Uniquehelp Limited

Harbledown Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 22 and 24 May 2018 and was unannounced.

Harbledown Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is part of the Nicholas James Care Homes Group and is registered under Uniquehelp Limited. It is a registered nursing home for 56 older people. There were 42 people using the service during our inspection; some of whom were living with dementia and conditions such as diabetes or impaired mobility or with more complex nursing needs. It provides adapted accessible accommodation over three floors.

We last inspected Harbledown Lodge on 18, 19 and 20 April 2017. We rated the service as requires improvement in two key domains safe and well led. The breaches were in respect of the assessment and review of risk to people using the service and safe use of equipment and premises, maintenance of accurate records, and the development and use of effective quality assurance systems.

Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the service. We carried out this inspection as part of our programme of scheduled inspections; we checked that they had implemented the action plan. At this inspection we found that whilst improvements had been made to meet previous breaches in regard to management of risk; there was insufficient progress to meet outstanding breaches in respect of record keeping and effective audit processes. We have rated the service as Requires Improvement overall, this is the third consecutive time the service has been rated Requires Improvement.

At this inspection we found that inconsistencies remained in the completion of records of food and fluid intake for those nutritionally at risk, and also in repositioning records of those assessed as at risk of pressure ulcers. This information was important to enable monitoring that people were receiving the assessed level of care and support they required. Quality assurance checks to monitor records were undertaken but not completed robustly. A few people experienced distress that presented as behaviour that could be challenging, measures to reduce risk around this were in place but had not been recorded in risk information to ensure all measures had been implemented to safeguard people; we have made a recommendation around this.

There was a new registered manager in post, who is proactive, and shows enthusiasm and commitment to develop the service and given time address many of the previous shortfalls. We have taken this into consideration in our response to this continued rating of requires improvement.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People, relative's and staff said they found the new registered manager approachable; she was a visible presence in the service. Some health and social care professionals thought the service was improving. Staff told us that they felt well supported, they were provided with appropriate induction and training to give them the skills and knowledge needed for their role, they had opportunities to express their views. The registered manager used a dependency tool to help determine how many staff were needed; this was kept under review. People, staff and relatives told us there was enough staff.

People were supported with their religious beliefs. Staff demonstrated values of kindness compassion and commitment in their day to day practice. They were respectful of people's privacy and dignity. They were not familiar with the providers stated values and lacked understanding of their responsibilities around Duty of Candour. These are areas for improvement. Staff however, understood how to recognise and respond to abuse of service users and to escalate their concerns if they needed to. People and their relatives felt confident to express their views and concerns. People and their relatives were invited to meetings and sent surveys to ask for their feedback, these were analysed and people were kept informed of the outcomes from survey results.

Medicines were safely managed. Staff understood how to protect people from harm and abuse and knew how to escalate concerns. People's consent was sought by staff in delivery of their daily care. Staff understood and supported people in accordance with the principles of the Mental Capacity Act 2005.

People were offered choice around the food they ate, and their preferences and specific dietary needs were taken into consideration to ensure their nutritional needs were met. People's health needs were supported and referrals to health professionals were made on their behalf as and when needed. End of life care needs were managed appropriately so that people remained comfortable and their wishes were adhered to.

People had individualised care plans that reflected their needs and how they wished these to be supported. People and relatives were involved and consulted about care plan content and review.

Staff encouraged people to be involved and feel included in their environment. People were offered varied activities and participated in social activities of their choice. Staff knew people and their support needs well.

The premises were clean and well maintained, servicing of equipment was undertaken at regular intervals to protect peoples safety. The premises were accessible; it had been adapted to meet the physical care needs of people with mobility issues. Equipment to help mobilise people was available and serviced regularly. Fire systems were serviced and staff attended fire drills several times each year so that they knew how to evacuate the premises. Contingency plans were in place to inform staff how to manage emergency events and staff was provided with out of hours on call support from senior managers. Accident and incidents were recorded appropriately and actions taken to minimise recurrence.

We have made one recommendation in regard to behavioural risk assessments.

We have made a recommendation about accessible information.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Omissions in recording of some areas of risk remained.

The premises were clean and well maintained, equipment was serviced.

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

The registered manager analysed accidents and incidents and ensured these were managed appropriately.

There were enough staff to support people. There was a safe recruitment process in operation.

Is the service effective?

Good

The service was effective.

The premises had been adapted to meet people's needs although signage could be improved upon.

People referred to the service were assessed before they were admitted although records of these would benefit from fuller completion to inform decisions about admission.

Staff received and appropriate induction to the service and completed a range of mandatory training some processes for recording training needed improvement. Staff felt supported and received one to one support at regular intervals and an appraisal of their performance.

Peoples health needs were monitored and appropriate referrals made to other health professionals. People were given a choice of menu options each day that considered their dietary needs and preferences.

Staff sought people's consents to care and understood and worked to the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring

Staff demonstrated compassion, kindness and commitment to the wellbeing of people and safe delivery of care.

Staff respected people's privacy and dignity. People and relatives were asked for their views about the service

Relatives were made welcome.

Is the service responsive?

Good

The service is responsive

Care plans provided an individualised view of each person's needs staff knew people's needs well. Care plans were reviewed regularly.

Improvements were needed to ensure people were provided with accessible information.

People and relatives felt confident of raising concerns if they needed to

A range of activities were provided on a group level and individual activities for people who chose to stay in their rooms

People's end of life wishes were recorded so staff knew how people wished to be supported.

Is the service well-led?

Requires Improvement

The service was not consistently well led

A range of audits were conducted but in some areas these were still not carried out robustly to effectively drive improvement. Learning from previous inspections and discussions with other professionals regarding poor recording had not been embedded.

A new manager was working hard to address shortfalls. Staff found the registered manager approachable and inspiring, they were given opportunities to express their views and receive information to inform their practice through shift handovers and staff meetings.

Relatives and people were surveyed and outcomes of surveys were posted for people to read.

The registered manager kept the care quality commission appropriately informed of significant events in the service.	

Harbledown Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection and took place on the 22 & 24 May 2018. The inspection team consisted of one inspector, an assistant inspector, 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 for older people with nursing needs and or dementia.

Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. Due to CQC technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give us some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the inspection we met and spoke with nine people living in the service and 11 relatives. We met and spoke with 15 staff including two representatives from the Provider, the registered manager, deputy manager, four members of the domestic and maintenance staff, two nurses, two team leaders and two health care assistants, as well as an activities staff member. We observed interactions between staff and people, to help us understand the experience of people who could not talk with us.

We inspected the environment, including the communal lounges and dining area, the laundry, kitchen, bathrooms, medicines storage, and garden area. We also visited some bedrooms to speak with people.

We looked at a variety of documents including five people's support plans; we also looked at risk assessments, daily records of care and support, activities information, menu records, three staff recruitment files, training records, medicine administration records and quality assurance information. We asked the provider to send us some more information in regard to other professionals who have contact with the

service, a business plan, and the risk assessment for the garden which they have done.

Before the inspection we contacted commissioners, the community nurse service, Health watch and the safeguarding lead for feedback about the service, after the inspection we contacted other health professionals including GP's, and community nursing staff who knew the home well.

We left a poster advertising our inspection at the service so that relatives who wished to speak with us could do so during the inspection or could contact us immediately following the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service "Nothing makes me feel unsafe here." The majority of relatives we spoke with made positive comments about the service and confirmed their relatives received safe care from staff.

At our last inspection in April 2017 under this domain we identified a breach of regulation 17 Health and Social Care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014. This was because we had found that records relating to the management and evaluation of wounds, repositioning charts and the application of some skin creams for people at risk from pressure sores were not always completed. We asked the provider to send us an action plan informing us how they intended to make improvements which they had done. At this inspection we found that wound care reviewing and evaluation had improved with only a few review dates not adhered to. Actions the provider had told us about to improve other areas of recording had not been embedded.

A number of people were assessed as at risk of developing pressure areas or were in receipt of wound care from the nurses. They had appropriate equipment in place to support skin integrity and checks were made on the correct settings of air mattresses. Administration of creams was better recorded. Staff had been successful in healing a number of pressure wounds. The procedure for supporting healing of wounds was that people at risk of developing pressure sores were repositioned every two hours to minimise the risk of skin breakdown. However, some records viewed contained omissions in recording where people had not being repositioned to these required intervals. No record was made as to why this had not been followed. These omissions made it difficult to track whether people had received the assessed level of care and that their treatment plan was being adhered to. The consequence of this not happening was that people's wounds could worsen or take longer to heal, or someone could be placed at greater risk of developing a pressure sore.

We found several examples of people who spent all, if not most of their days in bed, they were at risk of developing pressure sores or had them already and repositioning charts in their rooms made clear the intervals at which they should be repositioned to minimise further risks to their skin integrity. For example on 17 May one person was not repositioned between 9:00-12:30 and again between 14:10 and 19:20 pm. On 19 May they were not repositioned between 7:00 am-11:10 am. A second person who was receiving end of life care was not repositioned on 22 May between 7.30 am and when we checked at 11.55 am, on 23 May, they were not repositioned between 6:30 am and 11.30 am and then not again until 17:00 pm. A third person was not recorded as being repositioned on 24 May between 7.30 am and lunchtime (which was usually 1pm). Staff could not say why these omissions had occurred. Whilst there was no evidence that people had been harmed as a result Inconsistencies in recording of repositioning made it difficult for staff to judge whether risk reduction measures implemented worked effectively.

At our last inspection in April 2017 we had found that although all staff were aware of the nutritional and dehydration risks to people, records of fluid intake were not consistently completed. At this inspection we found food and fluid monitoring was still not being conducted robustly. Records viewed showed that some

people were recorded with very low levels of fluid intake and gaps in recording of meals eaten. People had drinks in front of them but some needed prompting, supervision or assistance to drink. Fifteen people required assistance with their meals. We checked room records for some of those who needed assistance. One person's food and fluid monitoring sheet recorded that on 24 May they had only drunk 25 mls of fluid between 01:00 a.m. and 14:20 pm, for the same person on Monday 21 May no food was recorded for breakfast lunch or dinner. This was a similar picture on 23 May. Records for the previous week showed no food intake was recorded on 14 and 17 May, with only breakfast recorded on 14 May. If this was not a recording issue no actions were recorded as to the reasons for no food intake or what actions staff were taking to improve this. For example allocating time for staff to spend encouraging people to drink or eat more. Another person was recorded as having drunk only 475 mls between 00:45 am and lunchtime on 24 May 2018. The providers' action plan had previously informed us that fluid monitoring sheets would provide a target intake based on people's weight but this was not evident on sheets viewed. The impact of poor recording of food and fluids meant that staff were unable to make an accurate assessment of whether people were eating or drinking enough, or whether further actions needed to be taken. This issue had been highlighted at our previous inspection. A health professional we spoke with after inspection confirmed that although they were satisfied that care was being delivered; they had also raised the need for improved recording in the areas we have highlighted. It was their view that staff were not actively using some of the documents they used to inform their practice; they were not always acting on the information collected.

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

At our last inspection in April 2017 we found that risk was not being well managed and issued a breach of Regulation 12 of the HSCA 200 (RA) Regulations 2014 we identified that improvements were needed to ensure incidents and accidents were reviewed effectively to reduce the risk of falls, and equipment was safely stored. We asked the provider to send us an action plan of how they intended to address those shortfalls and in what timescales, which they did. At this inspection we checked that they had implemented what they said they would do which they had.

At this inspection we found that there had been an improvement in the overall assessment and management of risks. Appropriate risk assessment tools were completed and in place to assess peoples risk of falls, skin breakdown or nutritional risks; risk reduction measures were implemented. A review of incident and accidents indicated there were some minor behaviour risks that occurred during personal care when people could become distressed. Care plans contained strategies to inform staff how to support people through times of anxiety and distress. We found only one significant incident of behaviour between February and 22nd May 2018, a number of measures had been put in place to reduce further risk and no further incidences had occurred since. However, an important observation and monitoring measure had not been added to risk information to inform staff and ensure they responded consistently, there was therefore a potential risk of this being overlooked or its effectiveness reviewed.

We recommend that the provider seek an appropriate expert source to provide guidance on the development of risk assessment in regard to managing behaviour and risk stemming from peoples anxieties.

The registered manager undertook analysis of all accidents and incidents. These largely consisted of slips trips and falls. There was improved evidence of a proactive approach to managing falls with appropriate referrals to GP's and falls clinics. Interventions such as the use of hip protectors, rearrangement of bedrooms, use of alarmed pressure mats, crash mats and increased monitoring of specific people, were all

measures to help reduce the impact of falls. Relatives and staff spoken with who had experience of the service told us that staffing was much improved and they felt there were enough staff on duty each day to meet people's needs. We observed staff to be busy but managing the current needs of people and responding to call bells and attending to people's needs. The registered manager informed us that she used a dependency tool to inform her how many staff were needed to support people's needs. This was kept under review should peoples dependencies change. The registered and deputy manager provided weekend out of hours on call support to the nurses on duty. They also took occasional weekend shifts themselves. At inspection there were three care staff vacancies. Gaps in shifts as a result of vacancies, leave and sickness were covered by regular agency staff. An agency staff member told us they had known the service previously and thought it was much improved with higher staffing to support people.

At our last inspection in April 2017 there was a concern regarding storage of oxygen bottles and signage of the presence of Oxygen for emergency services which had now been satisfactorily addressed. Oxygen not in use was stored safely in the medicines room. Nursing staff and some senior health care assistants had been trained to administer medicines. The systems for the ordering, receipt, storage, administration and disposal of medicines were satisfactory. Medicine cupboards were kept clean and locked. Allergies of each person were clearly recorded on every medication file. As required medicines and insulin protocols were followed. More secure facilities were in place for medicines that required safer storage and staff followed good practice in their administration. Medicines stored in the clinical room were randomly checked to ensure they were in date. Temperatures of the storage area and medicine fridge were recorded. Medicine administration records contained no gaps. Medical equipment in the clinical room had been serviced. A pharmacy audit of medication processes was undertaken twice annually. GP's reviewed peoples medicines as and when required.

Staff had been trained to be aware of their responsibilities in regard to safeguarding people from harm and abuse. Staff understood the forms abuse could take and knew how to report any concerns they might have to their supervisor or the registered manager. They were confident of using the whistleblowing process if necessary. Staff knew the agencies they could contact outside of the organisation if they thought their concerns were not being addressed.

At the time of inspection the service was clean with no unpleasant odours. A cleaning schedule was carried out by housekeeping staff to ensure bedrooms and communal areas remained clean and tidy. Staff used personal protective clothing as and when needed. An infection control champion undertook observations that staff were using personal protective clothing appropriately when going about their tasks; they conducted a walk-around of the premises to check good infection control was being maintained. Regular infection control audits were completed. The laundry had adequate washing and drying equipment to meet the demands of the service. There was an appropriate system in place for the separation of soiled laundry. The laundry was in need of updating and we found the laundry floor was not impervious in areas making it more difficult to keep clean. The housekeeper and maintenance staff were aware of plans to replace the flooring. We checked and replacement flooring was included in the current business plan for works to be undertaken, the timescale for completion was August 2018.

The premises were well maintained. Staff and relatives said things were repaired quickly. Water temperatures, checks and tests of fire alarm and firefighting equipment were undertaken on weekly and monthly basis. Health and safety walk rounds and checks were conducted to identify any hazards. All the required health and safety certificates were in date. Weekly fire alarm tests were completed. Staff attended two fire drills per year to ensure they understood the actions to take in an emergency. A service user told us "We have fire drills and when the alarm goes off my bedroom door shuts automatically." Improvements to the garden area were underway to provide a pleasant and safe environment for people to use in good

weather.

The provider had a recruitment process and system of checks in place to ensure that staff were recruited in a safe manner. Before new staff started work, identification checks were carried out and references and employment histories were obtained. A statement as to the health of the new staff member was made and Disclosure and Barring Service checks were undertaken. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Good

Is the service effective?

Our findings

Every new member of staff had an induction into the service when they started work at the home and completed an induction training programme over the following months. The service used the Skills for Care Certificate training for its induction training programme for new staff. The Skills for Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in health and social care. It is made up of the 15 minimum standards that should be covered if a person is new to care work and it should form part of a safe and effective induction training programme. The induction familiarised new staff with the service and people. The induction training programme covered topics to educate and support staff in their new role.

Staff said they received a good range of training that was kept updated. Relatives said they thought staff demonstrated they had the appropriate knowledge and skills to support people safely. The provider had a system for managing the ongoing mandatory and specialist training for all staff. We discussed with the registered manager at inspection some improvements that could be made to the planning of training for staff which they agreed to look at.

The registered nurses in the service were all correctly registered with the Nursing and Midwifery Council. A record in their staff files was kept of their accreditation and registration PIN numbers. However a central record of this information was not kept to provide the registered manager with an overview of when nurses were required to renew their registration, the registered manager spoke of now implementing a system to monitor this.

Staff said they received supervision from their supervisor at least four times annually and some supervision was provided as a group. Supervision provided staff with the opportunity to reflect on their work and discuss any issues with their manager and with their colleagues when it is a group supervision session. The registered manager is a registered nurse and delivered the clinical supervision for the home's registered nurses.

A new chef had recently been appointed and had already identified improvements that needed to be made to the kitchen area, in addition to those shortfalls identified at the last environmental health kitchen inspection. A kitchen refurbishment plan had been included in the business plan for the service. People's individual food preferences had been incorporated into the new menus. The chef was aware of those people that had specialist diets, needing their food fortified with creams, or needed to replace more fattening foods with fruit or lower fat items to aid a reducing diet. A cooked breakfast was offered on two days of the week. People said they could choose what to eat and that they enjoyed the food they received, "The food is very good with a good variety but we are given too much!" A relative told us, "My relatives eating and hydration has vastly improved since she moved here. She is also more communicative now." People who needed assistance with eating their meals were provided with one to one support.

The daily menu was written on a menu board outside the kitchen, the chef had introduced pictures of the meals on offer. We discussed how they might enable people to make more informed choices who could not

process written or pictorial information. The chef thought the introduction of a system to enable people to choose their meal at the time of dishing food up would better suit those with cognitive memory issues and planned to introduce this. Alternatives to the main meals were always available. People were provided with juices and water but also had hot drinks offered throughout the day.

A relative told us that they sometimes came in to assist their relative with meals because they wanted too. In their absence they had no concerns that their relative was receiving their meals appropriately. Our observations of people being assisted by staff with eating their meals showed this to be carried out in an unrushed manner and in accordance with their own preferences or assessed needs. People indicated through smiles, nods and some comments that they enjoyed the food they were offered. People asked for support if they needed it, we observed one person who was nonverbal using gestures that staff clearly understood requesting that they cut up their food. Staff were also observant and intervened where they thought a person might need support. People were offered second helpings and offered additional drinks. Staff were kind and patient and focused their attention on the people they assisted, talking and murmuring encouragement to them. Staff were observant and were observed wiping the mouths of people they assisted to maintain their dignity.

Staff were proud of their care and dedication to improving people's health. They spoke particularly of the more recent support they had provided to a person admitted in a very poor condition, of low weight and at that time nonverbal. Staff input, close monitoring of food and fluid intake and additional food supplements had resulted in a positive outcome; the person was now able to communicate their needs to others and enjoyed an improved quality of life.

Relatives told us that they were satisfied that their relative's health needs were attended to promptly. "We got a call from the home to say they had called an ambulance when our relative got a chest infection. They have also called the GP on other occasions. We are happy with these arrangements." We asked health professionals for their view of whether health needs were being met, none raised any concerns and several felt with the arrival of the new registered manager, the service was steadily improving. Several local surgeries provided a service to the home. A local GP undertook a weekly visit of their patients. Other GP's visited as needed. People were supported to access health appointments. Where specific health needs were identified people were referred appropriately to other health professionals such as dietitians, dentists, opticians, speech and language, podiatrist and chiropodists, the falls clinic and mental health team. The registered manager and nursing staff sought and acted upon advice from other health professionals as and when the need arose, for example from tissue viability nurses in regard to wound care. Care records showed evidence of these referrals and appointments for people. A health professional told us that they had known the service for many years; they said they had seen a marked improvement in the delivery of care that they had observed. In respect of a recent case they had found that staff were now listening and acting on advice given.

The premises had been adapted to support people's needs. The building was fully accessible. A passenger lift provided access to the first and second floors. Various hoist equipment was provided to enable people to get in and out of bed and spend time away from their rooms in communal areas to engage with other people. There was some signage and use of pictures on some bedrooms that aided people in recognising their own bedrooms, and communal areas such as lounges, dining room and toilets. An accessible and secure garden was provided to enable people to spend time outside in good weather, a raised flower bed was provided and people could be involved in planting if they wished. Bathing and showering facilities had been adapted for people with mobility issues.

The MCA 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 or are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests, and as least restrictive as possible. Staff sought peoples consent for everyday care delivery. Where there was a concern that a person may be lacking capacity to make some specific decisions, best interests meetings were held. The registered manager and staff understood that decisions taken that would pose a restriction needed to be authorised. People can only be deprived of their liberty so that they can receive care and treatment that is in their best interests and legally authorised under the MCA. The authorisation and procedures for this in care homes and hospitals are called the Deprivation of Liberty safeguards. People were supported with the least restrictions but we checked that there was an understanding and awareness of the Mental Capacity Act 2005 (MCA) principles; these were now embedded and implemented into staff practice.

People referred to the service were assessed to ensure their needs could be met before they were admitted. We spoke with a relative who spoke positively about the home visit conducted by the registered manager to assess their parent. They said it was explained to them what the home offered and the admission process was discussed with them. They said they had been impressed by the whole process and felt satisfied with their choice.

Good

Is the service caring?

Our findings

People spoke positively about how helpful and kind staff were, comments included, "The staff are very helpful. I like to have a laugh with them and they can take a joke." "It is very good how the staff look after me." We observed people in the lounges smiling and chatting amongst themselves or enjoying watching a television programme together.

Staff were attentive addressing people by their preferred name and observant of what they were doing. Responding if they noted something was wrong or someone needed help. Staff understood people's different methods of communication from gestures, body language or using word prompts to address people's diverse needs; this was not clearly documented in care plans and is an area for improvement.

There was a mixed gender staff team that enabled individual preferences around personal care giving to be accommodated if this was particularly important to people. Staff ensured that anyone whose first language was not English was appropriately supported to ensure they could make known their wishes and receive the support they needed and wanted.

People's protected characteristics under the Equality Act 2010, such as their race, religion or sexual orientation, were recorded during the assessment, and this was then transferred into the care plan. There were equality and diversity policies in place for staff to follow, and staff received training in this subject as part of their mandatory training.

Staff respected people's right to make their own decisions and supported them with how they wished to be seen to others. Staff took care in supporting people with their appearance, making sure people who liked to keep their hair in good order, had regular appointments with the hairdresser.

We observed staff in the dining room asking people about their meal, what they would like and whether they needed help with cutting it up. They were seen to seek consent before they did so. When a person began coughing staff gently patted the person on the upper chest to relieve this and provide encouragement and comfort. We noted staff entering bedrooms and checking that people were okay and could reach their drinks.

People were able to personalise their bedrooms if they wished. They provided their own televisions, radios, pictures and photographs and small possessions to make their room more homelike and personal to them. A lot of people kept their bedroom doors open as they liked to observe other people, visitors and staff going past. People shut their room door when they wanted privacy.

People told us they were satisfied with the manner in which staff supported them including their personal care. A relative informed us that in their opinion the standard of basic care delivered to people in the service had improved since the arrival of the new manager. The majority of relatives told us they were satisfied with the personal care routines their relatives received. "Our relative has a shower once a week and has regular bed baths." Records showed that people received bed baths washes, and showers or baths dependent on

their preference. We referred a relatives concern about the frequency of their relatives showering habits to the registered manager to review. Other relatives however were happy with the support around personal care people received Staff reported that they responded to people's individual preferences. They said people found having a bed bath or wash less strenuous or distressing and often chose this over a shower or bath.

Staff understood and respected people's privacy "Staff knock before they enter my room." A team leader informed us that they were a dignity champion within the service; their role was to help train other staff to understand how to deliver care that was compassionate and dignified. The dignity champion undertook informal observations of staff practice and helped staff to understand how they could make improvements to the way they delivered support to people. During the two days of inspection we noted only one instance where a person's dignity was compromised; this was addressed quickly once it was pointed out and we discussed this with the dignity champion as a learning point.

People were able to make decisions and choices about their care and support; those who were able to told us that they were actively consulted about their care and support plans. Relatives confirmed they were also consulted if they wished to be and attended reviews about their relatives care and support and felt able to comment and contribute to these.

People had individual members of staff allocated to them as their Key worker (a key worker is a member of staff who knows the person well and takes particular responsibility for ensuring the person has what they need and that all their needs are being met). A few relatives were unaware of who their respective relatives key worker was but were interested and positive about this so they could discuss aspects of their relatives wellbeing with them. This included any further needs around clothing and toiletries.

The dining room could not accommodate everyone but people could eat where they wished with some choosing their bedrooms. Other people ate in the dining room or lounge. In the dining room staff were seen to encourage people to eat and offered second helpings, they were attentive to people's needs and observant when they needed help. We observed that people assisted by staff to eat their meals were not rushed. Staff demonstrated kindness and patience, ensuring people had aprons on to protect their clothes and they had a napkin or towel to wipe their mouth to maintain a dignified appearance.

Call bells were accessible and people made use of them. We observed staff to be responsive and dealt with people's requests for support as quickly as they could.

The activities organiser produced a monthly newsletter which was circulated to every person and emailed to relatives on the mailing list; this informed people and relatives about events that had occurred, or were planned.

The registered manager had established a group email so that relatives could communicate directly through this regarding general queries. For more personal issues these needed to be addressed separately. People were supported to maintain their relationships with their family and friends. Relatives told us that they were made welcome when they visited and felt able to come and go from the service as often as they wanted. Sometimes a relative also brought in a well-loved and well behaved dog to visit with their family member and this was popular with other service users who were curious and interested. Relatives told us they were contacted by staff if their relative became unwell or there was an accident; they felt they were kept well informed.

People were supported to practice their faith where possible and religious services were arranged onsite for

people that wished to attend.

In good weather staff supported people to use the garden. A recent fete was held in the garden to raise funds for the activities programme. A relative informed us this had been a well-attended enjoyable day but a lot of hard work on the part of the activities organiser, volunteer relatives and staff. They spoke positively about the involvement of the new registered manager in this event.

Good

Is the service responsive?

Our findings

People we spoke with told us they were happy with the support and responses of staff to their care needs. Some of those spoken with preferred their own company and chose not to engage with others or to leave their bedrooms. The activities organiser took time to visit people in their rooms to help relieve their isolation. There was universal praise from staff, relatives and people regarding the dedication and influence of the activities organiser on improving people's quality of life. People and relatives said they felt able to raise concerns with the registered manager and staff if they had them.

There was a small and large lounge for people to relax in. The larger lounge held a large television and a selection of DVDs for them to watch. Many of the activities provided took place in one of the lounges. The activity organiser used an 'Activity Year Book' for residential homes that she worked from. The registered manager told us that NAPPA training was to be offered to the organiser to improve the quality and range of activities offered, tailoring them to the needs of people with dementia too. A relative told us "The activity coordinator does her absolute best to involve as many residents as possible; she does a marvellous job." People told us some of the activities they enjoyed. "We have planted seeds and done paintings. There is a cat in the home." Another commented on how they enjoyed visits from the Pets as Therapy dog, other people told us: "I stay in my room, I am happy in my room, I watch television and read, and I don't have any relatives who visit." Another said "I don't want to mix with others, I am happy staying in my room." A relative told us "When he was in a wheelchair I felt he was put to bed too early, but things are a lot better now."

People were provided with information about what they could expect from the service in service user guides. Newsletters and information boards contained information on forthcoming events or celebrated events that had taken place. For most people this was in a format they could understand. Staff understood people's individual methods of communication well including the gestures and body language they used to communicate their needs and wishes. This was written into care plans. There was some use of pictorial prompts for menus and food options, for people who found written information difficult to understand due to cognitive issues, there was some signage but this relied on people reading written information and may not be suitable for everyone. Whilst there was no obvious impact on people who we observed found their way around the service well, since the last inspection the accessible information standard as good practice has been adopted. This requires the provider and registered manager to provide information to people in formats suited to their needs. The provider and registered manager need to consider how they will meet the needs of people who may be unable to read information, or in some cases make use of pictorial information through for example sensory loss.

We recommend that the provider seek advice and guidance from a reputable source, to improve the range of accessible information available.

Peoples nursing needs were well met by nursing staff and treatment plans in place to improve or maintain people's health and quality of life. Care staff interacted well with people and understood their needs, observing and engaging with people in between and during tasks. For stimulation a programme of activity had been developed that took account of peoples own interests and choices. Activity attendance was kept

under review and activities changed if interest waned. People chose what they wanted to participate in. There was flexibility so that the activity could change on the day dependent on who was attending and their preferences. In reviewing attendance the organiser considered those people who kept to their bedrooms and chose not to engage. They took time getting to know this group of people, many of whom rejected initial contact and the idea of engagement. They were skilful at building relationships, over time they were able to establish particular activities to share with people. These were activities such as eating a sandwich together, pamper sessions for ladies which were popular, talking and discussion, some people had photo albums and enjoyed sitting and going through these with the activities organiser. The activities organiser was enthusiastic and people and relatives spoke highly of their kindness, and enthusiasm for improving activity provision for people and the possibility of external outings.

The service had a complaints policy and procedure. This was displayed and people received a copy in their information pack when they arrived. The provider Information Return (PIR) had informed us that only two formal complaints had been received and this was confirmed by the registered manager. Both were dealt with and resolved. People and relatives said that they were comfortable about raising concerns if they needed to, some had done so at times and were satisfied with the outcome. "I am very happy with care, I would say so if I was not". Staff and the registered manager were seen as approachable and open to discussion about concerns. A complaints record was maintained and the outcomes of investigations and the responses to people who had complained were recorded. The record showed the time frame in which complaints had been dealt with. Staff said they understood how people responded to issues that made them angry and upset and they would seek to understand what had caused this and try to put this right for the person if they were unable to vocalise their concerns.

People told us they were consulted about their care and relatives told us that they were involved, consulted and informed about their relatives care plan as much as they wanted to be. A resident of the day system was in place that ensured that person's care documentation was updated on that day; relatives were given advance notice of this so they could contribute. Each person's plan of support contained a holistic set of plans covering all aspects of their daily living needs for example method of communication, personal care needs, support with medicines, behaviour, emotional support, mobility. In some areas of need some people were shown as independent and required prompting or supervision only to support their independence. In other areas there was clear guidance for staff of the support required, and the person's preferences about how this was provided. Assessments of capacity, dependency and risk such as falls, pressure ulcers, and nutrition supported the care plan to ensure any identified risks were reduced by the measures implemented. Emergency short term plans were implemented for deteriorations in health to ensure specific support was provided over a short period of additional need. In discussion staff clearly knew people well. They were able to describe each person's individual needs and the support staff needed to provide to them. Care plans were reviewed regularly and annual reviews were held, relatives and professionals were invited.

The majority of people living in the service had health needs that required nursing input and some had life limiting conditions and were on end of life pathways. The registered manager told us that they implemented an emergency care plan usually in the last days of someone's life, and emergency medicines were available for use. People's end of life wishes were documented. People at the end of their life had all their immediate needs attended to including pain relief, nutrition, hydration, moving and handling, to ensure they were kept comfortable. A relative had informed us prior to inspection that end of life care at the service was good. A health professional commented that the provider had committed to enable the staff at the service to undertake the National Gold Standard Framework for End of Life Care but this was still to be implemented.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in April 2017 we issued requirement notices for improvement because the provider had failed to ensure sufficient risk measures were in place to proactively manage and mitigate further risk and reflect changing service user needs. To ensure that incident and accidents were reviewed effectively to reduce the risk of further, events and equipment was safely stored and correctly safety inspected. Additionally a failure to maintain accurate records, of peoples care and treatment including food and fluid monitoring, wound care reviewing and the repositioning of people at risk of developing pressure ulcers had posed a risk that some aspects of care delivery could be overlooked.

There were signs of improvement to address some of the previous breaches. A new manager had been appointed and had worked hard to improve the quality of care provided and address shortfalls within the service. An action plan had been devised that she was working through with the area manager, of improvements that were needed. Relatives and some health professionals confirmed that in their opinion the service was moving in the right direction. But there was still some work to do. Actions the provider had told us in response to the previous inspection, about how they would monitor aspects of the service for example record keeping had not been fully embedded.

A range of audits were in place to assess quality in areas such as medicines, fire safety, care and staffing documentation, catering, premises and equipment, infection control. These were undertaken regularly and should provide the registered manager and provider with a good oversight of service quality. Action plans had been produced for some audits but not others, even where there were clear shortfalls identified with compliance, for example the catering audit showed a number of non compliances although these were not explained, and no action plan was attached to demonstrate how these were being addressed. A food and hydration action plan stressed the importance of having pictorial menus rather than identifying the continued omission in recording in these areas that risked people's needs in these areas being overlooked. The present shortfalls made it difficult at times to evidence good practice in the delivery of care and support was being maintained. Although there was no evidence that recording omissions had impacted on care delivery, care records should document the specific care being provided, and this was not being highlighted by the existing audit processes.

A health professional spoke of an over reliance on the support mechanisms provided by the registered manager and improvements not being embedded fully in staff practice.

It was important that the management team lead by example and completed the documentation for which they were responsible to a more complete standard. For example staff records and the assessments of new people. Additionally the involvement of people in the staff interview process had not been embedded into practice, recorded or monitored.

This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place. There was a continued failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services. This is a continued breach of Regulation 17 (1) (2) (a) (b) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new registered manager wished to progress a move to an electronic recording system that she hoped would overcome some of the omissions in recording and improve auditing. Subsequent to the inspection the registered manager had overseen the implementation of electronic recording which made it easier to monitor delivery of care and support and to be alerted to omissions in recording by staff. A staff planner had been introduced that contained all staff records, this also recorded nurses current registration and when this was due for renewal, this was an improvement that provided the registered manager with better oversight of staff qualifications and registration. The registered manager had also implemented improved wound care recording and some people's wounds present when we inspected had now healed. The Garden had also been improved to provide a more accessible and pleasant outdoor space for people.

The majority of people, staff, relatives and professionals we spoke with said they found the registered manager approachable . She had a visible presence on a daily basis during the week, undertaking a walk round to every department to hear from staff and to speak to people. A relative described the service as "Now in a stable phase"; they told us they could see a difference in the atmosphere of the service with staff clearly happier since the arrival of the new registered manager. Relatives told us "Things have improved since the new manager arrived about a year ago, including the issue of name badges and the use of email to contact us." Another relative said "A board with staff photos and names is being addressed along with a named key worker." Staff told us, "I have been here for many years, I love the residents and I love the staff." Another staff member said, "I love working here; it is very homely." A health professional said they thought the service was now moving in an upward trajectory, but was not quite there yet.

In conversation staff demonstrated compassionate care and commitment to their support of people. Staff understood the need to help people retain independence for as long as possible. These are many of the qualities the provider promotes in their values called the six C's. However, staff were not familiar with the term although this was clearly displayed on the notice board in the front entrance. Staff could not tell us what the six C's stood for although the provider told us that these have been embedded in to their services and stand for care, compassion, courage, commitment, competence and communication. The Provider Information Return for the service also informed us that a duty of candour policy was in place but there was no evidence that the importance of this had been discussed with staff that were unfamiliar with the term and their responsibilities around this. We made the registered manager aware of staff's lack of knowledge around the organisation values and duty of candour. This was an area for improvement.

The provider ensured staff were kept updated about important changes in the law and regulations and re-issued updated policies and procedures for staff to read. For example the registered manager and staff were aware of the new changes brought into force as a result of the General data Protection Regulation (GDPR) which came into force in May 2018. They had taken some action to make relatives aware of the changes and how this would impact on staff responding to information requests.

Relatives told us that they were invited to attend relatives meetings and these occurred on a regular basis, "We attend relatives meetings every two to three months. Any issues raised are reported back on." Another told us, "I am happy my relative is here, particularly now there is a new manager. There is now more involvement with me and other relatives." A survey of relatives had been conducted by the registered manager since her arrival, only 15 surveys had been returned, these had been analysed for levels of satisfaction in a number of areas, responses had been collated and showed that satisfaction levels in all areas of those responding were between 95% and 99%. The outcome of the survey was displayed in the entrance hall for people to see.

Staff said they felt better supported and able to express their views in a one to one meeting with their supervisor, and within team meetings. Staff all spoke positively about working in the service and the good team work and communication between staff that had developed.

The registered manager understood the need to notify the Care Quality Commission should any significant events occur, in line with their legal obligations and had done so when required.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception and on their website.

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 17 HSCA RA Regulations 2014 Good governance The failure to maintain accurate records, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided is a continued breach of Regulation 17 (1) (c). The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services. This is a continued breach of Regulation 17 (1) (2) (a) (b)