Runwood Homes Limited

Humfrey Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place over two days on the 11 October and 13 October 2017, was unannounced on day one, and announced on day two.

Humfrey Lodge provides accommodation and personal care support for up 48 people including people living with dementia. The service is provided from within a purpose built building, with rooms and communal areas all on one level and located within a residential area. The service has a number of courtyard gardens which people are able to access if they choose. On the day of our inspection there were 47 people living at the service.

Humfrey Lodge had been through a period of instability with a change of three managers within the last three years. Since our last inspection, a new manager had been appointed and had registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in October 2016, this service was rated as Requires Improvement as we found that the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to provide and deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they met people's care and treatment needs. We also found the nutritional needs of people were not always being met, as there was inadequate monitoring of people at risk of losing weight and inadequate fluid intake. We asked the provider to take action to make improvements. They sent us their action plan which told us what steps they would take to improve and ensure compliance with legal requirements.

At this inspection, we found some improvement. Whilst the provider told us that the recruitment and retaining of staff continued to be a challenge, we found sufficient numbers of suitably qualified, competent, skilled and experienced staff available to meet people's needs.

The monitoring of people's food and fluid intake had improved. However, further work was needed to ensure where people gained excessive weight which could impact on their health and wellbeing, this was monitored and appropriate referrals made to specialists for advice and guidance.

We found some discrepancies with contradictory information recorded by night staff in relation fluid balance charts and repositioning records. We could not be assured that care and support recorded had actually been provided. Whilst care plans were person centred and detailed in places, some lacked specific information about people's care. For example, care plans did not consistently reflect the needs of people who required staff to support them with moving and handling, safely using specialist equipment. In response to our feedback, the registered manager responded promptly to our concerns and by the second

day of our inspection had taken immediate action to rectify the shortfalls we identified.

The registered provider had a system in place to ensure appropriate recruitment checks had been carried out before staff started working at the service. Staff received training to equip them for the roles for which they were employed.

Staff had received training to enable them to recognise signs and symptoms of abuse and said they were confident in how to report any concerns they might have. In relation to risk, we found the quality of information recorded in care plans varied.

People told us they felt safe living at Humfrey Lodge. They were satisfied with the way staff provided care and support and told us they were treated with dignity and respect. People's needs and choices had been assessed and care and treatment delivered in line with people's wishes and preferences.

Throughout our two day inspection, we observed staff asking for people's consent before providing them with care and treatment. People's capacity to consent to aspects of their care and treatment was documented in their care plans. Staff had been provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and related Deprivation of Liberty Safeguards (DoLS).

Medicines were managed safely and people received their prescribed medicines when they needed them. Staff were trained and verified as competent to administer medicines.

The service was clean, well maintained with infection control measures in place. Domestic and care staff had a good understanding of how to reduce the risk and spread of infection.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were offered choice. People were supported to access health care when required, including access to specialists when required.

We found that there was a clear management structure in place. Staff were aware of their roles and that of the management team. Staff, people who used the service, their relatives and stakeholders were all complimentary about the management team. They told us they found them approachable, engaging and had clear, person centred vision and values. There was an open culture where people felt comfortable to air their views and, provide honest feedback. The registered manager was a visible presence in the service. The registered manager and provider monitored the quality and safety of the service. Regular audits had been completed and any concerns addressed with action plans and timescales for actions planned.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We could not be assured that care support recorded had actually been provided. This was because there were discrepancies found with contradictory information recorded by night staff in relation fluid balance charts and repositioning records.

The risks to people from choking had not always been mitigated.

Staff understood their responsibilities with regard to safeguarding people from abuse and had received appropriate training.

We found improvement in the numbers of suitably, qualified and competent staff available to meet people's needs.

Medicines were managed well.

The service was clean, well maintained with infection control measures in place.

Is the service effective?

Good

The service was effective.

Staff received training relevant to their roles. Newly appointed staff received an induction and training, which provided them with the skills, and knowledge that they needed to fulfil the role for which they were employed.

People had balanced nutritious food provided. People were supported to access health care including learning disability specialists.

Staff had a good understanding of their roles and responsibilities under the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in the planning of their

care.

People were supported by staff who knew them well and were kind in their approach.

People's privacy respected and their dignity was protected.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed prior to their moving into the service.

Care plans outlined people's preferences and how they should be supported.

There was a system in place to manage concerns and complaints.

Is the service well-led?

Good

The service was well led.

There was an open culture where people felt comfortable to air their views and, provide honest feedback. The registered manager was a visible presence in the service.

There were clear communication systems in place such as handover meetings and communication books. The provider had systems in place to support staff and monitor performance such as, supervision, appraisal and staff meetings.

The registered manager and provider monitored the quality and safety of the service. Regular audits had been completed and any concerns addressed with timescales for action to address the shortfalls identified.

Humfrey Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 over two days on both the 11 October and 13 of October 2017 and was unannounced on day one but announced on day two.

This inspection was carried out by two Inspectors, an Inspection Manager, a Specialist Nurse Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing care and support for an older person.

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

We reviewed information available to us about the service, such as statutory notifications. A notification is information about important events, which the provider is required to send us by law.

Before our inspection, we contacted stakeholders. We received responses from one GP and one social care professional.

During our inspection, we spoke with 12 people who were able to verbally express their views about the quality of the service they received and eight people's relatives. We observed the care and support provided to people and the interactions between staff and people throughout our inspection.

We also spoke with six members of care staff including senior team leaders, the cook, three domestic staff, the activities coordinator, the registered manager and the regional operations director. We also spoke with two visiting health care professionals.

We reviewed care records for seven people. We also reviewed records in relation to medicines management, staff rotas, staff training, staff recruitment, meeting minutes and other records related to the quality and safety monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2016, we found there continued to be insufficient numbers of staff available at all times to ensure people received consistently safe and effective care. At this inspection, we found some improvement. There were sufficient staff available on both the two days of our visit to meet people's needs. The manager told us that there was one member of staff allocated to each unit, with the exception of Willow unit, which had two carers, as it was a larger unit. In addition, another two staff worked across all units to respond as and where required. This allocation of staff corresponded with our observations. We observed staff worked well as a team and call bells were responded to in a timely way.

People told us, "When I press the bell I don't wait long during the day and night. I feel safe, I have got my buzzer to hand", "I am happy enough here. When I ring the bell I don't wait long, they come more or less the same amount of time, all the time" and "The alarm calls the staff and they come pretty quick."

One relative told us, "There is the odd occasion when there doesn't appear to be enough staff around. I have noticed this occasionally at lunchtime. However, things have improved in the last year. It appears much more stable with familiar staff who can understand [relative's] needs without the language barrier there used to be. They are all very good."

We noted from the discussions with the registered manager and the operational directors audit report that whilst there had been some improvement, the recruitment and retaining of staff continued to pose a challenge to the service. The registered manager told us that at the time of our inspection there were 220 day and night care hours vacant. The registered manager told us there was ongoing recruitment with action plans in place to improve the pay and conditions to attract more staff.

Staff told us that since the last inspection the number of permanently employed staff had increased and that they worked well as a team to cover unforeseen events. Where necessary, agency staff familiar to the service were used to cover for staff annual leave and sickness absence. This staff told us helped to ensure continuity of care for people.

The provider had safe recruitment systems in place, which included background checks to ensure staff were safe to work with vulnerable people. Staff files reviewed contained information relating to the staff employed previous employment history, including any information relating to gaps in employment. References had been obtained which included both personal and professional references where possible and all staff had a Disclosure and Barring Service check (DBS) which had been obtained and reviewed prior to staff starting work at the service. The recruitment process was more robust and tested that staff had the skills and experience to meet the needs of people using the service.

We saw that one person who used the service was actively involved in the recruitment and selection of staff as they sat on the interview panels. They were consulted as to their views in making staff appointment decisions.

Everyone we spoke with told us they felt safe living at Humfrey Lodge. People trusted the staff to keep them safe. We found there were improved systems in place, which were designed to monitor the risks to people's health, welfare and safety and keep people safe.

Staff had received training in safeguarding people from abuse and systems were in place to reduce the risk of abuse. Staff were able to tell us what they would do if they suspected or witnessed abuse and information was available to guide staff if they needed to make a safeguarding referral to the local authority. Staff were aware of the service's whistle blowing policy and told us they would raise a concern about unsafe practice if they witnessed it. The service had reported safeguarding concerns appropriately and had notified CQC of any they were dealing with.

We found a range of risk assessment tools in place including, assessment of people at risk of pressure sores, falls, choking and moving and handling. Each risk assessment identified a scoring system, which identified the level of risk. This information was used to formulate the person's care plan, which provided staff with guidance as to steps they should take to mitigate the risk of harm.

We noted people identified as at risk of developing pressure ulcers had appropriate equipment in place, such as pressure relieving mattresses and pressure cushions in their chair. We saw that the pressure of the air mattresses had been regularly checked and set according to the person's weight.

We were not assured that care support recorded as given had actually been provided. We found some discrepancies with contradictory information recorded by night staff in relation fluid balance charts and repositioning records. We discussed our findings with the registered manager. On the second day of our inspection, we found that the registered manager in response to our concerns had taken immediate action. For example, they had requested an urgent assessment from a tissue viability nurse who assessed people with a pressure ulcer in situ. Their advice and guidance had been updated into the people's care plans. The registered manager had also carried out a night staff meeting. A review of the meeting minutes showed us that night staff team performance in maintaining accurate records had been addressed. These staff had also been provided with up to date guidance with steps they should take to maintain people's skin integrity, prevent pressure ulcers from developing and mitigate the risk of harm.

There were systems in place to manage the risk of falls. We saw equipment in place, such as sensor mats, to alert staff when a person at high risk of falling got out of bed. There was a system to analyse on a monthly basis the frequency of falls. This analysis enabled the provider to detect any patterns or trends to see if any further measures were needed to reduce the number of falls. We saw where action had been taken with referrals to the falls prevention team for specialist advice and support.

Where mobility equipment was required, we found the quality of information provided in care plans varied. For example, we found where staff were required to use slides sheets to support people to move safely in bed, care plans did not always identify that this equipment was in use or provide guidance for staff how to safely use these. We also found where hoist lifting equipment was in place, there was not always guidance provided to ensure staff used the correct sling type with a description of the sling loop to attach to the hoist. This was important to mitigate the risk of people falling from the hoist. We found for one person where the sling type had been recorded on the person's care plan this did not relate to the actual sling we found in the person's room. We discussed this with the registered manager who reacted promptly to rectify this. We found on the second day of our inspection the registered manager had updated relevant care plans with the information required. They also included photos of the equipment to provide staff with more comprehensive guidance to keep people safe from the risk of harm.

The risks to people from choking had not always been mitigated. We observed one person sleeping in a chair just prior to lunch when their dentures had fallen out of their mouth onto their lap. We saw one member of care staff gently wake the person and discretely and hygienically removed the fallen dentures to take them away for cleaning. However, another carer then took over and was responsible for supporting this person with their lunch. Later, as lunch had been served, we needed to intervene and ask the carer to find the person's dentures as they were struggling to eat their lunch without them. We reviewed this person's care plan, which recorded that this person required their dentures in place to eat safely and avoid the risk of choking.

Risks relating to the environment had been assessed and measures put in place to reduce these risks. The staff member responsible for maintenance had an overview of routine maintenance required and kept clear and accurate records. Fire detecting and fire-fighting equipment was regularly checked, as were water temperatures to prevent scalding and monitor Legionella risks. Electric hoists, including bath hoists were regularly serviced. The provider had carried out comprehensive health and safety audits. Where shortfalls had been identified action, plans were in place with timescales for action to be completed.

Medicines were managed safely and people received their prescribed medicines on time. There were systems in place for the ordering, safe storage, administration and disposal of medicines including controlled drugs. Information about what people's medicines were for and how they liked to take them was comprehensive and made clear to staff. Protocols were in place for 'as and when required medicines' (PRN) such as for pain relief. People told us their prescribed medicines were made available without delay.

We observed a drugs round and noted that people were asked about pain relief as a matter of routine. People told us, "I have my medicines regularly, they give them and we take them and they like to see you have taken them, I have them on time when I need them." And "If you want something to take away the pain you just pull the buzzer and they are there in a couple of minutes." Another person told us, I always get my medicines on time. I don't like them but I know that I have to take them. They also empty my catheter bag regularly."

We carried out an audit of stock against medication administration records. We found that these tallied. Body maps were used to indicate the site for application of prescribed creams, lotions and transdermal patches for pain relief. Records had been made to indicate where on the body transdermal patches had been applied to ensure alternate sites were used at each administration.

All staff who administered medicines had received relevant training and their competency was checked regularly to ensure their practice remained safe and effective.

A GP told us, "Medication is being managed better now. The staff have mastered requesting medication on line and there are not many requests for urgent drugs. We recently had a day when all medication was reviewed by myself, the deputy manager and the community pharmacist, which highlighted some alterations that needed to be made.

At the last inspection, we identified concerns relating to the overall cleanliness of the home. At this inspection, we found that the home was clean, fresh and odour free. We spoke to the registered manager about the improvements and were told that they had recruited more domestic staff and a housekeeper to oversee the cleanliness of the home on a daily basis. Domestic staff spoken to were clear about their responsibilities and tasks and were aware of infection control policies and procedures and we observed that they followed these in practice.

People told us they were happy with the cleanliness of their room and communal areas. The most recent residents meeting minutes showed that people had told the provider that there had been an improvement in this area, which they were happy with. For example, in the minutes of the August 2017 relatives meeting, a person had told the meeting that they 'were not happy with the cleanliness of their room.' In the minutes of the September 2017 residents meeting, the same person was quoted as having said, 'I've changed rooms now and I prefer it, it is nicer.' In the July 2017 meeting minutes, one person was recorded as having said, 'the smell is foul, the home doesn't ever smell nice.' In addition, the notes of the residents meeting on 31 August 2017 recorded that everyone mentioned that 'the home smells much better compared to last month. The cleaning audit showed that an area of the home is deep cleaned daily and that this was having a positive impact on ensuring an acceptable level of cleanliness.

However, we did note on occasion that food dropped during lunchtime in people's rooms was not always cleaned quickly. If a person's room had been cleaned before lunchtime and food was dropped, there was a risk that this would not be cleaned until the domestic staff did another check on the room later in the day. We also observed that the kitchen units within the individual kitchenette areas were not clean on the outside, with handprints and needed to be included in the deep clean for these areas to ensure they are kept hygienically clean.

Infection control and cleanliness audits were carried out monthly and any identified issues had an associated action plan where tasks were allocated and completed. This was evidenced within the action plan and at the next month's audit.

Good

Is the service effective?

Our findings

At our last inspection in October 2016, we found the nutritional needs of people were not always being met. We found inadequate monitoring of people at risk of losing weight and dehydration. Staff did not always accurately record the food that people consumed. This meant that the monitoring of people's nutrition and hydration was ineffective. At this inspection, we found some improvement with further work needed to ensure that the nutritional and hydration needs of people are met at all times.

We observed lunch, which was served in the main dining room and on individual units. All of the people we spoke with were complimentary about the food. Comments included, "The food is lovely", "Food is very good. The lady from the kitchen came last week to see me and asked if I enjoyed the food, it is very good", "Food is blooming good, always hot and fresh. We get two meal choices and if you don't like it, they would probably make you a salad. The cook comes round, she came round today. You can have seconds if you want." and "Food is lovely they don't give you too much. We are given a choice each day. I like my veg and the cabbage and the fish was lovely today."
We saw that the majority of people were offered choice and were provided with further helpings, condiments, and sauces to their taste. However, where people required adaptive aids to enable them to eat their meals more comfotably these were not always provided. When asked staff told us these were available to offer.

We saw that where people were provided with visual aids such as, two plates of food presented to enable them to choose which of the two meal choices of the day they preferred. However, the plates of food were unrecognisable as only small pieces of each type of food contained within the meal were placed on the plate. This meant that the plated food did not give anyone a good idea of what the choices were, as both choices looked the same. We discussed our findings with the registered manager. On the second day of our visit, we found that action had been taken to ensure adaptive cutlery and crockery was provided to those who needed them. They had also taken action to ensure that full plates of food were presented to people

It was evident throughout the lunchtime observations that staff had a good relationship with people and knew them well. They encouraged people to eat independently and were discrete in clearing away any food that had fallen to ensure dignity. After lunch the cook went round and spoke to people with a short survey asking them how they found their lunch, if it was hot enough and if there was anything else they would like to let them know regarding future planning of the menu.

We observed people being regularly offered fluids. Drinks were available in communal areas for people to access.
We saw from our review of records that where people needed to see a GP or had been identified as losing weight, staff had referred promptly to dieticians for specialist advice. However, one person's weight had increased by 10KG within the four months since they had moved to the service. We noted from a review of their care plan and discussions with the registered manager that no action had been taken to refer this person to a dietician for support and guidance in planning for any weight management. Left unmonitored this had the potential to put this person's health at risk given their other health care needs they lived with.

The registered manager told us in response to our findings that they would take immediate action to refer this person to a dietician for advice and support.

All staff spoke positively about the training they received. Two of the staff we spoke with were relatively new and were still in their probation period. They told us that had received a comprehensive induction, which included shadowing other more experienced colleagues as well as undertaking specific training on areas such as first aid, pressure ulcer prevention, safeguarding, moving and handling and dementia awareness. Staff told us that as a result of training they knew how to refer people to a tissue viability nurse in order to get advice and help in the management and prevention of pressure ulcers.

Other staff told us that their skills were kept up to date through a combination of e-Learning and face to face training. The registered manager had an overall training matrix, which showed that most courses had been delivered to the staff team and flagged up when refresher training was due. Training was a mixture of online sessions and face to face training with practical sessions. One member of staff told us about the pressure care training they had recently attended and how this had helped them identify the difference between a moisture lesion and an ulcer. They also said there were systems in place, which supported them with regular one to one supervision meetings and yearly appraisals. This meant that staff had been provided with opportunities to discuss their training and development needs.

Throughout our two day inspection, we observed staff asking for people's consent before providing them with care and treatment. People's capacity to consent to aspects of their care and treatment was documented in their care plans. However, we noted one person cared for in bed had long, soiled fingernails. The registered manager told us staff had struggled to support this person with maintaining their personal care, as they were resistant to this support when offered. However, there was no reference to this in their care plan, with strategies to guide staff in supporting this person appropriately.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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 take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We checked if the service was working within the principles of the MCA.

Staff had been provided with training in understanding their roles and responsibilities concerning the Mental Capacity Act 2005 (MCA) and related Deprivation of Liberty Safeguards (DoLS). The registered manager told us this training was now provided face to face rather than by e-learning. This enabled staff to ask questions and discuss scenarios to support their learning. Staff told us this training had supported them to become clearer about people's right to make decisions, including decisions, which might be viewed by others as unwise. We saw that Best Interest decisions had been appropriately taken on behalf of people who had been assessed as being unable to make a decision for themselves. For example, in relation to medication, the use of bedrails, delivery of personal care and receiving the influenza vaccination. We also saw that, where required, applications had been made to the local authority when it was felt that someone required their freedom of movement to be restricted and be deprived of their liberty in order to keep them safe.

Care plans described people's wishes with regard to whether or not they wished to be resuscitated should they suffer a cardiac arrest. Appropriate DNACPR orders (do not attempt cardio pulmonary resuscitation) were in place for people who wanted this and staff were aware of who had these in place. In the event of any

emergency senior staff had access to quick reference guides, which provided them with information as to who had chosen not to be resuscitated.

Care plans included information as to people's appointed legal power of attorney to make decisions on their behalf. Where people lacked capacity to consent to having bed rails in place, consent had been obtained and care plans signed to evidence this.

Staff were knowledgeable about people's healthcare needs and current health conditions. Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls prevention team, continence service, opticians, occupational therapists, dieticians and chiropodists.

People told us staff responded quickly if they became unwell. One person said, "I can see a doctor when I need one. The doctor comes here every week." A relative told us, "[Relative] had a urine infection and they quickly got the doctor to prescribe antibiotics. They always keep me informed of things like that."

People had access to regular eye screening, chiropodists and dentists. People told us opticians and a chiropodist visited the service regularly. We noted that people diagnosed with diabetes had their eye and foot care regularly monitored. Advice given had been recorded in care plans.

Prior to our inspection, we received feedback from stakeholders in relation to people's access to healthcare. For example, a local healthcare professional was positive about the way the service managed people's healthcare. They told us, "I have looked after Humfrey Lodge for the past 20 years and so have had a great deal of contact over that time. Usually problems are highlighted early and reported to the district nursing team or doctors." However, one social care professional told us, "There is some dependency on waiting for the weekly GP round to voice concerns. Recently, despite asking a senior carer to ensure that a GP was informed of a non-urgent medical condition, this was not followed through quickly and was also missed on the weekly round. I picked this up on my next visit 10 days later and the care team then took immediate action and the issue was resolved."

During our inspection we spoke with a visiting GP. They told us, "Staff here are quick to respond and keep us well informed of people's changing needs. We have a weekly surgery here and they keep a list of people we need to see. They also call us if needed in between."

Good

Is the service caring?

Our findings

People, who used the service and their relatives, told us they were satisfied with the way staff provided care and support. One person told us, "The staff are very nice. They call me by name. When they shower or wash me, they always tell me what they are going to do. The actual care has improved." Another said, "The staff are good and friendly. They come and see if you are alright and they bring you food and drink. They come and chat, they listen and I know some of their names."

One relative told us, "[Relative] was stressed when they first came to live here. Staff have been very friendly and thoughtful and have helped [relative] settle in really well."

We saw numerous examples of staff demonstrating patience and kindness whilst supporting people. We observed staff treating people with kindness and sharing a joke with them, which we saw was greatly welcomed. We observed staff touching people appropriately to reassure them when anxious and showing genuine interest in them. We heard one member of care staff asking one person, "Did you used to cook?" and encouraging the person to tell them about the food they liked to cook whist encouraging them to make a choice about the midday meal.

One person told us, "Even in the night they are there. A few weeks ago, I was in such a state and they wheeled me outside at 4am so I could have a fag and calm down. They work so hard, they never rush me and they do everything for me that I need doing. I like my privacy and sometimes I tell them to go away. They don't mind and they listen to me. They are very kind and they give us time, but they are busy, they are wonderful."

The housekeeping team clearly knew people well. Before lunch, they came into the dining room and had an impromptu singing session with people whilst they waited for their meals. There was lots of banter and these staff seemed to be genuinely fond of people.

People told us staff treated them with dignity and promoted their independence. Comments included, "I prefer to stay in my room and only go out to the toilet. They respect this. You are not on your own, I have my door open and I can see people and they come in to check on you", "Sometimes they cut up my meat, but most of the time I can manage myself", "They wash me and give me choice when they get my clothes out of the wardrobe. I can choose what to wear. I always get my shower and they never miss one. I like a shower in the late afternoon. They always treat me with dignity. " Another said, "Most of them are nice and kind and helpful. Just one rough one and I say to her, 'Be careful' and she says, 'Sorry, I don't mean to be rough'. They always know and say what is going to happen to me. They encourage you to do what you can for yourself."

Relative's told us they were always made to feel welcome. One relative told us, "Honestly, it is such a lovely place. I enjoy coming here it feels like one big family. They always come and have a chat with you." Another said, "We can visit anytime, they like meal times to be private but they always welcome you anyway. [Relative] likes the church service. [Relative] wants for nothing here, they are very good." In addition, another relative said, "They let me bring the dog in. I am made to feel welcome and [relative] seems to be well

looked after."

Good

Is the service responsive?

Our findings

People's needs were assessed prior to their moving into the service. This assessment involved the person and people important to them, such as a relative or those with authority to act on their behalf.

At our previous inspection, we found that staff did not always have easy access to care plans as they were locked away. They did not always have the opportunity to read them and be involved in their review. At this inspection, we found that staff had been enabled to have improved, easy access to where care plans were safely stored. Staff told us that they were able to look at care plans when people were first admitted to the service to enable them the opportunity to get to know people's needs and to review any updates.

We found care plans varied in the level of detail provided. They contained information about people's preferences such as what they liked to eat, how they chose to take their medicines, their day and night time routines, mobility plans and end of life wishes. They also contained information in how best to support people with effective communication. For example, one person's care plan read, 'speak to me in short words and show me what I need to do'. Care plans provided staff with clear guidance as to people's preferred night time routines and in meeting their care and support needs. For example, one person's night care plan described what they liked to wear to bed, the time they would choose to retire and how many pillows they liked.

We saw that for some people living with dementia their care plans recorded their life histories but not all had been completed. Some people's care plans contained a family tree. However, we could not always see how this related to their plan of care. For example, one person had worked in a builder's merchant and had also been a milkman. Staff told us this person was often awake during the night and taking items from other people's rooms. We recommended that this person might benefit from a sensory assessment with consideration of their previous lifestyle and the impact of this may have on their day and night time routines.

Staff told us that they received daily handovers at the beginning of shifts from the senior staff member. Reviews of people's needs had been regularly undertaken and we noted there was good relative involvement. However, it was not always evident how comments received were actioned. For example, One relative had stated, "Some staff are better than others, everyone is polite but experience and understanding of dementia is lacking in some staff. Care is often reactive instead of being proactive. [Relative] is not included in activities, they are aimed at older women."

There was a range of organised group activities available for people to access. Two activity organisers were employed to provide a programme of activities on a Monday through to Friday. The registered manager told us, care staff supported people with activities at the weekends.

One person told us, "There are activities which we are asked if we want to go to but it is my choice not to go. They don't mind I am quite happy." Another told us, "They recently put on a Bollywood show for us, with Indian food and staff dressed up in Indian costumes. We also get to do sewing, have singers to entertain us and tea parties. This makes people get together. Whatever they organise they put it on the notice board and

you can see what is coming up. I like the bingo and I often go out with my daughter." We observed whilst the majority of people involved in group activities were women, men also were invited and attended activities provided. We also saw that some men enjoyed outings with staff to local shops.

Activities, which took place during our inspection included, nail painting, colouring and arts and crafts. A weekly activities programme had been produced and this was placed on notice boards. This described a plan of activities such as; knitting, puzzles and games, a colouring club, movie night and cake decorating. A seasonal newsletter had also been produced which showed a number of photos of people engaged in chair exercise classes and shopping trips. However, further work could be carried out to ensure there was a plan in place to protect people being cared for in bed from the risk of social isolation.

There was a complaints process in place. One relative told us, "The manager is very approachable and I would not hesitate to raise any concerns if it was required." Another told us, "The manager's door is always open. If I have a need to talk through anything worrying, she is there to listen."

A review of the provider's complaints log showed us four complaints had been received in the last year. These related to shortfalls in the standard of laundry and cleanliness. We found a clear audit trail for these complaints, with actions taken in response and with outcomes evidenced.

People had access to regular residents meetings. One person told us, "We have residents meetings where we can talk about what goes on, what is planned and if you want to say something you can." We saw that these meetings were well attended. Subjects discussed were very similar each month, however this did mean the provider could track issues and see if these had improved. Issues discussed included, cleanliness of the service, laundry, food, staffing and activities. People were able to air their views and these were recorded. Action plans were drawn up if issues were raised that needed to be managed. We saw that there were clear actions for staff and dates by which the concern raised needed to be addressed. The minutes of the next meeting showed that residents were updated on any issues previously discussed and able to comment on any observed improvement or decline.

Relatives also had access to monthly meetings. However, these were less well attended. The manager also held weekly open door meetings where relatives had access to the manager to discuss any concerns they might have. This showed us that people had opportunities to comment and contribute to how the service was managed.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. Since our last inspection in October 2016, a new manager had been appointed and had registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC to manage the service. Humfrey Lodge had been through a period of instability with changes of three managers' within the last three years.

There was a clear management structure in place. Staff were aware of their roles, responsibilities, and that of the management team. They told us the registered manager was approachable, and had a visible presence within the service.

Staff, people who used the service and their relatives were complimentary about the registered manager. Comments included, "The manager's door is always open she is caring and supportive", "The manager comes out and helps on the floor. She helps to support us with getting people up, helps with cleaning and makes the beds when we need support", "If we are short we all pull together including the manager, it's like a little family here. Since this manager has been here the cleanliness and the atmosphere in the home has improved" and "Things have changed for the better, such as the cleanliness and the staff we have now are more caring. We work as a team and the manager helps if we need a hand, she makes an effort and stays in the evening. When she is on call she always comes when needed" and "Staff are more positive and the morale is good."

Staff morale was positive and staff told us that issues were openly discussed. There were clear communication systems in place such as handover meetings and communication books. The provider had systems in place to support staff and monitor performance such as, supervision, appraisal and staff meetings. Staff told us they were actively encouraged to question practice and make suggestions for improvements and their ideas were listened to. Staff meeting minutes showed us that staff feedback was encouraged.

The manager was well supported in turn by the regional operations director who praised the skills and expertise of the manager. They also commented on how successfully the manager had brought stability to the service, developed, and skilled her team.

Feedback received from a social care professional said, "I have built up a good working relationship with the manager and the deputy. I am able to speak to them any time about any issues. My own view is that Humphrey Lodge strives to be a caring supportive care home and they are friendly and helpful. Discussing with my colleagues they feel that the carers are very caring and try very hard to meet people's needs. Colleagues also have said that there has been improvement since the new manager and deputy manager have been in place. Care plans have been more up-to-date and clear when checking on my clients and I have observed people are treated with respect."

Feedback from a GP told us, "The new manager has brought a sense of calm to Humfrey Lodge. It is being run more efficiently and the manager and deputy manager are very caring and receptive to the residents'

needs. Usually problems are highlighted early and reported to the district nursing team or doctors."

The registered provider when asked in their Provider Information Return (PIR), 'What do you do to ensure the service is well-led?' They told us, "I have an open door policy and encourage staff, residents, outside professionals to come any time to see me. To ensure all staff are supported in their roles. I encourage all staff to attend monthly meetings and to put forward any ideas they have to improve Humfrey Lodge. I believe in being open and transparent. We need to learn if mistakes are made. Staff handover to me daily and I am aware of incidents or accidents. I regularly walk the floor, help and support in any way to ensure the standards are maintained.'

We also asked, 'What improvements do you plan to introduce in the next 12 months that will make your service better led, and how will these be introduced?' They told us, 'To continue with on going recruitment, continue to improve communication with staff and outside professionals. To attend all training that is offered to me and to bring new ideas into the home from my involvement with Prosper.' The registered manager told us they had signed up to and had been involved with the 'Prosper' project. This is a scheme to improve the quality and safety within care homes across Essex, funded by an independent charity working to improve the quality of health and social care in the UK.

The registered manager and provider monitored the quality and safety of the service. Regular audits had been completed and any concerns addressed with action plans and timescales for actions planned. Audits included; health and safety, infection control, medicines management, care plan audits, call bell monitoring and overall analysis of weights, falls and skin tears. During our inspection, we identified that where staff had identified bruising they had recorded this onto body maps. However, there was a lack of analysis, which would evidence any investigation as to how these had been sustained. We discussed this with the registered manager who by day two of our inspection had put in place a system for monitoring and recording a response to follow up investigations with outcomes described.