# Worcester Garden (No.1) Limited

# Worcester Lodge

## Inspection report

30-32 Castle Road
Walton St. Mary
Clevedon
Somerset
BS21 7DE

Tel: 01275874031

Date of inspection visit:
20 September 2016
21 September 2016

Date of publication:
18 January 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection was unannounced and took place on the 20 and 21 September 2016. Worcester Lodge provides accommodation for people who require personal care for up to 39 people. All people living in the home have dementia. The home has a more secure Garden Wing for up to 11 people with more advanced dementia and other complex needs.

During the inspection there were 30 people living at the home. The accommodation is arranged in one building with a lift between floors for the main house and the Garden Wing on one level. There were communal spaces including a conservatory, lounges and dining rooms. People had individual bedrooms and some had an en-suite bathroom. People living at the home had dementia so their ability to verbally communicate with us during the inspection was mixed.

Prior to this inspection the registered manager had resigned following a period of absence, so the deputy manager had been promoted to manager. A registered manager is a person who has been registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of this inspection the manager was completing their application to become the registered manager. During the inspection the manager was supported by a new deputy manager.

People told us they felt safe but there were risks to their safety in relation to falls, risk assessments and medicine administration.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef provided alternative options if people did not want the daily options to ensure their preferences were met. However, there were times when weight loss was not being reported so action could not be taken.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and staff had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. However, there were limited systems in place to ensure all incidents were investigated and measures were put in place to reduce the risks to people.

The recruitment process did not always follow the provider's own policies and procedures, which meant people were cared for by staff whose prior conduct including from previous employment had not always been checked.

The manager and staff had some understanding about making decisions for people when the lacked capacity to do so themselves. However, processes had not always been documented to demonstrate the required legislation had been followed. Where people had been prevented from leaving the home, the correct processes has been followed.

The manager and provider had followed their legal obligations to notify CQC. The provider regularly met with the manager to provide additional support.

Staff were receiving regular supervisions and appraisals and they received appropriate training to care for people and meet their needs.

There were some completed audits but the systems were not identifying all shortfalls in the home. This meant there was a risk actions would not be taken to improve care for people when there were concerns.

The provider and manager thought all care plans were personalised and contained enough information to inform staff how to meet people's needs. However, people were not always central to their care and care plans lacked detailed guidance for some people. This meant there was a risk staff would not provide appropriate care in line with their needs.

Staff supported people to see a range of health and social care professionals. Staff supported and respected people's choices and they knew how important this was.

People and visitors thought staff were kind and caring. We observed positive interactions between people and the staff. The privacy and dignity of people was respected and people were encouraged to make choices throughout their day.

People knew how to complain and there were good systems in place to manage the complaints. The manager and provider demonstrated a good understanding of how to respond to complaints.

We made a recommendation that the service seek advice and guidance about implementing the Mental Capacity Act.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## 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 always safe.

People were not always having their medicines managed safely. Patterns of falls and weight loss were not always being identified so action could be taken.

People were at risk of being supported by unsuitable staff because the provider had not followed their own recruitment procedures.

People were supported by staff who understood what abuse was and how to report it.

People had their individual needs met because there were sufficient numbers of staff deployed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Most people who lacked capacity had their human rights considered and respected but it was not always recorded in line with best practice.

People could see appropriate health care professionals to meet their specific needs.

People made decisions about their day to day lives and were cared for in line with their preferences and choices.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

### Is the service caring?

**Good**

The service was caring.

People told us they were well looked after and we saw the staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected.

Peoples' end of life choices were respected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive

People's care plans did not always cover all aspects of their care and needs.

People were not always supported by staff who were familiar with the information in their care plans.

People participated in activities which were sometimes personalised to their likes, but some felt there could be more choice.

People knew how to make complaints and there was a complaints system in place.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The manager and provider had some quality assurance programmes but these did not always identify shortfalls in the service.

The manager had a clear vision for the service and this had been communicated well to staff.

The staffing structure gave clear lines of accountability and responsibility and staff received good support.

# Worcester Lodge

**Detailed findings**

## Background to this inspection

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

This inspection took place on 20 and 21 September 2016 and was unannounced. It was carried out by one inspector and one specialist professional advisor nurse who was a specialist in elderly care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at paperwork from the local authority and other intelligence we held internally about the home.

We spoke with seven people that lived at the home and had informal conversations. We spoke with the manager, deputy manager, provider and six staff members, including the chef and carers. We spoke with six visitors including relatives and visiting health workers. Following the inspection we received two more visitor's feedback.

We looked at six people's care records and observed care and support in communal areas. We used 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 looked at five staff files, previous inspection reports, rotas, quality assurance audits, training records and supervision records, health and safety paperwork, minutes from meetings and a selection of the provider's policies.

Following the inspection the provider sent us further information including risk assessments, actions they had taken and correspondence with other health professionals.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe at the home but we found they were not always kept safe. Concerns were found with the management of medicines, lack of guidance to reduce falls, risk assessments not containing enough detail and action not being taken when people had lost weight.

People were not always kept safe from falling because their care plans did not always contain guidance for staff to help reduce the risk. There had been 208 falls within the home from the end of January 2016 to August 2016. Staff told us all falls were recorded as incidents, but there had been no analysis of the falls and it was not clear who had taken the actions in the care plans or lessons learnt identified. This meant patterns of falls would not always be identified so ways to reduce the risk could be put in place. We spoke with the manager who said all actions taken had been recorded in people's care plans. We found people's care plans sometimes had a lack of detail around these actions. This meant staff would not always have strategies of how to reduce the risk of repeated falls.

For example one person had been assessed as a high risk of falling. Their care plan informed staff to "Be aware of [their] location" and they "May lose [their] balance and fall over if [they have] inappropriate footwear – prompt [them] to wear appropriate footwear". There was no detail for staff on what "appropriate" footwear was. Staff said to prevent the person falling they would "Keep an eye out" and "We check regularly". They were unable to recall much detail from the person's care plan or suggestions of how to reduce the risks of a fall.

Monthly falls audits were undertaken but there was no detail of the seriousness of each fall, whether injuries had been sustained or where falls had occurred. This meant it was difficult to identify any trends in relation to falls such as places in the building or times of day. We spoke with the manager who said they always referred people to the falls team. The manager and provider understood things could be missed when the audits were not detailed. The manager told us they would review how incidents were recorded and the content of the audits.

Medicines were not always managed safely. The provider's PIR said all staff were aware of the provider's policies and procedures for medicines. We found they had not followed the policy in relation to covert medicines or checking medicine stocks. Covert medicine is when tablets are crushed and are hidden in food and drink. No checks had been made with the pharmacist to make sure it was safe to alter the medicines or mix them in food or drink. For example, one person's care plan had a form titled "Permission to administer covert medication form". The form had a statement which read "It is in the patient's best interests for the above medication to be administered covertly". The form did not list the medicine which could be given like this. Also it did not describe the means by which it could be given such as in food or drink and whether tablets could be crushed. A member of staff told us the person's medicine should be crushed and either added to the person's food or to their cup of tea. But the care plan stated medicines should be in food; there was no mention of mixing it into drinks. This meant medicines may not be as effective if not administered correctly.

We discussed this with the manager and the deputy manager who were unaware of the issue. Following the inspection, information was received by the provider from the pharmacist. This told them most medicines being crushed by the home could be obtained in a liquid form. They confirmed by crushing tablets it would usually be outside the medicine license. Medicine licenses demonstrate medicines are safe for people because they have been through a range of tests. The provider told us they would be consulting with doctors in relation to these medicines.

People were at risk of staff incorrectly applying topical creams or not having the cream applied as prescribed. There were not always documents to tell staff where to apply creams or the frequency. For example, one person's medicine administration record (MAR) said, "Apply [the cream] to affected area three times a day when required". The affected area was not documented which meant staff may not apply it correctly. Staff had only signed the chart twice a day for the last 12-days. The cream was to prevent discomfort for the person so there was a risk they could have been in pain with fewer applications. The provider's policy and procedures for topical medicines were not being followed which said, "Clear information must be available to inform care staff what the cream is for, how much to apply, the frequency of application and for how long". This meant people were at risk of pain and missed creams because staff were not always following prescribed instructions.

Medicines were at risk of going missing because regular stock checks were not completed in line with the provider's policy. This meant the provider was not checking there was the correct amount of medicines for people. Some medicines required additional security. The additional legislation to protect these medicines was not being followed. The provider's policy stated that stock checks should take place but not how often. We spoke with a member of staff who could not tell us whether the number of tablets in stock was correct. This meant people were at risk of pain or anxiety if their medicines went missing or they ran out.

When people were prescribed 'as required' medicines, such as pain relief, staff documented when this had been administered. However, there was no guidance for 'as required' medicine to inform staff what the medicine was, why it had been prescribed, when it should be given or the maximum dose. By not having guidance staff may not know what symptoms to look for and when the medicine should be administered. This meant people may not receive their medicine because many people had difficulties verbally communicating with staff.

People were not always protected from the risk of infections being spread. For example, staff used the hoist to move people when they had fallen and were unable to get up unaided. There was no process in place to clean the communal slings. This meant there was a risk of infections on the slings being transferred between people. We discussed this with the provider and manager who said they would implement a process to manage this. Following the inspection they showed us the system they had put in place to ensure slings were laundered between uses.

Where people had lost weight actions had not always been taken to prevent further weight loss. Three people were found to have had recent weight losses. One person had a weight loss of 2.4kg between June 2016 and August 2016. At lunch we saw they were struggling to eat because of their health condition and were prompted once to eat by a member of staff. Another member of staff told the person struggling to eat did require prompting regularly. The person's daily logs showed they regularly needed prompting. Their care plan said, "Care staff to aim to monitor [person's name] weight and Body Mass Index (BMI) and report any concerns". A person's BMI is a measure that uses a person's height and weight to work out if their weight is healthy. A second person had lost 1.55kg in less than a month. Their care plan said, "Any changes or concerns with [person's name] nutritional requirements to be reported"; it had not been reported. The third person's care plan documented a recent loss of nearly 3kg in three months. We spoke with the person's

relative who were aware of the recent weight loss, but said they did not know why it was happening. The manager had no knowledge of any of the people's weight losses. There were no systems in place to audit weight losses to ensure appropriate action could be taken. This meant people were at risk of malnutrition because staff were not reporting weight loss when it had occurred.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks of abuse to people was not always minimised by the recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. The PIR said all checks were completed prior to a new member of staff starting work; a new member of staff confirmed this. However, the provider was not aware their current recruitment practice did not follow their own procedures. For example, one staff file was missing an application form so their previous employers were unknown. Both the person's references did not demonstrate they were from previous employers. This meant there was not satisfactory evidence of conduct in previous employment. Another pre-employment check for a member of staff demonstrated there was a potential risk to people. The provider and manager told us they had verbally spoken about this prior to employing the person. There was no risk assessment to demonstrate they had considered the risk and protected people. Following the inspection the provider sent us a completed risk assessment which demonstrated the risks had been considered and measures put in place to reduce them.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. One person was asked if there was enough staff they said, "Yes I think so". All of the staff and visitors we spoke with said they felt there were enough staff on duty to keep people safe. We saw some staff running activities for people whilst others were assisting people with their care. On the first day of inspection in the Garden Wing one member of staff was supporting all the people at lunch time as the other member of staff had gone for their lunch break. We spoke with the manager who said they will change when staff took their lunch break. By the second day of inspection the changes had been put in place.

People told us they felt safe. One person said, "I feel very safe here, my room is quiet and I sleep well". When other people were asked if they felt safe they said, "Yes I feel safe" and "I think so". Visitors and staff thought people were safe at the home. Some visitors said, "I have no concerns about my relative being here" and "Absolute peace of mind is what we've got". A visiting health professional said, "Definitely, people are safe."

Staff, and records seen, confirmed, all staff received training in how to recognise and report abuse. They had a clear understanding of what may constitute abuse and how to report it. One member of staff said, "I have in the past reported concerns. I completed an incident form and told the person in charge. It was reported to the local safeguarding team". All other staff were confident any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the manager's attention they had worked in partnership with relevant authorities to make sure they were fully investigated. However, the manager had not always identified recent safeguardings until advice was received from the local authority. The manager confirmed safeguarding training at a managerial level was part of their plan now they were the person in charge.

Staff had a working knowledge about infection control and their role in preventing the spread of infection. Infection control is policies and procedures to reduce the spread of infection. All staff members knew when personal protective equipment such as aprons and gloves should be used. Staff told us and we saw there were supplies available throughout the building. We observed that staff wore aprons when serving food. The home was clean throughout.

There were suitable secure storage facilities for medicines that included those which required refrigeration. We also looked at medicines that required additional security. These medicines were appropriately stored.

Requires Improvement

# Is the service effective?

## Our findings

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.

We checked whether the service was working within the principles of the MCA and people who lacked capacity had decisions made in line with the Code of Practice. Most people lacking capacity had information showing the code of practice had been considered when decisions were made on their behalf. However, one person who lacked capacity had their door locked for long periods of time whilst they were out of the room. The manager told us and their care plan said it was to prevent social isolation and reduce the risk of pressure sores. Pressure sores are an injury caused when an area of skin is placed under pressure. Their care plan said, "[The person's name] often prefers to unwind in their own space by sitting in their bedroom" and the locked door may have prevented them from doing this. It did not document less restrictive options had been considered or tried. By not documenting whether less restrictive options had been considered this person was at risk of their human rights not being considered in line with the MCA. Following the inspection, the provider told us people often had their bedroom doors locked to prevent others entering them; if people asked staff to open the door they would.

A decision for another person lacking capacity had not been completed in line with the MCA Code of Practice. Their care plan showed an assessment of their capacity had been completed for moving bedrooms. A family member had been involved in the decision. However, there was no information showing why the decision had been made and which options had been considered. We spoke to the person's spouse who felt the move had been positive and for a good reason. Another family member was not as happy with the changes. This meant it was not clear if the decision had been made in the person's best interest using the least restrictive option.

We recommend that the service seek advice and guidance from a reputable source, about the Mental Capacity Act in order to update their practice accordingly.

People were asked for their consent before staff assisted them with tasks. People told us "They ask me if I need a hand with anything" and another person told us how staff always ask if they want a bath. Some people said they did not always consent to what time they got up. People said, "I get up when staff tell me to" and "I get up when I'm prompted to by the staff". All people we spoke with said they chose what time they went to bed. Staff explained if people did not want to get up, they could chose to stay in bed longer.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person

of their liberty were being met. We saw applications had been made when required and where they had been authorised there were no conditions. Staff understood the process and made sure anyone requiring a DoLS had one applied for.

People received effective care and support from staff who had the skills and knowledge to meet their needs. This matched what we were told in the PIR. Staff we spoke with said, "This is my first care job and I have had lots of training" and "There is always lots of training. I've done medication training, safeguarding, falls, infection control, lots and lots". The manager shared with us the comprehensive training records for staff including planned training. The PIR told us on-going training would be offered to staff. We saw some staff were completing further specialist training in health and social care. The manager told us the provider took training seriously and would always say "Yes" if more was required. Some people had complex needs which meant at times they could display behaviours which could be challenging to others. We asked staff if they had received training on how to work with these people but not all staff said they had. Two staff members felt it would be useful.

Staff told us and records showed they had regular supervision and felt supported. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. All of the staff we spoke with knew when their last supervision was and all staff who required one had received an annual appraisal. All staff said the management team were easily accessible and all said they felt able to approach them at any time.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. We saw new staff had begun their induction based on the Care Certificate. The Care Certificate has been developed by Skills for Care and is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The manager told us they had been giving new staff the modules and found it comprehensive.

Most people's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. People told us the food was "very nice, delicious", "it's hot and plenty of it" and "super-duper!". Following the inspection a relative told us "Dad frequently tells us that he enjoys his meals. The quality of food is good e.g. fresh soup and home made cakes." Most people sat at communal tables in dining rooms and there were drinks available throughout the day. The PIR told us choices were given for meals every day. We found people had a choice of main meals each day except for Wednesdays and Sundays when it was a roast for everyone. The chef said "I pop out and speak to the residents, ask for feedback. I love seeing people enjoy their food". One person said, "The food is good, although you don't always get a choice, but you can have something else if you don't like what's on offer". Another person had a health condition which made it difficult for them to sit down for long periods of time. They were provided with a range of finger foods they could walk around with. This meant when people had different needs at meal time the staff found a way to meet them.

Staff arranged for people to see health care professionals according to their individual needs. One person told us they were waiting to see a doctor, which staff were organising. Records showed people were reviewed by their GP, the district nurse, continence nurse, speech and language therapist, the chiropodist, and social workers. On both days of inspection, people were visited by healthcare professionals. Hospital Passports were in place for people who needed to access other healthcare services. Hospital passports are documents which contain important information about a person such as medication, diagnosis and care needs. These are designed to be transferrable between locations. One visitor said "When my relative was ill,

they got the GP in straight away and kept me informed". We saw other people had accessed the hospital following accidents which resulted in injuries. This meant people's health needs were met because staff were aware of when to involve other health professionals.

Good

# Is the service caring?

## Our findings

People and visitors told us they were supported by kind and caring staff. One person told us "The staff are all very nice. They do anything I ask and if I want help, it's there". Whilst another said, "I'm very happy here; the staff are all very kind to me". One visitor said, "The staff here are so understanding." and continued "I feel like the staff really do know my relative". Other visitors said, "All of the staff are lovely, really very nice" and "The staff are great, they talk to my mum, encourage her". Staff told us "This is like a proper home for people", "I love it here, it feels really homely. It's all about the residents and what they want" and "I treat the residents like they are my family. There's no point working here if you don't care". Following the inspection some relatives told us, "I have always found the staff caring and well informed" and "Dads care is exemplary at Worcester Lodge".

We observed staff treating people with kindness and compassion. For example, during one medicine round a member of staff reminded someone what their tablets were for; they crouched down to the person's level and said, "The doctor prescribed these for your aches and pains". A visitor said, "I like the staff attitude here, they understand, they don't rush people and are very gentle". A member of staff said, "I don't think any other care home would compare to working here. I can't imagine working anywhere else".

People's privacy was respected and all personal care was provided in private. One member of staff said, "I help people maintain their dignity by giving them choice. I will always try and make sure people are co-ordinated. For example, offering ladies jewellery, if they have it, that matches their clothes, keeping their hair looking nice". We saw people were supported to a private space or their bedroom when they required support with more personal elements of their care. Screens were provided when people had made a choice to stay in empty communal area for health appointments.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. One visitor said, "Whichever member of staff answers the door, they always know where my relative is in the building and how they are feeling that day". We saw people meeting with their visitors in a variety of places during the inspection including their bedroom. Staff offered alternatives when people chose to meet their visitor in a communal space. The staff respected the person if they wanted to remain where they were. This meant people had a choice about where they saw their visitors.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their bedrooms. Other people were more unsettled because of their health conditions so they were moving around the home. We saw staff stopping in the corridor when they saw people to check they were alright. We were told by the manager and staff when people were unsettled in the main house there was the option of moving to the Garden Wing. Family members, other professionals and, where possible, the person were involved in these decisions. One person recently had been moved to the Garden Wing after consultation and it had a positive effect on their behaviour towards staff and other people. Staff told us since moving the person had been calmer. They continued to say this indicated the person was happier because they were unable to verbally communicate whether they were.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. There were some resident meetings but these were not frequent. Staff and the manager told us lots of the feedback from people comes by talking with them on a regular basis. The manager continued if a person brings up a concern then they would try and respond to it in a positive way and resolve it quickly.

The provider had completed surveys for people, relatives and health and social care professionals. They had received a good response to all surveys. The provider explained this demonstrated the good relationship they had with other health and social care professionals. This is because the questionnaires were returned promptly in high numbers. Results from the questionnaires were analysed and where suggestions or changes were required action was taken. For example, one professional had suggested the Garden Wing was too 'Clinical'. The PIR had identified this action had already been taken. During the inspection we saw changes had occurred to make it more homely. There were ornaments and china around the place to reflect how people's homes might have looked prior to moving in. This meant when people, relatives and professionals made suggestions they were acted upon by the provider and manager.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. For example, when we needed to discuss the care for a person with the manager or nurse they took us to an office and closed the door. Other staff stood in corridors away from people to speak with us. If staff were in the communal areas they spoke quietly with us or involved the person in the discussion.

People had good support and were able to make choices about their end of life care. For example, we looked at the care plan for one person who was approaching the end of their life. The plan detailed how staff should care for the person and keep them pain free. The GP had prescribed medication which might be required. The plan informed staff that the person wished to remain at the home rather than be admitted to hospital.
I have always found the staff caring and well informed

Requires Improvement

# Is the service responsive?

## Our findings

People were at risk of their care needs not being met because staff were unfamiliar with their care plans, generic phrases were used and some did not contain enough information. One member of staff said, "I have not read them" when asked about care plans. Other staff told us "I haven't read the care plans, but I get information during handover or from other staff" and "No, I haven't read any of the care plans".

The PIR told us care plans will reflect individual need and wishes and be person centred but we found that not to always be the case. Person centred is when the care is focussed on the person and their needs. Care plans were not always personalised to each individual. Some lacked information to assist staff to provide care in a manner that respected people's wishes and met their needs. For example, one person had a health condition but there was no information to tell staff the signs their health was deteriorating; there was also no guidance on actions staff should take when this happened. Only one out of five staff spoken with was able to describe what to look out for and how to help this person. This meant the person was at risk of staff not responding to their declining health because care plan did not contain enough detail.

Other people had times when their behaviour changed and became more challenging towards staff and other people. There were no clear guidelines for staff on the triggers, patterns of behaviour and how to deescalate the situation. For example one person's care plan said, "May become agitated". The only guidance provided for staff was "reassure and promote a relaxing yet stimulating atmosphere". No information was provided on how to reassure the person or what a "Relaxing yet stimulating atmosphere" was or meant. No information was provided about the triggers for this change in behaviour. This meant the person may become distressed because staff were not clear what they should do to prevent or manage the situation. Another person's care plan said, "May at times become agitated". Again, there was no detail about the triggers to the agitation and little information about how to respond. Staff told us they knew how to support these people through experience. There was a risk new staff would not have adequate information to reduce the likelihood of behaviours escalating unnecessarily.

Care plans did not always contain details to inform staff when health and social care professionals had visited. For example, one person had been assessed as being at high risk of choking by a health professional. Following the visit their care plan was promptly updated. It read "Staff to be aware of potential choking and report any concerns". There were no details about how to prevent the person choking or further information from the health professional's guidance. We spoke with staff who knew some of the information by talking with each other. This meant the person's care plan did not provide information to help prevent choking despite input from a health professional.

This is a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. People and other important people were involved in this process. One person was staying at the home for a short period of time because their family

were worried they would be home alone for a period of time. They had been actively involved in the decision to move in and said, "They give excellent care. I take advantage of it". Staff told us about another person who had moved in on a trial period to see if they liked it. By allowing people to have these opportunities, people were able to be understood and their care needs followed. All people on a short stay or had moved in recently had care plans which were detailed. This meant staff had used the information from assessment to inform people's care needs.

Most people were able to take part in a range of activities according to their interests. Recently some people had taken part in a local flower show and won first prize. We saw people involved in quizzes and games of skittles run by staff. During a quiz about identifying names for each letter of the alphabet a person used their daughter's name. A member of staff responded by saying, "You have a lovely daughter" to them. On the second day of the inspection some people went out on a bus into the community for tea and cakes. The manager explained the provider paid for this by organising fundraising opportunities which contributed money to all the outings. Following the inspection a relative told us, "Organised activities happen regularly and I am delighted to see staff just 'having a chat' when they notice a resident sitting alone". However, some people felt they would like more activities. For example, one person told us they would like more musicians and another person said they wanted to go for more walks.

There were annual meetings for people who lived at the home and their relatives. People were asked for feedback in relation to activities, accommodation and food. The manager told us they have an open door policy and will speak with people regularly to get feedback. For example, one person had a quiet word with a member of staff to say they wanted to sit on a different table at mealtimes. By the next meal they had moved to a different table.

The provider had received a number of compliments from people, professionals and relatives. There were thank you cards from people including comments such as "A huge thank you to all staff for providing great care" and "A big thank you for the outstanding care". During 2016, health and social care professional visitor's feedback had been collected. Comments included "Worcester Lodge is a very friendly residential home; the staff clearly care about their residents" and "Staff are always knowledgeable about their residents".

People and visitors told us they knew how to complain but never had to. One person said, "Complaints get acted on quickly" whilst another said, "I have never found a reason to complain". There had been one complaint made during 2016. This had been resolved in line with the provider's policy and closed promptly.

Requires Improvement

# Is the service well-led?

## Our findings

There were some quality assurance systems in place to monitor care but these had missed shortfalls found on the inspection. Ongoing improvements were not being planned. For example, monthly medicine audits lacked detail so had not identified any of the shortfalls found during the inspection. By not recognising all the medicine management concerns people may be more likely to have pain. Medicine errors were reported and a medicine incident form had only recently been introduced. Although two medicine errors had been reported a third was found during the inspection. We spoke with the manager who agreed their own audit tool needed to be more detailed. The manager agreed the other medicine error should have been investigated. Following the inspection, the provider told us the additional medicine error had only occurred recently so they had not had time to complete an investigation.

Care plans were reviewed monthly. Care plan audits had been completed regularly but they lacked detail. This meant concerns found on the inspection had not been recognised. For example, the manager had not identified guidelines for staff lacked detail and generic statements had not been changed. When they had identified issues no action plan had been created to demonstrate who would complete the action and by when. This meant there was a lack of accountability and no way to identify if actions had been completed.

The manager was not completing audits on other areas of the service. For example, there were no food and fluid audits. This meant concerns about people's weight loss had not been identified by the manager. There were no management action plans for incidents to demonstrate what had happened and lessons learned. By not completing audits there was a risk people may receive poor care because measures to mitigate risks had not always been put in place.

There were no systems or audits in place to monitor the DoLS applications and authorisations. By not monitoring authorisations there was a risk legal requirements for renewing DoLS would not be met. For example, one DoLS was due to expire the week of the inspection. No application to extend it had been applied for. The manager was not aware of this and had no systems to monitor their DoLS. This meant there was a risk the person's human rights could be breached once the DoLS expired. Following the inspection the provider told us they had set up a new form; this would highlight when DoLS were due to expire and need renewing.

The provider had been completing regular visits to the home to support the new manager following the registered manager being absent. They told us they completed independent checks on the audits. However, apart from the questionnaires, there were no written reports or action plans for shortfalls identified. The provider told us they wrote down notes in their diary and then followed it up at their next visit. This meant there was a lack of effective systems to feedback to the management improvements which were required. The provider had not found shortfalls from the inspection such as medicine management, some care plans being generic and care plans not providing sufficient details to reduce the risk of falls. By not having a system which monitored the internal audits the provider put people at risk of harm and care not meeting their needs.

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

People, visitors and staff were positive about the manager. A health professional said, "[The manager's name] is brilliant". One member of staff said, "The management are nice" and continued to tell us they felt supported.

There was a staffing structure which provided clear lines of accountability and responsibility. Prior to this inspection there had been a period of instability in the home whilst the previous registered manager was absent. The provider and manager told us this had impacted upon staff morale. Recently this had been resolved by promoting the deputy manager to the manager's role. They felt some of the concerns found on the inspection may be a result of this transitioning period. All staff said there was an open culture, and were supported by the manager and the provider. The staff said communication was "excellent". Staff told us who they reported to and what they would do if they had a concern. The manager was supported by a deputy manager and senior members of care staff.

The manager had a vision for the home which was to make it a "home from home". They wanted all staff to treat people like it was their mum and dad they were supporting. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Staff meetings and handovers demonstrated another way the information was shared with staff. Staff told us the manager and provider were open to feedback including suggestions of change. The provider and manager told us "We are always open for suggestions" and understood this was a way they could improve the care provided for people.

Significant incidents were recorded and where appropriate were reported to the relevant statutory authorities. When the manager had not been sure they sought advice to make sure it was correctly completed. All incidents had been recorded and most people's care plans contained action which had been taken. The home had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure that the care people received was personalised. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure care and treatment was provided in a safe way for service users. This is a breach of Regulation 12(1)(2)(a)(b)(f)(g)(h) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure people received safe, effective and responsive high quality care which was person centred and had not fully put in place systems to monitor the quality of care people received. Those which were in place had not operated effectively to ensure compliance. This is a breach of Regulation 17 (1) (2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |