. The registered manager assured us that they were working with people to address the issues raised following the introduction of the pilot scheme.

People and their relatives were complimentary about the attitude of the staff and told us they worked hard to meet people's needs. We saw staff were kind and caring and had developed good relationships with people using the service. People were supported to make choices and to be as independent as they could be.

Preadmission assessments were undertaken but were not always as comprehensive as they could be and did not ensure continuity of care. Care plans were in place to guide staff but some did not provide sufficient guidance, for example in supporting people with dementia and in planning for people's end of life care.

People had access to a range of organised activities to promote their wellbeing. People spoke positively about what was available and we saw that a new café had been developed in one part of the service.

However we have recommended that further efforts should be made to enhance the lives of people with dementia.

Complaints were investigated in full and were responded to in a timely way. The service sought the views of people and others about the quality of the service provided. The findings were used to drive improvement.

There was visible leadership and people told us that the new management team were approachable and supportive. The service was improving and the culture was more positive. The registered manager had a plan to address the issues we identified about consistency of practice.

The registered manager and area manager completed a range of audits to monitor the safety and quality of the service. For example, there was routine auditing of care plans, analysis of accidents and incidents and checks on staff competencies. The information was analysed and action plans were generated in response to promote people's welfare and safety.

During this inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe

Risks were identified and there were systems in place to reduce the likelihood of harm but staff did not always recognise potential risks or follow the management plans.

Staff received training in infection control and protecting people from infection but did not always implement their training.

There were safer systems in place for the management of people's medicines.

Permanent staff were now in post and staff were deployed more effectively. Some people continued to raise issues about the availability of staff and we have received assurances from the provider about this.

There were systems in place to check on staff suitability prior to appointment.

Staff were aware of the signs of abuse and the actions they should take if they had any safeguarding concerns.

Improvements were made when things went wrong.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Staff training was in place but staff did not always work in a consistent way or follow recommended practice.

People had choice of meals and received support they needed but the organisation and delivery of meals could be improved .

The registered manager understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but staff would benefit from further clarity on consent.

People's health was monitored and they had access to a range of

**Requires Improvement** ●

health professionals.

### Is the service caring?

Good ●

The service was caring.

People's dignity was promoted.

Staff were kind and compassionate in their approach.

People were supported to maintain their independence.

People were supported to express their views about the quality of the service.

### Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People needs were assessed prior to their admission but the arrangements for emergency admissions were in need of review.

People had a care plan which included information on their care preferences but sufficient information was not included on how to meet people's complex needs. People's wishes and preferences regarding their end of life care should be clarified as part of the care planning process.

People had access to activities to promote their wellbeing but support to people with dementia could be enhanced.

Complaints were used in a positive way to improve the quality of care.

### Is the service well-led?

Requires Improvement ●

The service was not always well led.

The service was improving and the culture was more positive. The registered manager had a plan to address the issues we identified about consistency of practice.

There was visible leadership and people told us that the new management team were approachable and supportive.

People's views were sought and used to inform the quality of care.

The provider undertook a range of audits to check on the quality

of care and drive improvement.

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# Loganberry 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 12 and 13 December 2017 and was unannounced. On the first day of the inspection the team consisted of three inspectors, a pharmacist, a specialist professional advisor in nursing care for older people and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this occasion their expertise was in dementia care and care of older people. One inspector completed the second day of the inspection.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports and the details of complaints, whistleblowing concerns, safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury. We also spoke with the local safeguarding team and the quality team at Essex County Council about their view of the care provided.

In some parts of the service people were not able to verbally communicate with us so we spent time observing care and interactions between staff and people who used the service. We spoke with 29 people living in the service, 16 relatives and 21 members of staff. We spoke with five visiting professionals as well as the management team which included the registered manager and regional managers. We reviewed care and support plans, medicine administration records, recruitment files, staffing rotas and records relating to the quality and safety monitoring of the service.



# Is the service safe?

## Our findings

At the last comprehensive inspection in June 2017 we found the registered provider was not meeting the requirements of the law in that staffing levels were not sufficient to meet the needs of the people who lived there. We took enforcement action and served a warning notice requiring the registered provider to address the concerns we had identified with staffing.

At this inspection we found that there had been some improvement. The service was no longer dependent on agency staff and the registered manager told us that they were fully staffed. This meant that people received more consistency of care from staff who knew them. We observed that staff were deployed more effectively and staff breaks were better managed. Staff were observed responding to call bells within a seven minute period.

People and relatives had mixed views about the staffing levels at the service. Some people told us that staff were always busy but people's needs were largely met. A relative told us, "The staff do what is needed but that's it, they are always rushed off their feet. I feel sorry for them because they're always rushing around but I think [my relative] is content." One person told us, "The mornings are pretty well staffed but it is not so good in the afternoon. Things have improved at night." Other people's experience was less positive. One person told us, "It's very short of staff," and said they had not had a proper wash, only a, "Lick with a flannel." Another said, there is, "No way near enough staff to help everybody; we have to wait many times for a staff member to be free to help you."

Staff too varied in their feedback about staffing. One member of staff told us, "Everything is rushed." Another member of staff told us, "There is not enough staff at weekends, some people don't turn up and it puts more pressure on staff...and things get missed."

Other staff told us that staffing had improved and there had been a number of new initiatives including the introduction of call bell champions, who monitored call bells to ensure that people received a prompt response. One member of staff told us, "If I hear a bell ringing and I am in the lounge with the residents, I have to tell the other staff. It is working better, we have been doing this for three to four months now and do it across the 24 hours. We are getting to residents quicker and tell them that someone will be with them soon if [other staff] are doing hoisting." The provider undertook some testing on the call bell system to monitor response times and this found that call bells were responded to promptly. However these findings did not always correspond with people's experience and the registered manager agreed to look at increased monitoring.

Following the inspection we sought assurances about staffing levels from the registered manager and provider. They told us that they had developed a new dependency tool which looked at people's needs and the staff numbers needed to meet these. According to the providers dependency tool there were sufficient staff employed. The registered manager provided us with an action plan which set out steps that they were going to take to address the concerns which included reviewing the location of offices and ways they could reduce the need for staff to leave the units, for example to access the main kitchen.

We recommend that staffing levels are continually reviewed and that observational evidence is used to support the dependency tool to ensure people's needs are met in a timely way.

At the last comprehensive inspection in June 2017 we found the provider was not meeting the requirements of the law in that people's medicines were not being managed safely. Records were not being properly completed. Proper consent was not always obtained for administration of covert medicines and there were issues with medicine storage. We served a warning notice setting out our concerns and what needed to improve.

At this inspection we found that there had been improvements in the management of medicines. Medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely in clean and tidy treatment rooms, and the temperatures of the storage areas were recorded regularly. The controlled drugs registers were correctly completed.

The medicines administration records we looked at included information about allergies and a photograph of the person to make sure they were correctly identified. Staff had completed the records to show that medicines were administered as prescribed. Medicines with frequent dose adjustments such as Warfarin were correctly recorded in line with instructions from the doctor. For people who were prescribed antipsychotic medicines, we saw that staff requested regular medicine reviews from the person's GP.

Some medicines were prescribed to be taken when needed, for example for pain. We saw plans to guide staff on what the medicines were for and we saw that administration was clearly recorded. However for variable doses such as one or two tablets, the plans did not include detailed guidance on how to decide how many to offer. Some people were prescribed medicines for distressed behaviours or restlessness. Staff told us that they would try approaches such as talking to the person before offering medicines and we saw that these medicines were used only occasionally. However, the medicines plan did not form part of an overall management plan to guide staff in taking a consistent approach in supporting people who had become restless. We recommend that clearer guidance is provided to staff on supporting people with dementia who exhibit distressed behaviours.

One person had been prescribed medicines in advance to manage symptoms at the end of their life. The medicines were correctly recorded on the administration chart and were available for use. However there was no written plan to describe the circumstances in which treatment should be started which could lead to a delay. This was brought to the registered manager's attention during the inspection and was immediately addressed.

Prescription creams were stored securely and applied by senior staff during the medicines round. Creams such as emollients for dry skin were stored in people's rooms and applied by care staff while supporting the person to wash or dress. Staff had access to written instructions on how to apply the creams. However, they did not make a record themselves but told their team manager who signed the record on their behalf, which meant that the record did not include who carried out the task. We recommend that the registered provider review this practice as information should be factually recorded and accurate.

Infection prevention and control policies were in place but not consistently followed. At our last inspection we identified that staff were not always clear about their responsibilities regarding infection control. At this inspection we found that staff had received training in infection control and cleaning schedules were in place to record the cleaning undertaken. However there was a strong smell of urine in some parts of the service and we observed a member of staff working in a way that placed people at risk of infection. The member of staff was observed providing assistance to an individual with personal care, carrying soiled

laundry and then helping with food without washing their hands. The registered manager told us that they would address this issue with the member of staff and would increase monitoring of practice.

Risk management plans were in place to guide staff on how to reduce the likelihood of harm. The management plans were detailed but staff did not always recognise potential risks or follow the guidance. For example one of the people whose care we looked at had been identified as at high risk of falls but we saw that the call bell had been placed across the floor of the room creating a potential hazard. Another individual had a catheter and had been identified as being at high risk of urinary tract infections. We found that the individual's drainage bag had been placed on the bed rather than on a stand increasing the risk of infection and the backflow of urine.

Information was provided in people's care plans on the management of risks associated with pressure ulcers, malnutrition, diabetes and mobilising. People's moving and handling plans were in place to guide staff on what equipment, type of sling used and action to take to ensure a safe manoeuvre. The equipment specified was available. Pressure relieving mattresses were also in place to reduce the likelihood of people developing skin damage. Incidents and accidents were monitored to identify patterns. Where individuals had fallen additional checks were undertaken to identify any complications and referrals were made to the falls service for further advice.

The systems in place for the oversight of equipment and management of environmental risks were effective. We saw that checks were undertaken on fire safety equipment to ensure that it was safe to use and staff were clear about the process to follow in an emergency. There were systems in place to reduce the likelihood of equipment failure and checks were undertaken on window restrictors, hoist slings and moving and lifting equipment to make sure that they were not faulty.

Staff understood the need to report safety incidents and any concerns. The provider had a health and safety lead which collated information and acted on any issues to improve safety across the organisation.

Staff had undertaken training on how to recognise the signs of abuse and how to safeguard people. Most staff were able to outline the actions they would take to protect people and the remainder referred to contact details which were available on the staff noticeboards. They told us that they completed body maps where they monitored changes to people's skin and any bruising. We saw from the records that incidents had been recognised as safeguarding and appropriate referrals had been made. The registered manager maintained a log of any safeguarding concerns which had been raised and actions taken.

Recruitment processes were in place to check on staff suitability in order to protect people. Examination of two staff files confirmed that relevant checks, including identification, criminal records check and appropriate references had been obtained on newly appointed staff.

## Is the service effective?

### Our findings

Improvements had been made to training since the last inspection and the manager had organised a number of face to face sessions for staff in addition to the company's mandatory training. Staff were positive about the training and the registered manager maintained oversight of what was completed through a training matrix which identified when refresher training was due.

The service supported people with a diagnosis of dementia and we observed that some people's needs were complex. The feedback we received about the quality of training and staff skills in the area of dementia care was contradictory. Some family members expressed concerns that staff did not have the skills to manage the challenges presented by their relative's dementia and this meant that their relative did not always receive the personal care they needed. However, others were positive about the care their relative received. One relative told us, "[My relative] has Alzheimer's and has verbal aggression, staff have coped well and from what I have seen staff have appropriate training for challenging behaviour. They demonstrated good knowledge of what [my relative] was capable of doing and told me to move otherwise [my relative] might kick out and hurt me, this showed that they knew [my relative] well."

We saw that the service had recently appointed a number of new staff and the management of the service were working on areas such as consistency. However we found that further efforts were needed to consolidate learning and best practice for dementia care as well as infection control and moving and handling people. For example, we observed staff supporting individuals to move using the hoist and this was undertaken well. Staff were confident and caring in their approach. However, we also observed two staff in different parts of the service assist people to get up from the chair by using a move which was not recommended as it could cause injury. We discussed our concerns with the registered manager and they told us that the newly appointed managers were working alongside staff to check on their competency and drive improvement. Staff were also being assisted to assess leadership training such as 'Train the trainer' and 'Dementia leadership' to drive good practice at the service.

New staff completed the Care Certificate which is a set of minimum standard that should be covered as part of induction training of new care workers. We also saw that staff's competency was being assessed throughout the probationary period to ensure learning was understood and being applied. Staff told us, as part of their induction, they had spent time shadowing more experienced staff so that they could learn about people's needs and how best to support them. Following completion of their induction, staff were able to access additional qualifications such as the Qualification Credit Framework (QCF).

Peoples care and support were delivered in line with current standards and guidance. The providers leadership team ensured that the manager was kept up to date with evidence based guidance including that from skills for care. The provider had oversight of the guidance, equipment and assessment tools used in all of their services and had systems in place to monitor their effectiveness and update and adapt where necessary.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Where people lacked the mental capacity to make decisions the staff in the service were guided by the principles of the MCA. Mental capacity assessments had been completed appropriately and best interest decisions made with the involvement of relevant others. However, not all staff fully understood the principles of consent. For example we saw that some people had capacity but key documents had been signed by a family member who did not have the legal authority to consent on their behalf. Some other examples had been identified as part of the provider's care plan audits and it was agreed that a wider audit would be undertaken.

The registered manager told us that they had made applications as required to the local authority on behalf of people where their freedom of movement had been restricted, to ensure their best interests would be assessed by those qualified to do so. We had previously raised concerns that some of the restrictions that were in place were not always the least restrictive. For example doors between the units had codes which meant that people could not leave the units to go onto another unit.

We saw that a number of people had decisions they had made recorded such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders in place which set out their wishes not to be resuscitated in the event of a cardiac arrest. These were maintained in people's care records, and we saw that there were clear arrangements in place for their access in an emergency.

A choice of meals were available. People were involved in decisions relating to the food on offer and we observed staff showing people the meals to help them decide on what they would like to eat. Some meals were well presented but other foodstuffs did not look appetising. The service had recently changed the timing of the main meal as part of a pilot scheme and they told us that the change at some of the providers other services had resulted in positive outcomes for people. A number of people in Loganberry Lodge expressed dissatisfaction with the change but we saw that there had been consultation and a range of surveys on food were being undertaken to ascertain people's views. The registered manager told us that this was a pilot and would be reviewed.

One person said, "Dinner is now at 5.00pm, I don't like it, it upsets my system, I've always had my main meal at lunchtime. I feel sick and out of kilter. I was told there was a meeting about it but I wasn't there, not that I can remember. On the whole the food has improved in quality and variety, it is more interesting now but I can't eat at that time." Another person told us, "They changed the dinner time last week and I don't know why. We used to have sandwiches for tea and hot dinner at lunchtime; I have always been used to having a hot meal at lunchtime." A relative told us, "Expecting old people to eat a main meal before they go to bed is ludicrous, most older people prefer to eat dinner at lunch time, they changed it recently, I am led to believe the food quality is poor that is what residents tell me."

The registered manager told us that efforts had been made to improve the oversight at mealtimes to ensure that people received the support that they needed. Our observations were that in some parts of the service, the arrangements worked well and staff were organised and attentive to people's needs. However in others, there was a lack of oversight or organisation, which meant that some people who were vulnerable or asleep did not get the support they needed. We saw for example that one person had not been served a meal but when we asked a staff member they were unclear whether or not the person had been given a meal. Another

meal was observed sitting beside an individual and had become cold, as staff were not available to support them when the meal was served.

The service uses the malnutrition universal scoring tool (MUST) to identify people at risk of malnourishment and we saw referrals made to dieticians where appropriate. Recommendations made by dieticians had been recorded within care plans. A laminated sheet was used to highlight the risk and remind staff to offer additional snacks. People at risk were subject to increased monitoring including being weighed more regularly.

People had good access to fluids and we observed that people had drinks within reach. Records were maintained for those identified as being at risk. We had some concerns about the accuracy of these records as we observed a member of staff completing the food and fluid records for each person on one unit for the morning, one after another from memory. We could not see that this was an accurate record.

The provider carried out a monthly audit where they monitored people who had lost weight. There were actions recorded such as the provision of snacks and referral to the dietician where risk had been identified. We noted that one person had not been referred to the dietician as highlighted and this was brought to the unit manager's attention. The registered manager told us that they were in the process of reviewing the records and audits to ensure greater consistency across the service.

People had access to a range of health care professionals and support. Where risk was assessed to an individual's health and welfare, referrals were made to the relevant healthcare professionals for support and guidance. For example we saw that people at risk of falls were referred to the falls prevention team and an individual at risk of choking was referred to the speech and language team. Their advice and guidance was incorporated into their care plans for staff to follow.

We spoke with a number of visiting health professionals as part of our inspection and they gave us contradictory feedback. Some told us that the service was improving and staff were more alert to people's health needs but others told us that they were not always as proactive as they could be. Regular meetings were being set up with the district nursing services to look at communication and how best to respond to changes in people's overall wellbeing.

Some people were prescribed insulin injections for diabetes which were administered by visiting district nurses. In line with company policy, staff were not trained to carry out routine finger prick blood tests to check blood sugar levels. They were trained to look for symptoms and could call for help when needed, but were not able to respond quickly when oral glucose or additional insulin was required to manage sugar levels. We were told that this policy was being reviewed by the provider and additional training would be considered for staff to enable a more immediate response.

The home's environment was pleasant and comfortable. The service was well maintained although we did identify shortfalls with heating in some areas and the manager agreed to seek specialist advice to address this. People's rooms were personalised with items which were important to them. A new café had been recently opened on the ground floor to provide a relaxing space for people to use and see their visitors.

## Is the service caring?

### Our findings

People told us that they had good relationships with staff. One person told us, "All the staff are very kind, they are wonderful but they get changed around so much, you get used to staff and they get used to you, we build a relationship and then you don't see them. We like to see the same staff because they know you." Another person told us, "The carers are very good, very kind and I have no concerns on the carers."

Staff morale had improved since our last inspection and staff were more positive about their role. Staff told us that they enjoyed working at the service and there was a good team. We saw caring interactions between staff and the people they supported. Staff were friendly and communicated well telling people what they were doing, for example we heard one member of staff say to an individual, "I am going to leave your frame here," for them to access when they needed it. Staff were attentive and we heard them ask people if they could help with anything or if they could get them a drink.

Staff showed concern for people's wellbeing. For example, we observed one person becoming distressed at lunchtime constantly asking for their mum. The member of staff responded by holding the person's head close and stroking their hair. This alleviated the person's distress and then the member of staff encouraged them to eat. Another person was becoming anxious about where they were. A member of staff gave them reassurance, told them that they had a room ready and took them along the corridor to show it to them.

People were supported to express their views and be involved in making decisions about their care. For example we observed that one person was supported to attend their review and enabled to be part of the decision making process. People told us they were supported to make choices and decide how they spent their day. One person told us, "I go to sleep and wake when I want to; I have a bath with the help of somebody." Relatives we spoke with told us that they were made welcome at the service and were involved where appropriate.

A new key worker system had recently been implemented and we were told that it was progressing well. Staff were encouraged to liaise with both family and management in people's best interests. There was a laminated sheet in people's room which had a photo of the keyworker and outlined their responsibilities. One relative told us, "Both my parents have a meaningful relationship with their keyworkers. One is part time and I can go weeks without crossing paths but I can ask other staff and they are up to speed on how my [relative] is." There were new staff in post but some of the longer serving staff knew people well and were able to tell us about individuals, their needs and what they enjoyed. We observed staff talking to an individual about their wedding anniversary which they were due to celebrate.

An initiative called the "Butterfly effect" had recently been introduced. The aim was to encourage staff to communicate and interact with those people who stay in their room by providing accessible information about people's interests. For example for one person it was recorded, "When you flutter in to see me feel free to say hello. Offer me a drink and biscuit. Please ask if I need anything else. I love to chat about boxing...this is my passion."



People's privacy, dignity and independence was respected and promoted. People told us that staff treated them in a way that respected their dignity and we observed staff speaking with people appropriately. Staff closed the curtains and the doors before assisting with personal care. The manager told us that all staff completed training on values and attitudes in care. People told us that they were encouraged to be independent and maintain their current levels of mobility. One person told us, "I had a stroke and could not walk and the staff have helped me and encouraged me to walk again and I can now walk with my walker. It is all down to them."



## Is the service responsive?

### Our findings

At our last inspection of the service on 1 June 2017, we rated responsive as requires improvement. This was because care was not person centred. We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan and overall we found improvements had been made to care planning, care plans better reflected people's needs and were more person centred, however some gaps remained and we found that people did not consistently receive care which was responsive to their needs.

Prior to the inspection, concerns were raised with us about the preadmission assessment process and its robustness. We found that the service had admitted some people on an emergency basis which meant that their needs assessment was based on the information provided by the hospital and local authority. The service did not complete their own assessment until the individual arrived at the service. For one person this meant that they did not have the equipment they needed on site on arrival and this impacted on their care. A family member told us how information was not provided and the service was still chasing information well after the individual was admitted. We recommend that the service review their assessment procedures for emergency admission to ensure that the assessments are comprehensive and ensure good continuity of care.

The assessment was used to develop care plans which were largely informative and up to date. The care plans included information about people's personal history, care preferences and interests. For example we saw that they included information on any aids or adaptations needed for communication, such as glasses and hearing aids. Peoples preferences were also included such as, what people liked to eat, the gender of staff to support them and whether they wished to be checked during the night. However for some individuals with complex needs including people with dementia, we found that some of the documentation lacked detail. For example, one of the people whose care we looked at was pacing around the room and asking to go home. The care plan did not provide sufficient information to guide staff on how to support the person, such as how to divert their attention and engage with them in a meaningful and consistent way.

Staff had access to care plans but we were not confident that they all knew the contents. A number of relatives had reminder lists for staff which stated, 'put in dentures' and 'check batteries in hearing aids'. One of the people whose care we looked at did not have any dentures in place and it was not clear why they had not been supported to access them. This was addressed directly with staff who assisted the individual.

Prior to the inspection, a number of relatives expressed concerns about how their relative was supported with their personal care. We identified issues with the management and oversight of continence as some people were observed to be wet and there was a strong smell of urine in some parts of the service. At the last inspection we identified issues with how they monitored peoples bowel movements and while changes had been made to the documentation this did not enable daily monitoring and therefore was not fully resolved. The registered manager told us that they would look again at the documentation but had already identified that staff would benefit from more training on the management of continence and had arranged for continence staff to come to the service to provide training on this area.

We found that the provider was in continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received handovers at the start of their shift on the wellbeing of the people they supported to enable them to support people safely. We saw that staff completed a range of recording tools to enable people's needs to be monitored. For example we saw records to evidence that people were regularly being offered personal care and showers. This corresponded with what people told us, one person said, "My bath is lovely, I am not allowed to do it on my own, I have it once a week and I am happy with that."

Relatives told us that they were kept informed of changes in their relative's wellbeing, "If [my relative] is not well or has falls I get a phone call, they are very good at that." Another told us, "We are very satisfied with care from the home, the level of communication is very good and they phone and tell me if the doctor, or nurse visits and tell me of any changes in [my relatives] failing health."

We looked at the arrangements in place to support people at the end of their life to have a dignified pain free death. We found that apart from statements such as, 'Funeral plan in place' and 'want to stay at Loganberry' people had no detailed information setting out their views as to how they would wish to be cared for at the end of their life and if needing to receive palliative care. We spoke with the registered manager about the lack of detail for one person who was on a palliative care pathway and they responded by redrafting the individuals care plan. The manager told us that staff would be attending sessions on end of life care, facilitated by the GP which would include guidance to staff on approaching the subject of end of life and gaining crucial information in a sensitive way from people themselves and/or their relatives.

Activities were provided to promote peoples wellbeing. The service employed an activities coordinator and a number of activity staff and the registered manager told us that a new staff appointment had been made to build on the team. On the day of our visit we saw some activities were provided in the communal areas and the member of staff worked hard to ensure that those individuals who wished to could join in. One person told us, "The activities are good, the guys a great motivator" The activities included a quiz and a gentleman's club. Another person told us, "The entertainment manager comes and tells me what is on. There is a notice in the hall saying what activities are on and I go and look on the wall, it would be helpful to have a list." A third person said, "I don't mind it here, they have got the activities well organised, the armchair exercises loosen you up, I like the bingo."

Despite the organised activities, in some parts of the service we found that people spent long periods of time asleep and disengaged. Staff were busy and did not always have time to engage with people. We saw in one of the lounges we visited used by people with dementia there was a puzzle, a cuddly toy and some books on the shelf. Further efforts could be made to enhance the lives of people with dementia for example with the provision of items for people to touch and receive comfort.

The service encouraged people to develop relationships with those who were important to them to avoid social isolation. Since the last inspection the registered provider had developed a new cafe in one part of the service. This was inviting and comfortable and it was positive to see it being well used on the day of the inspection. One person proudly told us, "I suggested the name of the café, 'Tea Cosy'." The registered manager told us that they would be facilitating the use of the Café by the Alzheimer's society and encouraging access by relatives and the local community.

People and their relatives told us that their concerns were investigated. One relative told us, "If we've had a problem the management have always been able to resolve it." There was a complaints procedure in place for people to use to raise concerns which referred people to the regional manager, the local authority and

CQC. We looked at the records of complaints and saw that concerns had been investigated and where shortfalls were found, apologies had been given and actions identified. In addition to complaints, we also saw a record of compliments which included the following, 'Thank you for the first rate care my relative has received since they came to the home.'

## Is the service well-led?

### Our findings

At our previous inspection Loganberry Lodge was not meeting the requirements of the law and was placed in special measures. The management team had started to make changes at the service but it was too early to see if they could be sustained.

At this inspection we found that the service had continued to improve although there remained some issues around consistency of practice which still had to be addressed. However, people's experience of the service was better. One person told us, "It's improving, we went through a bad patch." A relative told us, "Management has changed, staff were unsettled but no issues now."

A new management structure was in place and we found that the culture within the service had improved. There was visible leadership and a greater focus on providing person centred care. The registered manager was proud of some of the changes that had been made to how care was delivered and the fact that they were now fully staffed. They were aware of some of the challenges presented by a new staff team and had a plan to address some of the issues around consistency that we found.

Staff spoke positively about the new senior team and told us that they had opportunities to contribute to developments. Staff told us and records confirmed team meetings were held to discuss operational issues and people's needs. Records we looked at confirmed the dates of the meetings as well as the minutes.

Staff told us they received regular supervision and annual appraisal regarding their performance. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. The registered manager told us that it was planned that the new managers would take responsibility for different areas of practice and would drive improvement in these areas.

The registered manager told us they engaged with people using the service, their families, the public and staff to ascertain their views of the care. Relatives confirmed this. One relative told us, "The manager is accessible and has an open door." We saw relative and resident meetings were held and surveys conducted looking at areas such as the provision of meals and activities. We saw that the registered manager and provider used the information to make changes to the provision.

The registered manager and provider collated a range of information on quality and risk. The data was clear and well organised and where shortfalls were identified action plans were in place. Incidents and accidents such as falls were logged to identify any patterns and actions were clearly documented. Similarly with weight loss, there were systems in place to review people's weight over a number of months and clearly see that action was being taken. The registered manager had oversight of specific risks, for example people who were prescribed specific types of medicines or those who had a specific health condition which required additional monitoring.

The manager and the regional operational staff undertook a number of audits to check on the care delivery

as part of the provider's quality auditing system. These looked at a range of areas including care plans, infection control, medicine and health and safety. These audits had identified some but not all of the issues that we found. Where areas had been identified there were clear timescales for improvements and the registered manager received regular support visits from the provider's area manager. The registered manager told us they attended regular management meetings with managers from others services owned by the provider to share ideas and best practice. The provider also organised for an external company to undertake a compliance visit report and there was an action plan in place in relation to this.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  Peoples care did not always meet their needs. Care plans did not always provide sufficient guidance to staff to ensure people's needs were met.