Qualia Care Limited

Downshaw Lodge

Inspection report

Downshaw Road
Ashton Under Lyne
Lancashire
OL7 9QL

Tel: 01613307059

Date of inspection visit:
12 November 2018
13 November 2018

Date of publication:
23 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Downshaw Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Downshaw Lodge provides accommodation, nursing and personal care support to male adults with a range of needs arising from their physical and mental health. People living at the home have a dementia diagnosis and, as a result of their illness, may present with behaviours that challenge. The accommodation is split into two units, named Mason and Sheldon, situated over 2 floors and provides 45 bedrooms and a range of communal and activity areas. The home has a large outdoor garden area at the rear for leisure and activities. The service is located in the Ashton-under-Lyne area of Tameside. Downshaw Lodge is part of a large organisation; Qualia Care Limited. This inspection was the first inspection since the change in ownership of the home.

At the time of our inspection there were 45 people living at Downshaw Lodge.

This inspection was carried out over two days between 12 and 13 November 2018. Our initial visit on 12 November was unannounced.

The service had a registered manager in place. 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.
We identified breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were around medication errors, infection control and management oversight. You can see what action we told the provider to take at the back of the full version of the report. We also made recommendations around making the home environment more dementia friendly.

We looked at the safe management and administration of medicines and found medication was not always managed safely. We found regular checks and balances were carried out by senior staff; however, we found medication errors during our audit of safe medication management. We were unable to ascertain if people had received the right medicines in the right amounts at the right time. As a result, we requested immediate action be taken to ensure the safety of the people involved. We checked with the registered manager, who had taken appropriate action, and found no-one had come to harm as a result of the errors.

We identified concerns regarding infection control practice within the home. A recent infection control audit carried out in July 2018 had identified the same concerns we found during the inspection. We found some areas of the home were not always clean.

There were systems and checks in place to monitor the quality of the service to ensure people received safe and effective care. However, these checks had not always addressed the concerns we found during our inspection.

Systems were in place to safeguard people from abuse. Staff were aware of their responsibilities in reporting any issues or concerns so that people were protected.

People were supported by sufficient numbers of staff. Relevant recruitment checks were carried out to make sure people applying to work at the service were suitable.

Care files we looked at showed plans and risk assessments documenting people's specific care and support needs. These plans outlined how people needed to be cared for in an effective and safe way

Care records at the home showed us that people received input from health care professionals, such as psychiatry and social care workers. People were supported to visit the dentist and general practitioner.

The home has good links with partnership agencies and the community. Several people accessed the community on a daily basis and people were offered a range of activities and events to take part in.

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.

There was a complaints policy in place and we saw that complaints were acted upon. The registered manager also regularly sought the views of people living at the home and their relatives. They were able to demonstrate action taken at the home as a result of this feedback.

The required safety checks and maintenance for the building and equipment were in place and were regularly monitored.

Mealtimes were sociable and food was of high quality. People and their relatives told us they were happy with the menu and food choices provided at the home. Kitchen and care staff were aware of people's specific dietary needs.

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.

Errors were identified regarding the proper and safe management and administration of medicines.

We identified concerns around infection control at the home.

Safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people.

Staff were knowledgeable in recognising signs of potential abuse and the action they needed to take help protect people from the risk of abuse.

Is the service effective?

Good

The service was effective.

Suitable arrangements were in place to meet people's nutritional needs.

Relevant health care support was provided to ensure people's health and well-being was maintained.

The registered manager was aware of people living at the home who required authorisation to deprive them of their liberty and had ensured the legal safeguards were in place and up-to-date.

Is the service caring?

Good

The service was caring.

We observed established, positive relationships between people and those who cared for them.

People were treated with dignity and respect and spoken with in

a kind manner.

The registered manager arranged for people to have an advocate if they did not have family or friends to help them.

Is the service responsive?

Good

The service was responsive.

Care plans were comprehensive and reflected people's needs and care choices.

People and their relatives were encouraged to feedback and complaints were acted upon.

People were supported to access the community, go out with family and partake in activities at the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had a manager who was registered with the Care Quality Commission (CQC).

We received positive feedback from relatives regarding the management team.

Systems of audit and control were in place; however, the concerns we found had not been identified or rectified.

Downshaw Lodge

Detailed findings

Background to this inspection

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

This was the first inspection of the service since it was registered with a new provider.

This inspection took place on 12 and 13 November 2018 and the first day of inspection was unannounced. The inspection was carried out by two adult social care inspectors and a specialist nurse adviser on day one and by one adult social care inspector on day two.

Before we visited the home, we checked information we held about the service, including information gathered from local authorities and statutory notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

On this occasion, we had asked the service to complete a Provider Information Return (PIR) and this had been returned to us. This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We walked around the home and looked in all communal areas, bathrooms and store rooms.

During the two days of inspection, we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff. This included four people's individual care records, a sample of five people's medication records and four staff personnel files to verify safe recruitment practices were in place and that training and regular supervision of staff had taken place.

As part of the inspection process we observed how staff interacted and supported people at mealtimes and

throughout the two days of our visit in various areas of the home. We spoke with three family members who were visiting the home. We also spoke with the registered manager, the activities co-ordinator, the maintenance technician, the cook, the housekeeper, the clinical lead and three care staff. The registered manager was supported by the provider's area operational manager.

We attended the early morning staff handover meeting on the first day of our inspection to assess daily communication transfer of people's immediate care needs.

Requires Improvement

Is the service safe?

Our findings

Relatives we spoke with told us they felt their family member was safe at the home. One visiting relative told us, "He has lots of seizures and staff know when they are coming and are prepared." Another family member told us, "He's not aggressive or violent any more…Much better now."

As part of our inspection we conducted an audit to check the proper and safe management and administration of medicines at the home.

We looked at whether anyone living at Downshaw Lodge received covert medicines. Covert medicines are medicines that are given without the person's knowledge. Covert medicines should only be given when the person is deemed to lack capacity, and has been assessed as being the least restrictive option and in the person's best interests. During the medicines audit we found two people within the sample were receiving covert medicines and had the relevant best interest decisions in place.

We visited the treatment and medication room on Mason unit with the nurse on duty and found it to be untidy. Medicines should be stored in areas with temperatures below 25 degrees and be monitored daily, as high temperatures can compromise the quality of the medicines. Temperatures of this area were checked and recorded daily by staff. However, we found recordings where the temperature had gone above 25 degrees and the room temperature rose above this level during our audit. The nurse told us that if the room gets too hot they will open a window; however, the window was open and the temperature was still too high. When not conducting a medicine round, medication trolleys should be locked and stored securely in the locked medication rooms. However, despite the medication room being locked, we found the medication trolleys were not locked and we saw? a rack of dossette medications left out of the trolleys. We also found the fridge containing medicines was not locked.

During the medicines audit we looked at a sample of five people's medication administration records (MARs). Each person's MAR had a front sheet which contained a photograph and details of any allergies. However, we found a number of concerns and errors during this review. We found that not all people had a PRN protocol in place that directed staff on how and when to administer medication that had been prescribed 'as and when' and these doses had not always been recorded accurately. Where PRN protocols were in place, they had not always been signed, dated or countersigned.

During our checks of medicine stocks, we were aware that four people's medicine counts did not correlate and indicated that people had not received all their medicines or potentially had received too much. We requested the registered manager contact the GP, pharmacy and the local safeguarding team to seek reassurances that no one had come to any harm as a result of these identified errors. However, medication errors had potentially placed people at the risk of harm. We recommended during the inspection that the registered manager and clinical lead conduct a full medicines audit to ensure any further potential errors were identified and acted upon to safeguard people.

The registered manager told us that prior to our inspection, they had identified concerns around the safe management and administration of medicines. To address these concerns, they had employed a nurse clinical lead to audit and improve medicines and to provide clinical supervision of nursing staff. The clinical lead had been in post for two weeks at the time of our inspection; however, we could see during the inspection that progress was being made and improvements to the system were being introduced.

During our tour of the home we checked to see that areas were clean and good infection control practices were employed. Staff had access to personal protective equipment (PPE) and we observed staff wearing this appropriately throughout the inspection when serving meals or providing personal care. We saw that communal areas, the laundry, kitchen and bathrooms were clean; however, two bath-lifts were not clean on the underside. We found not all bedrooms were clean. In two bedrooms we found floors, crash mats and sensor mats were not clean. We found an area where wheelchairs were stored and these were soiled and had not been cleaned for some time. We requested these were removed and cleaned during the inspection. In the communal lounge an old bowl of cat food was found at the side of a cupboard. The registered manager told us care staff currently had some cleaning responsibilities; however, they told us they had identified the need for additional cleaning staff and plans were in place to recruit extra staff.

The registered manager explained that the home lacked storage space and this had led to laundry bag trolleys being stored in bathrooms. This meant that people using the home had access to soiled laundry. An infection control audit had been carried out the health authority four months before our inspection and a review of this report revealed the same concerns we identified. This meant previously identified infection control concerns had not been acted upon as a result of the audit. During the inspection, the registered manager told us they had arranged for the laundry trolleys to be taken out of bathrooms and placed in an unused room and this was actioned the same day.

We found Downshaw Lodge was not conducting their service in line with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections Guidance.

The above examples regarding medication and infection control demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During the inspection we looked at four staff personnel files to check that safe recruitment practices had been undertaken. We reviewed these files to check they contained required information including, a full work history, photographic identification checks, health information, a minimum of two references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. We found that the personnel files contained all the required information. This meant that robust and safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people. These files did not include agency staff employed at the home. The registered manager told us they received pen portraits from the agency prior to any agency staff coming to work at the home. We also checked nurses employed by the home were registered with the Nursing and Midwifery Council (NMC) and their registrations were found to be up to date.

We looked at the staffing arrangements in place at the home to ascertain if safe and appropriate levels of staff were on duty during the day and night. The manager used a dependency tool to calculate how many staff should be on duty and this tool was reviewed monthly.

During the inspection we found day staff were visible around the home and we reviewed staff rotas for the previous four-week period and this showed us consistent staffing levels were in place. The home used a

number of agency care staff; however, we could see from the rotas that regular agency staff were used. Two staff we spoke with told us they had concerns over the use of agency workers to support people with complex needs. One staff member told us, "They are good carers, but to work here you have to know the people and they don't." Another staff member told us the home used the same agency staff and that "there would always be a permanent member of staff on shift." Visiting relatives also told us they had concerns when agency staff were providing support as they felt they did know the person as well as regular staff. They told us, "They don't know everyone's little ways." Another relative told us they felt there was enough staff on duty but did not like it when agency staff were working and said, ""They don't know [person's name] well". We spoke with the registered manager who told us they were currently recruiting to vacant posts and they always tried to use permanent staff to cover any absences. They also told us agency carers do not support people living at the home who had more complex needs.

We reviewed four people's individual care records and found that people had comprehensive risk assessments in place that had been reviewed on a regular basis. These risk assessments were detailed and assisted support workers to identify potential risks specific to the person and how to manage these risks. We found that people had personal emergency evacuation plans (PEEPs) in place. A PEEP provides additional information on accessibility and means of escape for people with limited mobility or understanding. This includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a fire.

Downshaw Lodge had fire safety records detailing essential, regular safety checks, such as, fire drills, fire system weekly checks, emergency lighting and fire-fighting equipment. We saw that these checks had been carried out regularly. Other safety check systems for the home and equipment, such as, hoists, electricity systems, legionella and gas boiler checks were in place and up to date.

As part of our inspection we looked at how accidents and incidents were recorded, analysed and acted upon to minimise the risk of future accidents and incidents occurring. Reporting systems and processes for monitoring were in place. However, on review we found forms were not always completed fully and all information was not transferred to the monitoring logs, thus making it difficult to identify trends. The registered manager told us they had identified this issue and had held a team meeting the previous week to agree a new protocol for processing accidents and incidents to ensure all details are captured. Untoward incidents were also recorded and monitored by the registered manager. We saw where action had been taken to minimise the risk of future incidents, for example, improved lighting in the garden.

Suitable arrangements were in place to help safeguard people from potential abuse. There was a safeguarding adult policy and procedure in place. We saw evidence that staff had received up to date safeguarding adults training. We reviewed the safeguarding investigation file and found appropriate action had been taken to investigate and action any safeguarding referrals. Notifications had been sent in informing us of safeguarding incidents at the home. Staff we spoke with were all able to tell us how to safeguard someone and what action to take if they suspected someone was at risk from abuse.

Good

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.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that DoLS applications had been submitted to the local authority for relevant people living at the home and authorisations had been received or were awaiting approval. The deputy manager kept a tracker document that showed information on applications and approvals so that it could be seen at a glance; which people had a current DoLS in place and when a new application needed to be made. This meant the registered manager could be reassured that anyone at the home had been assessed and the legal safeguards were in place.

Staff had received training in DoLS and MCA and they were able to demonstrate their understanding of least restrictive practice. We saw staff ask people for their consent during our observations and people were given choices around what food or drink they preferred or where they would like to sit.

We observed the mealtime experience for people living at the home. People chose if they would like to eat in the lounge, dining room or in their own room. Each person was asked what they would like from three different meal options and were offered a selection of meal accompaniments. A choice of drinks was also offered and people were asked if they would like it served in a cup or a mug. Food looked and smelled appetising and music was playing in the background. We saw one person refused their lunch; staff chatted and encouraged him to have just a small meal and then a dessert. People who needed assistance were supported and were not hurried. Afternoon tea was served and again people were given choices of drinks and snacks.

As part of our inspection, we looked at the menus and food choices available to people living within the home. The cook told us they had a 4-week menu of freshly cooked food each day, including home-made cakes and fresh fruit. Although there was no programme in place to include people's specific preferences, the cook told us, "We try different things and see what they like; we've just had a run on chicken kiev." Birthday cakes were home made for each person and people had a choice of a hot cooked breakfast each morning and a 'full English' was served every Friday. Records were kept in the kitchen area to monitor cleaning, maintenance and food temperatures. The kitchen had received a level 5 food hygiene rating from the Food Standards Agency in January 2018, the highest level available. Relatives we spoke with were complimentary about the food at the home, they told us, "The food here is good."

People with certain health conditions require their food to be prepared in a specific way to ensure they can eat their food comfortably and safely. For example, a 'Category D' diet means that food needs to be of a minced or mashed consistency. Some people also require their drinks to be thickened to aid safe swallowing. In the care plans we reviewed we saw that choking risk assessments were in place and, where necessary, people had been referred to the speech and language therapy team (SALT) to assess their swallowing ability. Where a person had been prescribed a special diet, we checked to see how staff ensured they received their food and drink safely. We spoke with the cook and looked at information kept in the kitchen area to inform kitchen staff of people's specific dietary requirements. We found that the cook was knowledgeable and held information in the kitchen illustrating people's individual dietary needs and preferences. The cook showed us how they made biscuit smoothies so that everyone could enjoy their biscuits in an afternoon, including those on a special diet. Information on people's specific dietary needs was also displayed on a whiteboard in the clinic room accessible only by staff. During meal and snack times staff had a list of people who required their food or drink to be prepared or served to their specific dietary requirements. These safeguards were in place to minimise the risk of people receiving their food and drink not as prescribed.

During this inspection we reviewed four people's personal care files to check if people were supported to maintain their health and well-being. We saw people were supported to access other health care professionals, such as the continence service and dieticians alongside other services, such as an optician. Downshaw Lodge has a nurse on each unit and each unit is overseen by the newly appointed clinical lead. Staff and relatives told us they were confident they could report if they were concerned about someone's health and action would be taken. During the inspection we saw one person had become unwell and medical assistance was sought and action taken straight away by the clinical lead.

As part of the inspection we looked at whether staff received training and the necessary support from the provider, such as, supervision and personal development, to enable them to carry out their duties competently. The registered manager produced for us a training matrix that showed most staff had received their up-to-date mandatory training; however, we did identify a small number of gaps where staff did not have elements of training in place. For example, food hygiene and health and safety. We spoke with the registered manager who showed us these staff had this outstanding training booked in with the training provider for the next few days. Staff we spoke with confirmed they completed regular training.

We looked if the physical environment at Downshaw Lodge reflected best practice in dementia care. Throughout the building we found attention had not been paid to ensuring the home's environment was conducive to people living with dementia. We found no use of photographs on doors to aid people to orientate around the home and there was no evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and bathroom / bedroom doors. Corridors were not always specifically decorated with regards to differentiation of colour. We signposted the registered manager to available toolkits to utilise in order to conduct an assessment and make improvements of the home's environment to help people living with dementia move around the home more easily.

We recommend Downshaw Lodge consider current guidance on dementia friendly environments to make the home more conducive to the people living at the home.

Good

Is the service caring?

Our findings

Visitors we spoke with were happy with the care given to their relatives at Downshaw Lodge and were complimentary about the registered manager and care staff. One relative told us, "I'm very happy with everything here, he's well looked after." Another family member told us how the care and attention at the home had significantly reduced their relatives level of aggression. They told us, "[Name] seems settled and the staff make a fuss of him…he and they have a lot of banter together. He's not aggressive and violent anymore"

We visited a number of people's bedrooms and saw they were mostly decorated in a personalised way. People were encouraged to bring in their own furniture and decorations; however, some people chose not to personalise their rooms. We saw where one person's bed had been repositioned at their request, so they could view the garden better. One relative told us they had been encouraged by the registered manager to bring in mementoes of their life, their career in the motor industry and family. Another visitor told us the registered manager had placed pictures of their relative's favourite football team in the hallway near their room and they always made sure they had front row seats at the television when his team was playing and gave banter. They told us, "Staff always give him grief when they lose."

The registered manager told us the maintenance technician always tried to get the men involved in work he was carrying out, if it was safe to do so. We observed clear established friendships between the maintenance technician and the men living at the home. The maintenance technician told us that the relationships with the men living at the home was one of the best parts of the job. On two occasions we observed men were assisting by passing items to the maintenance technician and overseeing his work. This demonstrated clear involvement of people and mutual respect between staff and people living at Downshaw Lodge.

We observed throughout the visit that staff talked kindly to people and were encouraging when providing assistance. Staff were attentive and interacted with people in a kind and caring manner. It was evident there were friendly relationships between staff, people living at the home and their relatives. One visitor named particular staff members and described in detail how each one interacted in a friendly and caring manner with their relative. For example, they told us their relative starts to laugh every time they hear a particular staff member's voice and how he "loves to bits" another staff member. They went on to tell us, "Staff are family now." Other relatives we spoke with told us, "All the regular staff know the guys really well. [Name's] face lights up when he sees some of the staff."

People at the home looked cared for and we saw they were treated with dignity and respect throughout the inspection. Visitors told they felt their relative was treated with dignity and they told us that if their relative needed to use the bathroom, "It's no big deal, they just ask if they can borrow him for five minutes." Staff we spoke with talked in a caring way about the people they supported at the home. We asked one person if they would be happy to have a relative living at the home, they told us, "I would feel confident my relative would be cared for at Downshaw Lodge and be treated with dignity and respect." The home has a

designated men's barber shop; however, this was being used for storage during our inspection. The registered manager told us the hairdresser was still visiting the home regularly, but was using an alternative room.

We noted that a number of people living at the home did not have visiting family and this had been recognised by the registered manager and action taken to bring someone in to the home to be an advocate for them. An independent advocate can help people make decisions around where they would like to live and how they would like their care delivered. This demonstrated the registered manager respected the individual rights and care needs of people.

In the care files we reviewed, we saw that people had a communication care plan that outlined people's individual needs and their preferred way of communicating with staff. This information enabled staff to effectively communicate with people who, because of their condition, may not always be able make their needs and choices easily known.

Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them. Through talking to staff and members of the management team, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality. However, to fully embed the principles of equality, diversity and human rights we recommend the service consults the CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource'.

Good

Is the service responsive?

Our findings

We looked at how people's current care needs were communicated between staff and found there were a number of communication exchanges that took place each day. There were shift handover meetings that occurred morning and evening where staff would use a form to ensure that all people who used the service were discussed and any important information handed over to the next shift. We observed the morning handover on Mason Unit on the first day of our inspection. We found staff discussed each person's care needs and what people's plans were for the that day, for example if someone was going out for an appointment. Staff discussed how well people had been overnight and whether they needed any additional health monitoring that day.

Diaries were also kept on each unit to record any important information to be passed between each shift leader. The use of handover and communication diaries meant that staff and the home manager were kept informed of any issues or concerns around people and the home and allowed them to respond in a timely manner.

The registered manager conducted a daily clinical walk round of each of the units. This walk round used a crib sheet for checking areas of care such as GP requests, wound care, any staff issues and the presentation of people living at the home. This meant the registered manager was keeping a daily overview of how the home was running and enabled them to take appropriate action where necessary.

The care plans we reviewed were comprehensive, person-centred and detailed how people liked to have their care and support needs met. Regular reviews of care plans had taken place to ensure they reflected people's current care and support needs. Some people at the home had special requirements such as, cultural and religious needs. One person's family liked to bring their own food into the home and one staff member's religious needs meant they needed to take time out to pray. These needs were accommodated by the home. The kitchen staff told us they were able to purchase food that was required to suit people's religions or choices, such as Halal, Kosher or vegetarian. Local church services were also held at the home on a regular basis for the men who wished to practice their religion.

The registered manager told us of a scheme they used at the home known as 'resident of the day' that was used for all people living on the two units. A review of the person's care needs took place for the individual nominated as 'resident of the day' and included a discussion with the chef around meal choices and with care staff around their care, such as their likes and dislikes about their care and support. The registered manager described this review as "a bit of a pamper day", where the person received extra time and social interaction with staff and management.

During the inspection we saw people living at Downshaw Lodge accessed the community and a variety of activities. Staff and relatives told us there was a range of activities for people and we observed people engaged in these activities during the inspection. The home employed a part-time activities co-ordinator who organised group and individual activities for people to participate in, if they so wished. The activities

co-ordinator and registered manager told us they felt social stimulation was a very important part of care delivery and a lot of effort and resource went in to ensuring people were able to access activities of their choice. Several men accessed the community on a regular basis; one man liked to go fishing and another liked to visit the book makers and town centre regularly. The registered manager told us they actively encouraged people to pursue their recreational choices, even if that meant taking risks. Risk management plans had been put in place to ensure the safety of the people and staff whilst accessing the community. The activities co-ordinator told us they recognised that some people preferred their privacy and did not like to participate in activities. They knew one person liked to read books, so they encouraged them to visit a local charity shop and supported the person to bring back a bag full of books they had purchased.

People living at the home had access to wifi and the large televisions in communal rooms were able to access the internet and also had a pay per view system to watch films on demand.

The home had close links with a nearby retirement housing complex. People from Downshaw Lodge often accessed activities that are available at this complex; these included parties and dance classes.

Downshaw Lodge had a large, enclosed garden that included outbuildings, flower beds and a smoking shelter designed to look like a bus stop. People from the community visited the home on a regular basis; these included a local bowling club who came to play bowls in the outside area with the men. Other regular visitors included, local singers, a pet therapy dog and an animal petting show. The activities co-ordinator also organised several events, such as, a bonfire night party complete with fireworks, a barbeque and birthday parties for residents if they so wished. Football matches were also a big event at the home with people who wished to participate gathered around the television with non-alcoholic beers. The home had recently been bequeathed a sum of money and people were asked to vote on what they would like to buy. The men had chosen a football table and this was to be delivered after the inspection.

NICE quality standards on the mental wellbeing of older people state that older people in care homes should be encouraged to take an active role in choosing and defining activities that are meaningful to them. This promotes their mental health and well-being.

We looked at how complaints were responded to and managed at the home. The home had a corporate complaints policy in place outlining to the organisation's home managers how to respond to complaints. There was information displayed in the reception area around how to make a complaint. We saw documentary evidence that complaints were responded to and acted upon appropriately.

Requires Improvement

Is the service well-led?

Our findings

The home had a manager in post who had been registered with the Care Quality Commission since July 2017 at this location.

A registered manager has responsibility under their registration with the Care Quality Commission to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. We found that the registered manager had knowledge and documentation that showed us they were aware of their obligations. However, we found two breaches of the regulations during our inspection.

We asked relatives for their opinions on the management and leadership of the home and we received positive feedback. We received comments such as, "[Name] is a great asset to the home. I can go to them with anything and they will sort it out. I've been to them with lots of things and it is never a problem."

A system and process of auditing was in place. Support structures were in place so that the registered manager and provider had oversight of operations at the home. The registered manager was supported during the inspection by the area operational manager. We found the registered manager to be knowledgeable around the quality systems and files were organised and easily accessible. Audits were in place and regularly carried out for ensuring an overview of the home. Examples of these audits included, hand hygiene, medication, kitchen, laundry, falls and dependency. However, although the provider had policies, processes and checks in place, they had not identified and actioned the concerns we found during our inspection regarding infection control and the safe management of medicines.

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

The registered manager told us they would regularly carry out night checks where they would visit the home during the night to gain an overview of the service provision at night and spend time with night staff. The registered manager told us they had an open-door policy where staff and visitors could come and speak to them anytime. We saw that regular team meetings took place. Details of these meetings were minuted and actions recorded. This meant the registered manager was keeping staff up to date with things going on with the home and organisation.

The registered manager had submitted statutory notifications to CQC. These are notices of specific events which had occurred within the service as required by law.

The registered manager had co-ordinated a relatives' support group named 'Friends of Downshaw Lodge'. This group brought together a number of relatives and management and has linked in with a national older people's charity. They had recently been successful in a bid for funding and been awarded money for activities at the home. The registered manager told us they already had a lot of involvement with the

community, but their aspiration was to increase this further. Several men were booked onto a trip to see a local football team play the following month; however, the registered manager told us, "My dream is to take all the guys to a premiership football match."

Throughout the inspection we gave feedback to the registered manager, and area support manager, our findings that required attention. They acknowledged our findings and made any required amendments or improvements during the inspection.

During the inspection, the registered manager and management team were visible around the home and it was clear management and staff knew people well. The registered manager and all staff were co-operative and helpful throughout the inspection.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Errors were identified regarding the proper and safe management and administration of medicines. We identified concerns around infection control at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The system of audits and checks had not always identified and actioned the concerns found during this inspection.