Westwood Lodge Ltd

Westwood Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7, 9 and 13 November 2018 and was unannounced, which meant the provider did not know we would be visiting.

At the last inspection in April 2018 the provider was placed in special measures. We found a breach of regulation 12 as care and treatment was not safe. We also found breaches of regulations 9,10 and 17 as people were not always treated with dignity and respect, care was not always person-centred and good governance was poor.

Following the inspection, the provider sent us a detailed action plan to explain how they would address these concerns. We also met with the provider and registered manager and they gave us their assurances that the issues found would be taken extremely seriously and rectified.

At this inspection the provider had made many improvements, but we still found some previous issues were outstanding which needed to be addressed. The overall rating is no longer inadequate, which means they are no longer in special measures.

Westwood Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Westwood Lodge Care Home provides accommodation for up to 44 people with residential and nursing care needs. People had a range of health care needs, including those with mental health, alcohol misuse related conditions and those living with dementia. At the time of the inspection, there were 31 people living at the service.

The service had a registered manager who had worked at the service for many years with the last two as registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service also now had a deputy manager who had been appointed since our last inspection.

People told us they felt safe, and although improvements had been made, further action was required and this needed to then be maintained.

Medicines management had been improved, however, we observed some poor practice. Although no person came to harm and it was dealt with immediately, this type of issue had been raised at the last inspection as a concern.

People's needs had been assessed prior to moving into the service and care plans had been developed.

However, care plans were not always in place for all identified need and they were not always reviewed in a timely manner. Risk assessments had improved but not all had been put in place. There were two different care plan formats in use, including a newer version which was much more person centred. The registered manager was aware that further work was required.

Quality monitoring systems had improved and a range of audits and checks had been implemented, including infection control and medicines monitoring systems. The audits had not always identified what we had, and the registered manager said they would be reviewed further. A quality assurance person had been employed for a period of months to oversee and support the registered manager while these new processes were put in place.

The provider had spent considerable amounts of money in improving the environment for the people who lived there, including a new wet room, carpeting and new flooring. Staff told us people appreciated the money spent and it had made a difference to everyone.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Everyone we spoke with were complimentary about the care provided by staff. We observed very positive interactions and people's dignity and respect were maintained at all times.

People told us they were satisfied with the improvements in their meal time experience and the food prepared. Food was served at suitable temperatures and people were supported where necessary with their dietary needs. We have made a recommendation about meal time experiences to ensure they are well planned and encouraged social events at all times.

Staff at the service had worked hard to ensure the environment was clean and tidy for people and were keen to maintain this. Staff wore protective clothing appropriately, including the use of aprons and gloves. Infection control was now fully monitored to ensure good levels of hygiene were maintained.

Activities were provided for people, including crafts and access into the local community. Observations over three days found further review was needed particularly with those people who lived with dementia or who were immobile. During the inspection process the provider also increased the monthly activity allowance as we found it was not sufficient, with occasions when staff spent their own money.

Staff were supported with regular supervision sessions and yearly appraisal. Appraisals were due to take place in the next month. Robust recruitment procedures were in place and staff had been risk assessed where necessary. Staff had received training in various topics to support them in their roles and the provider had planned further training to take place, including eLearning.

We found one continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to good governance.

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.

Good progress to the management of medicines had been made but further improvements were required.

Generally risks to people using the service were assessed and reviewed, but needed updating in places.

The service was clean and tidy.

Robust recruitment procedures were in place and staff knew how to protect people from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's nutritional and hydration needs were met. Although we have made a recommendation about people's dining experience.

Inductions were in the process of being reviewed. Staff received regular training, supervision and yearly appraisals.

People's rights under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were protected.

People had access to a range of healthcare professionals to maintain their health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People, relatives and professionals said staff were caring.

People were supported to access advocacy services when needed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff knew people well and provided personalised care. Care plans were not always in place and some lacked detail.

Activities had improved and the registered manager was in the process of further review.

The service had a complaints policy and people knew how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We found the service had improved in many aspects. However, quality assurance checks needed to be reviewed in light of our findings, particularly regarding record keeping.

Meetings took place for staff but these were going to be held more often.

Feedback had been gathered about the service provided but this had not been analysed for further improvements.

There was a registered manager in place and a new deputy had been appointed.

Westwood Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 7, 9 and 13 November 2018 and was unannounced on the first day which meant the provider did not know that we were going to inspect. The inspection was carried out by one inspector, one specialist advisor and one expert by experience. A specialist advisor is a person who specialises in a particular area of health and social care, for example medicines, moving and handling or quality assurance. This specialist advisor was a nurse specialist. 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including statutory notifications we had received from the provider about deaths, safeguarding incidents, deprivation of liberty applications and serious injuries.

Prior to the inspection we contacted the local authority commissioners and safeguarding teams for the service, Healthwatch in the area and the local fire authority. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services.

We also made contact with a practice linked GP for the service, a pharmacist for the clinical commissioning group (CCG), the behaviour support service and a community psychiatric nurse.
We used any comments received to support our planning and judgement of the inspection.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who used the service and three family members. We also spoke with the registered manager, deputy manager, three nurses, a cook, an activity/senior carer, one domestic, the maintenance person and eight members of care staff, including senior care staff. We observed how staff interacted with people and looked at a range of records which included the care records for six people who used the service, medicines records for 15 people, five staff personnel files, health and safety information and other documents related to the management of the service.

After the visit we asked the registered manager to send us further information regarding the management of the service, which they did in agreed timescales.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in April 2018 the provider was rated as inadequate with a breach of regulation 12 regarding medicines and infection control. At this inspection, we found the provider had made considerable improvements and although the service was no longer inadequate, it still had some areas to further improve upon.

Medicines management had improved but further work was needed. We observed one nurse had dispensed three different people's medicines into pots, placed them on a tray and was administering them together. People could have received the wrong medicines, but no harm came to people as we observed the medicines being administered. The registered manager dealt with this situation immediately. Other observations of people's medicines being administered confirmed they had been undertaken correctly.

Creams and ointment (topical medicines) recordings were not always completed fully after administration on medicine administration records. People and staff confirmed this was undertaken and the registered manager said they would address this straight away.

The majority of 'as required' medicine protocols were now in place. 'As required' medicines are those required intermittently, for example, for pain relief. Protocols are recorded information on how, why and when people require these medicines to be administered. This is particularly important to people who are no longer able to communicate. The registered manager confirmed that a new paper format sent to them from the Clinical Commissioning Group (CCG) would be implemented and later confirmed that this had been completed and all protocols had been updated.

Covert medicines were in place for a small number of people. Covert medicines are those which are given to people without them knowing. We did not always find information to confirm agreement with this practice. However, documentation was updated during our inspection with support from a local GP and visiting pharmacist from the CCG.

Thickeners (for fluids or food) which were used for people with swallowing difficulties, were stored securely when not in use. However, we saw on one occasion staff had left containers unobserved on a tea trolley while they were busy supporting one person. We brought this to the attention of the registered manager who said she would speak with all staff to ensure it did not happen again.

A number of accidents and incidents had been recorded and reported including in connection with people's behaviours which challenged staff at the service and falls. Referrals had been made to various healthcare professionals, including a community psychiatric nurse to ensure that people received appropriate care. We saw accidents and incidents were checked by management and used to track trends, although the format lacked some detail. After discussion with the registered manager, they agreed they were going to update the analysis format to include timings for example, to further enable more robust monitoring.

Infection control procedures were good. The registered manager had sought the advice of the local infection

control lead for care homes. The service was clean and tidy with no odours and a large range of improvements had been made to the service to address the previous inspection concerns. This included glove, apron and hand gel dispensers, a new wet room, new flooring in all bathrooms, bedrooms and communal areas, and an improved porch at the front of the building. Staff told us a considerable amount of money had been spent and it had made a difference. A healthcare professional we spoke with said, "It's nice to see some money being spent, it's made a real difference." The registered manager told us work was continuing and she was closely monitoring the service now. Staff wore aprons and gloves when providing personal care and staff entering kitchen areas wore protective equipment to ensure people were protected from risk of harm from food related hygiene issues. We noted a small number of carpets, particularly in people's bedrooms were in need of replacement but the registered manager confirmed that this was in hand as part of the ongoing refurbishment process.

A large number of worn and dated commodes had been replaced, although we did observe one commode with a tear in the covering which could have been an infection control concern. The registered manager said she would address this and confirmed later that the commode had been replaced. Mattresses had been replaced and were set correctly with the person's weight where required, and there was an ongoing programme to monitor these.

We noticed that access from the ground floor to the upper floors in one part of the building was not always secure. This was particularly important for those vulnerable people who were at risk of falls for example. We spoke with the fire authority about these concerns as access impacted on fire exits. The provider put in place an interim risk assessment and confirmed they were planning to implement locks connected to the fire system so that should a fire occur, access would be automatically available to the fire exits.

The premises were maintained inside and out, including for example, installation of a new shed for excess kitchen storage. Equipment was serviced to ensure it remained safe to use. Certificates were available and up-to-date, including those for electrical and gas appliances. Fire safety checks were undertaken, including fire drills and checking of emergency lighting. People's detailed personal emergency evacuation plans were in place which would support staff and emergency services to evacuate people from the building in a safe fashion. Two staff members told us they could not remember the code to evacuate from part of the building, although they said they had been told. We raised this with the registered manager who reminded all staff.

People told us they felt safe, comments included, "Been here 19/20 years. I'm generally quite happy (with safety)"; "I love it here now. I didn't like it at first, but I got used to it. I used to sleep upstairs now It's like a second home to me" and "I am safe here, doors are locked and no one can get in, staff are nice." Staff received training to support them identify abuse and policies were in place. Staff said they would not hesitate in reporting any concerns they had.

People were supported with their finances if a need was identified. We sampled a number of records and found them to be in good order, with accompanying receipts and separate money wallets kept for each person. Other people had control of their own money. One person told us, "Yes, if I've got any other problems, I go to my solicitor who controls my money." One person who looked after their own money told us that some money had gone missing. This was currently being investigated.

Risks people faced in their day-to-day lives had been assessed, including those for falls or moving and handling. There was new risk assessment paperwork in place and not all records had been updated to the new format. We also found a small number of risk assessments which had not been completed or fully signed off by management, including those in relation to the use of sensor mats, where people were at risk of falling. We raised this with the registered manager who told us these would be addressed and all

paperwork would be updated.

There were enough staff on duty throughout the inspection to meet people's various needs. People confirmed this. Comments from people included, "Why aye! (yes – enough staff)"; "They are good people (staff) here…when they've got time they listen"; "They always have time for you…to chat" and "I get funny dreams. I'm just going to tell you and I forget what I'm going to say…they're (staff) good (understand)."

Call bells were connected in people's bedrooms and in other communal areas, but we found some were not easily accessible to people and they confirmed this. One person said, "Can't reach it." We checked people's care records and found no reason for call bells not to be accessible, for example, if a person was at risk of self harm. We spoke with the registered manager about this and she said she would review this, including why a number of call bells had been tied up in bathrooms and toilets.

On the first day of our visit staff did not always check our identification on arrival. We discussed this with the registered manager and they reminded staff in shift handovers of the need to ensure identification was always asked for. On the second day of inspection identification was requested.

Correct recruitment procedures were in place and had been followed. This included, receipt of references, identification checks and completed risk assessments where staff had returned a positive Disclose and Barring Service (DBS) check. This meant that any issues on a staff members DBS return had been assessed to ensure they were appropriate to continue to work with vulnerable adults. The registered manager had checked all the PIN numbers of nursing staff and had records to confirm this. All nurses who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN.

Requires Improvement

Is the service effective?

Our findings

People's needs had been assessed before they came to live at the service to ensure that staff could meet them. Healthcare professionals told us that staff spoke to them to ensure they had all the information they could receive to ensure a smooth move. The registered manager confirmed they visited people in hospital and their own homes to complete this.

People received the choice of a range of nutritious meals to meet their dietary needs. People who needed additional support were given this. We observed one person who was at risk of weight loss, not eating well. Staff encouraged them with a range of food until they eventually chose something to eat that appealed to them. One staff member told us, "We will try all the things they like until we find the thing they want and will eat." People were offered drinks throughout the day.

Dining rooms were clean and bright with well set tables. One dining room had tablecloths, placemats, cutlery, salt and pepper and a battery operated candle decoration in place. People told us that food and refreshments had improved since our last inspection, although we did receive some less positive comments. Comments included, "I like everything. The food is good. I've not complained about it much. Favourite dinner is spaghetti and curry and rice"; "It's hitty missy. It comes on a hot trolley. You get a choice, but it's not what you would cook for yourself. If you don't want it, you can have sandwiches, they will accommodate you"; "The tea trolley sometimes has biscuits, but not always"; "They give you too much food, but even if you just take one bite, they (staff) make a note of it" and "The food is okay. You get something different every day, it's good." One person thought meals were not always hot. The provider had purchased hot food trollies and we observed food was hot during our inspection visits.

People were able to have choice in where they had meals. Staff said that four people regularly had their meals in their bedrooms, and people who didn't want to sit in the dining room were able to sit in the nearby lounge with trays. One person told us, "I like eating alone, don't like to eat with others."

Lunch time experience was limited in social interaction and could have been better planned. During lunch staff spoke to people in a friendly and kind manner and although people appeared comfortable and happy with their experience, there was limited communication between staff and people. We noted on the first day of inspection that the lunch time experience did not appear well planned and appeared disjointed in the approach staff took to supporting people, with some people waiting a little longer than others for meals and no clear plan on which person was going to have their meal first.

We recommend the provider review the lunch time experience to ensure it is sociable, pleasurable and well planned.

Staff told us that people also preferred and chose certain staff to perform personal care tasks. For example, the activity coordinator showered and shaved some people who would only allow them to complete these tasks as that was their choice and staff supported this.

An induction programme was in place, which included shadowing more experienced staff. The registered manager told us this process was being reviewed in line with the Care Certificate, but would be more detailed. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

Staff received training in a range of topics, including moving and handling and fire safety. In discussion with some staff, they told us that they lacked skills in challenging behaviour training and after a number of incidents at the service did not feel fully equipped to deal with all the challenges that people may present them with. One staff member told us, "I know some of the staff are a bit frightened." We discussed this with the registered manager, who confirmed they would prioritise this type of training for staff to further support them and keep them safe from harm. Just after the visit the registered manager sent us information to confirm they had been in touch with the local challenging behaviour team to discuss training options.

Medicines competency checks had been undertaken with nursing staff, including the registered manager. However, we found it not appropriate for a relative to undertake a competency check and asked the registered manager to review this. The registered manager confirmed that a local pharmacist would undertake particular competency checks in future until a suitable alternative was found.

The registered manager confirmed that a local pharmacist had agreed to undertake application of creams/ointment training with care staff at the service. The registered manager was also in the process of implementing competency observations for staff applying creams/ointments (topical medicines) to ensure they were applied correctly.

Staff told us they felt supported. Supervision sessions with staff had improved and occurred regularly. Appraisals were planned to take place by the end of November 2018. A new deputy manager was in post which added another level of support to all staff. Staff told us the registered manager and deputy manager were both approachable. One staff member said, "The deputy is lovely. Could go to (Name of deputy) or (name of registered manager) at any time if I needed help with anything."

Handovers took place at the start of every staff change of shift. Written confirmation of the verbal handover was available. Diaries and handover information supported staff to plan what tasks were required for people on any given day.

People continued to have good access to a range of healthcare professionals including weekly GP visits to the service, specialist nurses, psychiatrists, opticians and dentists. Two people told us they did not always have access to address their healthcare needs, we checked and found no evidence to suggest this was the case. One person told us they wanted to have their hearing aids reviewed and did not know who to ask. We raised this with the registered manager who immediately made a referral for this person. One community psychiatric nurse told us, "We receive calls from staff to ask advice, which is good."

The Mental Capacity Act 2005 (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 and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The service was working within the principles of the MCA. For example, conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Some people were unable to go out into the community alone, but felt supported by staff and were taken out to do shopping or go to the post office for money when they needed to.

Staff worked as a team. A large amount of work had been undertaken within the service to address issues found at the last inspection and we noted that the maintenance person had played a large role in this work, including organising clearance of many areas and liaising with contractors to ensure work was carried out. Staff told us, "Talk about team work, (Maintenance person's name) has been great, he has been really good in helping get things sorted here" and "We do work together for the best for residents. Some of the staff come in early or do a bit of shopping for people. We have fund raised before now for residents. The staff are all good here."

People were pleased with their bedroom environment. Comments included, "It's all right…it's nice"; "My bedroom is how I like it thank you" and "They have decorated, it is good." However, one person told us that the heating in their bedroom was an issue for them as they could not control the temperature and that some days were extremely hot with windows having to be opened. Although they confirmed the maintenance person could turn the heating on and off, they said, "I cannot ask them in the middle of the night when it is boiling and I cannot sleep." We raised this with the registered manager who said they would address it.

The service had been adapted for the people living there. Appropriate signage was in place. Bedrooms doors had names of people, to help them identify their room. One person confirmed that they did not want anything on their bedroom door and this has been agreed to. They said, "I don't want anything on my door, it's my room and I know that." Other rooms, including bathrooms and toilets had signs to help people find them. Thoughtful use of colour to doors helped people identify areas and provided visual prompts especially useful for those people with orientation needs and memory loss. Efforts had been made to improve soft furnishings, including carpets, ornaments and pictures. People's individual bedrooms had been personalised where possible. The service was also accessible to wheelchairs and had adapted bathrooms and showers.

Plans were in place to renovate the enclosed garden area in the spring, with raised flower beds and further seating for the comfort of people who lived at the service.

Good

Is the service caring?

Our findings

Staff were observed to be kind and caring throughout the inspection. We observed positive interactions with people. Comments from people included; "Staff are perfect (gave thumbs up). I love every one of them"; "They'd do anything for you…anything at all"; "I can't sleep, and so I cannot wake up in the morning. They come in all cheery and say wakey wakey!"; "I couldn't fault them" and "The staff are all really nice. You might get an odd one (agency) who are not as good, but cannot say more than that really." One staff member was overheard talking to one person about coming in on their day off to take them shopping for Christmas presents for a family member.

People were supported emotionally and listened to. We observed one person become anxious and staff rallied to calm them. One staff member was overheard singing to one person who joined in and visibly enjoyed the interaction. We saw many staff holding conversations with people about various topics, including what was going to happen at Christmas in terms of activities. Another person wanted to buy items from the local shop and a conversation took place regarding this.

Although not every person had visitors to the service, those we spoke with told us they were able to visit at any time, although they avoided meal times. Relatives told us staff were caring and looked after their family members well. One relative said, "It's a lovely place. He's well looked after and they take him out." Another relative said, "The staff are good. They do what they need to and he is as happy as he can be" and "Staff are always spot on and dead nice when I visit. Offer a cup of tea and I always feel welcome. That's one of the reasons we chose this place."

People were cared for by staff that respected people and maintained their dignity. We completed a number of observations during the inspection and found these were positive. People were refreshed after meals when food residue was apparent, clean bedlinen was in place and staff displayed care and compassion to the people they cared for.

People were supported to remain independent. One person was observed playing a violin to three other people sitting in one of the lounges. Another person was encouraged to go out into the community safely. A further person was observed helping to clear away cutlery after lunch was finished. One person who went out unsupported told us, "They (staff) ask will I be back for lunch or tea. It was a bit strange at first. I'm not on medication now, so can go out on my own. I even got carried away once and ended up in Edinburgh. I've got my bus pass."

Explanations were given to people as staff went about their work, for example when medicines were being administered. We observed one nurse explaining what the medicine was and why it was going to be beneficial for the person to accept it.

Resident meetings had taken place to allow people to express their views. Meeting minutes showed discussions had taken place regarding a wide range of issues, including meals and activities. One person told us, "We will be talking about Christmas at the next meeting…bound to!"

People had been involved with advocacy services. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. One person had received support with a Deprivation of Liberty application. The registered manager was aware of services in the local area to support people should they need the use of this type of service in the future.

Requires Improvement

Is the service responsive?

Our findings

After moving in to the service, care plans were put in place to support staff to meet people's identified needs. However, we found that not everyone had the care plans in place to correspond with the support they required. For example, one person had issues with skin integrity and was at risk of pressure damage, but had no care plan in place to document how staff should support them or what measures needed to be taken to minimise skin damage. People who were supported with their medicines had no care plan in place. One person who had needs in connection with their moving and handling, again, had no care plan in place. A further person who had nutritional needs was offered food but refused on many occasions but because staff knew them well they were able to offer alternatives. However, there was no specific information recorded to direct staff (particularly important for temporary or agency staff) on the action they should take. We discussed this with the registered manager who said that all care records would be fully reviewed and rewritten with new paperwork.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the service was responsive to their needs. Comments from people included, "I have a shower when I want"; "They (staff) take me out when I need to go to get clothes"; "I like to wash in the sink and now and again have a bath. The staff will help me then if I want" and "The staff have helped me to sort out all sorts of things. Not sure I could have done it on my own." We spoke to the registered manager about our findings and they later sent us an action plan to confirm this had either been addressed or was in the process of being addressed, including updating care plans and ensuring staff completed new recording forms thoroughly, for example, in relation to bathing.

People confirmed they received person centred care and from observations staff knew people well despite care records lacking detail. Although there had been improvements this continued to not always be fully evidenced in people's care records, for example, in relation to behavioural and bathing information. We also could not be sure if people had discussed alcohol reduction as part of their care package or been given harm minimisation advice where appropriate. Care records included documents to support any visits to hospital in the form of a 'hospital passport', social profiles, some history of the person's past life and background, monthly monitoring, personal belonging information, sleep information, and individual observation charts. A care plan for specific wound care interventions including dressing plan and observations was in place for one person which detailed how staff should respond and what was required to support this person fully.

The activities provided in the service were displayed on noticeboards and recorded after completion. These included, bingo, hand massage, board games, sing-a-long sessions, play your cards right games, jigsaws, floor games, remembrance sessions and other various music. At weekends we were told horse racing (Saturday television) took place and Sunday was a film day with crisps and popcorn. The activity co-ordinator was making knitted poppies with people for Remembrance Sunday, and there was a plan in place to take people out to attach them to railings.

People were monitored when they used the smoking room to ensure they remained safe. Records were kept which described the conversations which had taken place during this time, including discussions about their memories, which showed person centred interactions had occurred.

Comments about activities from people included, "I can go into town on Fridays in my wheelchair with one of the carers"; "We used to go on trips, but the finance/money is less now. We used to go on a charity bus"; "I've been here for 18 years and I used to do a lot of arts. I like to copy and draw…can't do it here. They haven't got the time or money to pay for it"; "Bingo's all right. You get a bar of chocolate if you win" and "We do bits and pieces, but we have been told there is no money." We spoke with the registered manager and provider about activities and the comments made. They told us that stimulating entertainment was to be booked once per month at the service and that any activity materials requested would be made available. We later received a plan outlining what actions were going to be undertaken which agreed with what we had been told.

People had been involved in producing their care plans and we saw evidence of this by means of signatures in care records, but not all. One person said, "When I moved in I got asked loads of questions. They (staff) wanted to find out about me I suppose." We spoke to the registered manager about this who said they were updating records and this would be checked as part of that.

People said they knew how to complain and would if they needed to. One person told us they would raise any issues they had at 'resident' meetings. Another person told us, "I would complain to the manager or one of the staff if I needed to." One complaint had been recorded and this had been dealt with by the registered manager although an outcome and written response to the complainant was not recorded.

At the time of the inspection, there was no person receiving end of life care. From the information and previous professionals, we had spoken with, there continued to be no concerns about the care which would be provided to anyone at this stage of their life. The service had a link GP who visited every week and had forged good links with palliative care nurses in the community.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in April 2018 the service was rated inadequate with a breach of regulation 17 in connection with good governance as the provider and registered manager did not have a good oversight of the service.

At this inspection we found many improvements had been made but some issues remained which meant the provider continued to be in breach of this regulation.

People's records continued to not all be in place, this included care plans which we have referred to in other key areas.

A range of updated audits were in place, including those in connection with infection control and mattress checks. However, we found the medicines audit had not found the issues we had during our inspection. The registered manager agreed that it needed to be further reviewed.

The medicines policy needed to be updated. For example, there was no mention of topical medicine procedures or medicines administered covertly; and medicines which were 'as required' were not detailed enough. We discussed this with the registered manager who said this would be updated. Many updated policies were in place and these continued to be updated and reviewed.

At the last inspection, a monthly accident returns form was completed to monitor the number of accidents over the course of a month, although this did not show enough information, for example, times, staff on duty and where the accident occurred. Accidents continued to be monitored, but the details were still not robust to monitor these fully.

Other incidents were not fully monitored which made it difficult for management to confirm if a pattern was taking place. We found that one person had been involved in many incidents over the last few months, including assaults on staff. Without looking through all of this person's daily records, there was no further monitoring to confirm how many occurrences had taken place. We spoke with the registered manager about this and they said they would look into it.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One incident had not been notified to the relevant authorities, although action had been taken, for example in relation to some missing money. This is being dealt with outside of the inspection.

There was a registered manager in post. They had worked at the service for over 10 years and were a qualified mental health nurse. People at the service thought the registered manager was approachable, visible and 'nice'.

Comments included, "Yes…the Manager comes around"; "she's good" and "I see her about all the time, she seems nice and I can speak to her if I want to." Healthcare professionals continued to think highly of the registered manager. A visiting GP told us, "The manager is very responsive. I have nothing but praise for the home and the staff that work there." A community psychiatric nurse we spoke with said, "Overall the manager gives good guidance."

The provider wished to achieve a high-quality service from conversation we had. They were honest and open and willing to make changes as necessary. They had developed a strategy to support the service after our last inspection in April with the appointment of a temporary quality assurance person. We were told that the new deputy would continue to support the service achieve further improvements and these would be overseen during provider visits.

The new deputy was extremely positive and people and staff told us they liked them. One person said, "(Name) is good fun, he listens." Another person said, "Canny (nice), they are always singing and help me when I ask them." One staff member said, "He's canny, seems nice."

The registered manager completed a 'walk around' of the service, and undertook regular observations which made them visible to people and staff. They operated an open-door policy and staff told us they could ask any question they had to either the registered manager or the deputy manager. One staff member said, "I have no problem asking (name of registered manager) and (name of deputy manager) anything if I need to. I usually go to one of the nurses though."

People and their relative's views had been gathered in a number of ways, including from attendance at meetings and from questionnaires and surveys undertaken. One person told us, "At 'residents' meetings, I tell them what I think." A relative told us, "My older sister goes to meetings." However, surveys which people had completed were not analysed to check for themes, although we confirmed via records of meetings with people that discussions had taken place regarding some of the issues raised, for example, in connection with food. The registered manager said they would consider this for future surveys and questionnaires.

Records had been archived and care records were now stored in secure and locked rooms. The office used by management was much tidier and records were filed and easy to access.

Staff had the perception of not being fully involved, engaged or communicated with. Staff meetings had been held but not regularly, particularly in regard to nursing staff. One nurse told us, "Meetings are not very often and should be, because we need to know what's happening." We saw minutes of only one nurse specific meeting having taken place since we last inspected in April 2018. We did, however, see memos and recording of other communication with staff, including nursing staff. After discussion, the registered manager later confirmed that they were increasing the number of meetings held to ensure all staff felt communicated with.

Meetings continued to take place for people and relatives at the service. However, we noted that the last meeting was attended by one relative only. Relatives we spoke with felt they did not need to attend meetings as they could "Speak to staff whenever they needed." The registered manager told us they would still review meeting times and procedures to ensure as many people and relatives as possible could attend.

The service continued to host weekly visits by a local GP (as part of the Vanguard project) connected to the service. From conversations with the registered manager and staff, they had made relations with a variety of community links, including not only health care professionals, but local residents via summer fetes in the past and with the local post office which people used.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were in need of further review to assess, monitor and improve the quality of the service or mitigate risk. Accurate and complete contemporaneous records were not always maintained. Regulation17 (1)(2)(a)(b)(c)(d)