Werneth Lodge Limited

Werneth Lodge Care Home

Inspection report

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Date of inspection visit:
19 December 2017
21 December 2017

Date of publication:
30 January 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Werneth Lodge on 19 and 21 December 2017. Our visit on 19 December was unannounced.

The service was last inspected in October 2016, and rated Requires Improvement. There were two breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to the way the service was governed. Following the inspection the provider sent us an action plan which stated the breaches would be addressed. At this inspection we found significant improvements in all areas.

Werneth Lodge is a residential care home that provides accommodation and personal care for up to 42 older people, including some people who live with dementia. At the time of our inspection the home accommodated 38 people. Lounges, the dining area and bedrooms were well laid out with consideration of easy and unobstructed access for people who used the service. The bedrooms were bright with large windows letting in natural light. All were en-suite with additional bathrooms on the corridors.

When we looked around the home, we found it looked clean, although the area around the lift entrance at the main door was sticky from spilt drinks.

People told us that they felt safe in Werneth Lodge, and when we spoke with staff they demonstrated a good understanding of how to prevent abuse. We saw that the service had safeguarding procedures in line with legislation and local authority policies so when incidents of potential abuse occurred these were reported and appropriate action taken to protect people from harm.

Care records showed that risks to people's health and well-being had been identified, and where risk had been identified corresponding detailed care plans were put into place, and reviewed on a regular basis. Risks were assessed in relation to each individual, taking into consideration their choices, abilities and mental capacity. Environmental risks were considered; when we looked around the home we saw that steps had been taken to prevent injury or harm, and records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions.

We saw that when recruiting new staff, appropriate processes were in place to ensure that they had the right quality and character to work with vulnerable people, and once in post all staff received regular supervision and appraisal and were provided with training opportunities to develop their skills. There were sufficient staff on duty, and we saw that they had time to spend talking and interacting positively with the people who used the service.

Systems were in place to ensure that all medicines were stored correctly and dispensed by staff trained to provide medicines safely, and where health needs were identified we saw staff followed advice given by professionals to make sure people received the care they needed.

People who used the service were offered choices, and capacity and consent issues were considered. Where

people lacked capacity, best interest decisions were taken and documented to show that decisions made were in their best interests. Where people were subject to a deprivation of liberty the service sought the appropriate authorisation to provide care and support.

The service recognised and responded well to people's needs and wishes, and respected cultural and social norms and values. Attention was paid to people's nutrition and hydration needs. People told us they were generally satisfied with the food offered, but some told us ways they felt meals could be improved. The service employed an activity coordinator, and regular activities were arranged. On the second day of our inspection the service held a Christmas party, and we saw people who used the service enjoyed this day. Relatives and friends told us they were welcomed at Werneth Lodge, and we saw that they had been invited to the Christmas party.

We saw that people were treated with respect and dignity by kind and patient staff. We observed and overheard kindly interventions and people who used the service said they felt valued and a part of the community. Privacy was encouraged and people who had capacity held keys to their rooms.

People were involved in planning their care and reviews and their wishes and needs considered and acted upon. A complaints procedure was available and people told us that they knew who to speak to if they wanted to make a complaint. We saw copies of the complaints procedure were available on corridors. There was no copy by the front entrance, however, but when we informed the registered manager she agreed to place a copy there.

To help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided, and ensure good recording of information. Communication amongst staff ensured that information was passed on in a timely manner. The service sought the views of people who used the service and other stakeholders to provide and improve on service delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood how to keep people safe from harm, and when allegations of abuse were made these were thoroughly investigated.

People told us that they felt safe and there were enough staff to meet their needs.

Werneth Lodge has a good system in place for the recruitment of staff.

There were effective systems in place for managing medicines.

Is the service effective?

Good

The service was effective.

Staff were well trained and people felt confident in their abilities to care for them.

Capacity and consent issues were considered, and where people were deprived of their liberty the correct authorisation had been applied for.

There was good liaison with health care professionals.

Is the service caring?

Good

The service was caring.

Staff treated people in a caring and compassionate manner Staff agreed that this was important and spoke kindly about the people they supported.

People's privacy and dignity was respected, and personal information was securely stored.

Is the service responsive?

Good

The service was responsive.

The service had systems in place for receiving, handling and responding appropriately to complaints.

People contributed to their care reviews and were consulted on service provision.

Care plans reflected people's needs and how they would like their care to be delivered.

Where possible, people were encouraged to voice their opinions about the quality of their service, and their views were taken into consideration.

Is the service well-led?

Good

The service was well led.

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

Systems were in place to assess and monitor the quality of service provision, and the service had developed good systems to audit the quality of care provision.

The manager and registered provider understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Werneth Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 21 December 2017. The first day was unannounced. The inspection team consisted of one adult social care inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically working with older people and people living with dementia.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Werneth Lodge, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

During our visit we spoke with the registered manager and area manager for the provider. In addition we spoke with the deputy manager, a senior care worker, four care workers, and the cook. We observed how staff interacted with people and spoke with twelve people who used the service and four visiting relatives. We also spoke with one visiting health care professional.

We looked around the building, including all of the communal areas, toilets, bathrooms, the kitchen, and the garden. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We observed how staff cared for and supported people, and looked at food provision.

We reviewed the care records for four people, four medicine administration records and five staff personnel files, and other documents related to the management of the home, such as maintenance records and service invoices.

Prior to our inspection we reviewed the information we held about the service, and contacted the local authority safeguarding and commissioning teams to obtain their views about the service.

Good

Is the service safe?

Our findings

People told us they felt safe at Werneth Lodge. One person who used the service said. "They take care of me, I feel safe"; another remarked, "I love it here, I couldn't want for anything. I love my room and there's always someone nearby". A third told us that they always felt secure, and that, "It's reassuring to know there's someone around in the night".

The building was secure; visitors were required to ring the bell, and on entry sign the visitor's book. When we arrived at the home, we were asked to show our identity before we were allowed to enter. However, the layout of the buildings meant that the main entrance was not monitored and there was no oversight of who was entering or leaving the building. This increased the risk of intruders getting in to the building or people getting out and becoming lost. To minimise this risk, the door was alarmed and we saw a notice on the door reminding people who used the service and guests not to allow entry or exit without first checking. On the second day of our inspection, we were allowed in by a person who used the service, but they wanted to know why we were visiting, and informed a member of staff. When we spoke with the area manager for the service, they agreed to review the security of the main entrance, and consider installing surveillance cameras.

People were protected from harm and abuse. A member of staff told us they had received training in protecting vulnerable adults from abuse and that they would report any poor practice to the manager immediately. They recognised that staff can sometimes pose the biggest danger to vulnerable people, but, "We don't allow that here. Accidents and incidents can happen when staff get stressed and lose patience, but there is no need to stress here. If we are having difficulty we can walk away, and get someone else to take over, or leave the person to calm down for a few minutes." A visiting relative agreed that people were protected. They told us, "My [relative] is happy here, I know he's looked after". We saw staff remained vigilant and were able to prevent harm occurring. For instance, when one person who used the service became agitated with another, a member of staff intervened and calmly de-escalated the situation.

There were appropriate policies and procedures in place around safeguarding and staff we spoke with were confident that they would recognise any issues and report them immediately. The service had procedures to protect vulnerable people and a copy of the local social services safeguarding policies and procedures to follow the local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. We saw that there had been relatively few concerns raised, but where they were, incidents were reported, and the registered manager investigated any issues and acted on the findings. There was a whistle blowing policy in place, which staff were aware of and they told us they would report any poor practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations. The staff we spoke with informed us that they were aware of how to pass on any concerns about poor practice and felt that if they were to do so they would be listened to, but told us that they had not had to use the whistleblowing policy. One care worker told us, "We have guidelines to follow if we see anything untoward. If I saw something I would report it to my manager, and if I was not comfortable with their actions I would take it further".

We saw the service had taken a proactive approach to managing risks. These included analysis, identification and review of environmental risks and hazards. For example, a fire risk assessment identified ways to minimise the risk of fire, including regular servicing of fire equipment, alarms and fire drills, and preventative measures to reduce the fire risk where people smoked. Personal emergency evacuation plans (PEEPs) had been developed for the people who used the service, and there was an up to date copy of the plan on the back of the each bedroom. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The manager kept a schedule which showed when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cooker; and when full checks were needed for water temperatures and legionella testing. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

We looked four care records which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, risk of falls, eating and drinking, communication and hygiene. We saw that where risk had been identified a corresponding detailed care plan was put into place to help reduce or eliminate the identified risks and these were reviewed on a regular basis.

When we looked around the home we saw that steps had been taken to prevent injury or harm, for example, corridors and walkways were free from obstacles. We saw that the service had invested in 'silent minders' as an alternative to crash mats next to beds. A silent minder is an electronic device which detects body movement and triggers the nurse call system. This meant that if a person tumbled out of bed the staff would be immediately alerted. The registered manager told us that these were used in preference to crash mats as they were less restrictive and because crash mats could cause a trip hazard.

Risks were assessed in relation to each individual. We saw specific risks, such as inappropriate behaviour, or verbal aggression had been assessed with detailed instruction to staff to minimise the risk. Staff told us that where people presented with behaviours which could be challenging, any behaviours were reported and used to regularly review care plans.

Information was shared at the beginning and end of shifts, so staff coming on duty were aware of any concerns. When we asked, people told us that they were consulted and given information about the risks to their safety, and helped to make appropriate choices. For example, we asked two people about risks to their safety when they left the building unescorted. One told us that they were able to go out alone, and did so on a daily basis, whilst the other told us that if they were to go out on their own they would soon get lost! This was reflected in the person's risk assessment.

We saw that there was a good ratio of staff to people who used the service. The registered manager informed us that they used a dependency tool to determine how many staff would be required. There were generally six care staff on duty, including at least one senior care worker during the day with three waking night staff. There was some flexibility should needs change, for example, if more staff were needed due to illness of people who used the service or end of life care. In addition, the registered manager and deputy manager operated a 24 hour on call system. We looked at the staff roster, which was planned in advance, with little need to seek extra support. We were told that any sickness was generally covered by regular staff,

who would be paid overtime, or gaps could be covered by the registered manager or her deputy. The registered manager told us that they had never had to use agency staff and believed familiarity with people who used the service was important.

At the start of each shift, staff told us that they were allocated responsibilities, but that they worked together to ensure that all needs were met. We heard call bells were responded to promptly, and people told us that they did not have to wait long if they needed support. One person who used the service told us, "I have never had to wait. There is always someone around and they are quick to jump in and help".

We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of residents. We looked at four staff records. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a job description, and two references. Where necessary, checks were made to ensure that people were eligible to work in the United Kingdom. Checks had also been carried out with the Disclosure and Barring Service (DBS) before the member of staff began work. The DBS identifies any people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staff being employed at Werneth Lodge.

People told us they received support to take their medicines as prescribed, and in the way they preferred. One person told us, "Yes, they look after my tablets for me, and always explain what they are for. They always give me a drink to wash them down".

Senior staff were trained to administer medicines, and we observed one medicines round during our inspection. The senior care worker checked the dosage and that they were for the right person before placing the tablets into a small pot. They approached the person, addressed them by name and explained what they were offering. They then checked the person had a drink and watched as they swallowed before recording appropriately on the medicine administration record (MAR Sheet).

All medicines were stored in a locked treatment room. Both the fridge and room temperatures were recorded on a daily basis. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

The Senior Care worker on duty would hold the keys, with a spare set locked in the manager's office. Medicines were dispensed from a lockable trolley using a controlled dose system, which minimised the risk of incorrect dispensing.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. We saw controlled drugs were stored in a further locked cabinet, and the controlled drug register was checked on a daily basis at the start and end of each shift and countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

MAR Sheets included a photograph of the individual, and noted any intolerance to medicines and allergies. The records we checked were accurate, up to date and matched the medicines in stock. There were no gaps in signatures. There was also a signed log of all returned unused medicines. The registered manager conducted a monthly audit of medicines, including checks for any errors. Where these had occurred, we saw that appropriate measures were put in place to prevent any future reoccurrence.

Where people were able they were encouraged to take control of their own medicines and we saw one person self-administered all their medicines and creams. We saw this person had been provided with a lockable cabinet which they kept in their room, and took responsibility to take their own tablets. Similarly people who were able to applied their own creams. Skin creams were kept in people's rooms and if staff administered these this was recorded on a separate Topical Medicine Administration Records (TMAR) which was kept with the creams.

We saw that two people sometimes received medicine covertly. Medicine given covertly is the administration of any medical treatment to a person in a disguised form, such as sprinkled over food. We checked the case records and medicine administration records for one of these people and saw that the decision to provide covert medicine had been considered in line with the person's capacity and in their best interest, and included written authorisation and instruction from the person's general practitioner (GP).

We looked around all areas of the home, and saw that it was free from any unpleasant odours, well maintained and generally clean. One person who used the service told us, "It's nice, my room is good and clean." However, we noticed that the area around the lift at the front entrance had been neglected. We saw that a number of the more able residents would congregate in this area and the timber frame was sticky from spilt drinks. We also found a cleansing dispenser at the end of one corridor was empty on the first day of our inspection, and had not been replenished on the second day. When we raised these concerns with the registered manager she agreed to conduct a daily walk-around to check that all infection control measures and cleaning duties were competed.

Bedrooms had matching furniture and were personalised with people's own belongings. They had locks to ensure people's belongings were protected, but a mechanism to ensure that people could not be locked in their rooms. We saw some people had their own keys and could keep their rooms secure.

Communal bathrooms were clean and hygienic. They were decorated in pastel shades with pictures on the wall that gave a homely feel to them. Thermometers in each bathroom allowed the staff to ensure the water temperature was not too hot or cold. We saw that where dangerous or hazardous equipment was stored doors displayed warning signs and 'keep locked notices'. When we tried these doors, we found that they were locked.

We checked the kitchen and saw that it was clean, and that kitchen staff regularly monitored the fridge temperatures and stored food safely to prevent any risks of cross contamination or food wastage. The kitchen was awarded four out of five stars in a recent food hygiene rating from the Food Standards Agency. When we asked about this we were shown the report and saw that all recommended action, including ensuring walls and units were properly treated to prevent the spread of infection had been carried out.

In the laundry, we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

We saw that toilets had posters detailing safe hand washing techniques, and that soap; paper towels, disposable aprons and hand gel were available, further reducing the risk of cross contamination.

Staff we spoke to understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Staff had attended infection prevention and control training.

When we spoke with staff they demonstrated an understanding of the importance of safety measures to protect themselves and people who used the service. We saw that when accidents and incidents occurred these were recorded, investigated and actions implemented to prevent future reoccurrence.

Good

Is the service effective?

Our findings

Prior to their admission into Werneth Lodge, the registered manager or deputy would complete a preadmission assessment, and after they moved into the service their needs were continually re-evaluated as they became familiar with their environment and the staff who supported them. Throughout their stay people were encouraged to maintain their independence and lifestyle choices. One person told us, "I enjoy living here; I choose not to wear my hearing aid and they don't mind". Another told us that they went out unaccompanied each day and we saw that there were no restrictions placed on people who had capacity to make their own decisions, "I can go out when I want," they told us, "There are no restrictions on when or where I go but they like me to be back by Ten o'clock, and I'm okay with that".

When we spoke with people who used the service and their visitors, they told us that they felt the staff were well trained and knew them well. One person told us, "They know their stuff. There are a lot of people in here and we're all different, but they know all of us well and how we want to be helped".

People who used the service informed us that there had been a number of new staff who had started over the previous half year but, "I give them full marks, the staff are very sociable. I've no complaints".

Staff told us, and we saw from records that when they started at Werneth Lodge they received a full induction and were subjected to a probationary period of three months. One care worker we spoke to told us they enjoyed their induction as they felt they were given time to get to know the people who used the service, and the daily routines. Although they had previous experience working in a care setting, their work during the first week was supernumerary and spent shadowing staff and being observed supporting people. They did not work unsupervised until they and their supervisor felt they were competent to do so. We saw staff personnel files records which showed that the staff member and registered manager had signed off each required competency once the level of competence had been reached. One carer told us about their induction: "For the first four days I did five hour shifts with a member of staff watching. I wasn't allowed to do anything until they were sure I could. I went everywhere and spoke to everyone, and spent time getting to know the [people who used the service]. I learnt their life stories, and found out what helps people and how to support them when they are unhappy, or when they wanted time alone".

During their induction period all staff completed training in a variety of subjects, such as food safety, infection control, manual handling first aid and safeguarding vulnerable people.

The service set clear expectations for staff and provided on-going training to ensure staff had the skills to carry out their role. From the training matrix (record), which mapped out the training staff had completed, we saw that nearly all care staff had completed some training in a variety of subjects, such as safeguarding adults, first aid, medication, food hygiene, dementia awareness and safer people handling. On completion certificates were stored on personnel records. We saw one person had recently completed courses in dementia awareness, handling information and understanding mental health. This person was able to explain how they had put their learning into practice to support the people who lived at Werneth Lodge.

During this inspection we saw that the registered manager kept a timetable which showed that all staff received a supervision session every three months and a yearly appraisal. Supervision meetings provided staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at four staff supervision records which showed that meetings were productive and staff used the opportunity to discuss issues of concern, identify areas for improvement and reflect on their core values. In addition staff were asked to complete a "Continual Professional Development Plan". This provided them with the opportunity to consider what they wanted in terms of on-going training and personal development. Where issues of concern had been identified, either by the member of staff or their supervisor, an 'on-going report' was completed to monitor staff performance and identify any improvements in conduct or service delivery. Clear records, signed by both the supervisor and the person being supervised, were kept on the staff file. Staff we spoke with told us they valued the opportunity to discuss their work with a senior member of staff and that it encouraged openness and honesty.

We saw that staff communicated well with each other and passed on information in a timely fashion. All staff attended a changeover meeting at the start and finish of each shift. This helped to ensure that staff were given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood. Staff shared information about individual people who used the service and tasks were delegated appropriately and shared fairly.

Attention was paid to people's nutrition and hydration needs. The area manager told us the owners did not place any restrictions on the food budget, and when we toured the kitchen we found the larder and freezers were well stocked. People were weighed regularly and where appropriate a food and drink chart was used to monitor the amount given and the amount consumed. If necessary staff would make referrals to dieticians or speech and language therapists for advice on diet and swallowing. We saw when we looked at care records that diet plans were followed, and when we looked in the kitchen we saw lists showed the number of people who required their food to be prepared in a specific way, such as pureed, or mashed. The list also showed the number of people who needed specific diets due to medical concerns such as diabetes, or cultural needs.

As people rose, they were offered a cooked breakfast or could chose cereal, porridge and toast. The main meal was served at lunchtime, with a choice of two main courses followed by a desert. A further meal was provided at teatime, for example, soup and sandwiches, and people were offered supper before retiring to bed. Throughout the day snacks and hot and cold drinks were offered, and people could ask for fresh fruit.

We observed lunch in the dining room on the first day of our inspection. People were brought into the room in an unhurried manner and made comfortable. We noticed that some people preferred to eat in their own rooms and so their meals were taken through to them, and where necessary a care worker would assist them with eating.
There was a pleasant relaxed feel to the meal times. Each table had salt, pepper, sugar, milk and serviettes available. Staff made sure all residents had a hot drink and there were jugs of juice on each table.

Meals were plated up in the kitchen and sent up to the dining room using a food lift. People who required specific diets were asked their preference prior to the meal so this could be prepared; others were offered two plated up meals so they could look at it and make a decision, there was a choice of 2 hot dishes or a salad.

The food looked as if it was hot and plentiful, and people had adapted cutlery, cups and plates to assist them to maintain their independence. There were enough staff to serve meals and assist people, and we

saw they worked well together, talking and helping each other, and offering more drinks, but there was not much interaction with the people who used the service. We asked one person who used the service about this and they told us, "It's a busy time for staff, we can talk amongst ourselves. Once they have served up they have more time to spend with us".

When we asked people about the food they were generally satisfied. One told us, "The food is okay, and there is plenty. If we want more we can ask" and another said, "The food is plentiful and good." Others suggested ways they felt the food service could be better. One person who used the service said, "The food was lovely but it's not as good now, it doesn't taste as nice and they put too much gravy on." They felt it would be better if gravy and sauces were served separately rather than added in the kitchen. Two others told us they were not impressed with the sandwiches. One said, "There's not enough variety, we get little [sandwiches] with processed meat in", and another told us, "I want wholemeal bread but don't always get it, they use processed meats and cheap cuts". We raised this with the registered manager who informed us that they had appointed a new cook who was due to begin work, and that this would provide an opportunity to review the quality of meals.

People had good access to healthcare and staff monitored their physical and mental health needs. One person who used the service told us, "I can always see my doctor when I need to". Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. We saw evidence in care files and case notes of referrals, for example to mental health liaison officers, with records of advice taken and implemented by care staff. Where specific needs, such as eye care or concerns about pressure care were identified specific care plans were drawn up to meet any needs identified. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

Werneth Lodge is a large building which has had an extension to join the main building to an adjoining coach house. The lounges, dining area and bedrooms were well laid out with a thought to easy access for staff and residents. There were two passenger lifts and two stairways to access the upper floors; these had safety gates fitted to prevent falls or other accidents. All bedrooms were en-suite with additional bathrooms off the corridors. The bedrooms we looked at were bright with large windows letting in natural light. The building enclosed an accessible grassed courtyard with benches for people to sit in better weather. There was a designated smoking area by the garden door. In the main part of the home there were three lounges where people could sit and talk, or watch television, and another lounge in the coach house which was generally used by people who were more independent. This lounge also included a computer where people could access the internet. We were told that this was rarely used as people had begun to use their own mobile phones to seek information or maintain contact with relatives and friends.

We were told that people were not always taken to the same lounge or seat unless they wanted to; this encouraged a social mix and avoided people getting possessive about communal space. During our inspection we saw the people who used the service did appear to mix with each other. People who were capable were able to move freely around the home with access to the stairs and lifts. Throughout the building there were plenty of information notices displayed, such as the complaints procedures and an activity calendar.

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.

People can only be deprived of their liberty to 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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. 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.

The registered manager told us and we saw information to show that thirteen applications to deprive people of their liberty had been made, of which nine had been authorised by the supervisory body (local authority). We had been notified of these authorisations. Where these were due to expire there was evidence of requests for a review. When a DoLS had been requested or authorised the information was stored within the person's care records, along with details of why the DoLS had been agreed, and any conditions relating to the restriction. We saw that the registered manager kept a separate record to show when a request had been made, authorised, or due to expire. This reduced the risk that the authorisation could expire without the knowledge of the registered manager, and allowed a quick check to determine if the deprivation made was legally permissible.

Capacity assessments had been completed to determine why people needed a DoLS authorisation. When we looked at the care records we saw evidence of best interest decisions which indicated why the service was applying for a deprivation of liberty in the person's best interest. This helped to make sure that people who were not able to make decisions for themselves were protected.

Good

Is the service caring?

Our findings

Throughout the day we observed staff being kind, patient and respectful to people who used the service. People told us, "I feel cared for", and "[The staff] look after me; they are good people." When we spoke with visiting relatives, they agreed, one person told us, "All the staff are really caring, even the new ones seem to know how to look after [my relative]. No job is too messy for them, it's all done with kindness". A member of staff told us, "It's a very laid back and relaxed atmosphere, and that helps the [people who use the service] to feel at ease. We have time to spend with people, so we get to know them and their foibles." Another person who used the service we spoke with said, "I'm not lonely here…. I can always sit next to my friend if I want to". We saw that staff were vigilant to people's needs and ensured that they were given opportunities to interact with each other or in conversations with staff.

When staff interacted with people they were caring and compassionate. When transferring a person using a hoist, for example, we saw they did not have to wait either for the equipment or staff to help them, and during the manoeuvre they talked reassuringly to the person whilst moving them. We also observed a member of staff spent some time with a person becoming anxious about an upcoming event. The member of staff sat closely to the person, maintaining eye contact and listened attentively to the person's worries. They helped the person to articulate their fears, then consider a number of options, providing reassurance and calmly offered support to help find an appropriate solution to the person's concerns.

When we looked in care files we saw that these included a good pen picture of each individual, including important milestones and people in their life, and acknowledged their likes, dislikes, cultural needs and values. When we talked with staff they were able to show an awareness of the people who used the service which reflected the written information. This meant that the service was person centred and based on the person's needs and wishes. We saw that staff understood and respected the level of support people needed so people were involved as far as possible in decisions about their care and how it was delivered. For example, one person told us, "I look after myself. Staff only help if I ask them to", and another said, "I choose to eat my meals alone and that's not a problem. They let me choose if I want to join in activities". Where people were unable to express their needs and preferences we saw that the service maintained regular contact with relatives and friends, and encouraged their involvement. Care records reflected if the person had a legal guardian or if a relative had power of attorney to help make decisions regarding financial or welfare matters. When we reviewed care records we saw that relatives wishes were recorded, but where these might be at odds with the needs of the person who used the service, we saw that the views were considered before a decision in the best interest of the individual was made with all interested parties involved in the discussion.

People were treated with dignity and respect, and without discrimination. There were enough staff to spend time with people who used the service and when we spoke with them, care staff were able to indicate how they understood people's preferences, and wishes. For example one care worker told us how they were able to relate to a person who used the service due to a shared interest in a particular but unusual issue.

We saw that people were clean, dressed appropriately and well presented, and men were clean shaven.

Staff were also vigilant to people's appearance, for instance we observed staff discreetly adjusting people's clothing to maintain their dignity such as pulling tops over their stomachs.

Information held about people, including all care records were securely stored in locked offices when not in use. This helped to protect the personal information held about people who used the service. Staff had access to the notes and we saw that they regularly consulted care plans and assessments to ensure that they were providing appropriate care and support.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs and provided them with support when they required it. One person who used the service remarked, "The staff here know how to meet my needs and how not to. They know what I can manage myself and they let me do it. Where I struggle, they are there to lend a hand." Another told us more simply, "I like being here, they will always bring me drinks", and another person told us that "I know I can always ask, there's always someone around".

We looked at four care records. Information about each person was detailed and written in a person centred way focussing on their abilities and strengths. The care records contained detailed information to guide staff on the care and support to be provided. They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded in detail. Charts were completed to record any staff intervention with a person, for example, recording food and fluid intake, when staff turned a person in bed where it was an identified risk regarding pressure areas, and when personal hygiene was attended to.

When we last inspected Werneth Lodge in October 2016 we found that records did not always show when people who used the service had been seen by visiting professionals. At this inspection we saw that care records now included a section to record all visits, and specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records. The records were reviewed regularly by staff to ensure the information was fully reflective of the person's current support needs.

We had also noted at the last inspection that food charts did not accurately record the person's daily nutritional intake. When we reviewed nutrition and hydration charts on this inspection we saw that these had been amended to show the amount of food and drink offered and the amount consumed, thus giving a better indication of people's nutrition where the person was at risk of dehydration and pressure area issues.

From our observations and discussions with the registered manager and staff it was apparent that some of the people who used the service did not have the capacity to be involved in the planning of their care. We saw that this was reflected throughout the care files and capacity and consent issues were clearly recorded with a rationale as to why this was in their best interest and recording the views of their relatives, staff were vigilant to their needs and any changes were reflected in care plan reviews. When we spoke to visiting relatives they told us that they were kept informed of people's needs and their views were solicited.

Where people did have a greater understanding of their needs and how they could be best met people were encouraged to voice their opinions, and one person we spoke with agreed that they had been involved in reviewing how their care was delivered: "I am invited to reviews, sometimes my social worker will arrange it, and they ask me about my care, but I've never got anything to complain about. I am well looked after".

The service employed an activities coordinator who arranged communal activities on a daily basis, including contracting visiting entertainers and arranging trips out to the local area. An activities notice board

advertised planned events, but we noticed that this was a guide rather than a rule, and some activities appeared vague. For instance, plans for one day were for a "trip out", but offered no alternative if the weather wasn't good or for those that could not go out.

Communal activities were held in one of the lounges, which meant that these who did not wish to participate could spend time elsewhere. We saw that those people who did not wish to join in were offered other stimulation during the day; staff would spend time talking to people either individually or in small groups. When we looked at one care file on the first day of our inspection we noticed that the person's preadmission assessment indicated the person enjoyed a particular board game, but this had not been noted in his care plan. We pointed this out to the care staff, and when we returned on the second day of our inspection we saw that they had bought the game and arranged for staff and other people who used the service to play it.

The second day of our inspection coincided with the Christmas Party. This was well attended; relatives of people who used the service had also been invited. In addition to a visiting entertainer, staff had provided a lavish buffet and people were seen dancing and singing. Afterwards, people who used the service told us that they had really enjoyed the day.

A service user guide was given to all residents. A copy in their care files explained how to make a complaint, to whom and how it would be dealt with. In addition the complaints procedure was on display in communal areas. We noticed that there was no copy in the entrance area, but when we pointed this out to the registered manager she agreed to place a copy of the procedure and complaints form in the entrance area where it would be easily accessible.

We looked at the complaints log and saw that there were no outstanding complaints and any received had been appropriately dealt with, with written evidence of investigation and a follow up response to the complainant, including apologies where this was appropriate. Where complaints had been substantiated there was evidence that action was taken to reduce the risk of further incidents. We spoke with a relative who informed us that they had made a complaint previously and that they felt comfortable with raising the issue. They were satisfied that the complaint had been appropriately dealt with.

When we looked at care plans we saw that they provided an opportunity to consider how people would like to be cared for at the end of their life, but some of the plans we reviewed merely indicated if there were any funeral arrangements in place, or if the person expressed any wishes in the event of their death. Where appropriate a 'do not attempt resuscitation' form (DNAR) signed by the person's GP was kept at the front of the person's file. A DNAR form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). When we asked, staff admitted that they had not received any training on end of life care. We raised this with the Area manager who agreed to look for training for staff in this aspect of care. At the time of our inspection nobody was receiving care at the end of their life, but we saw a recent complimentary letter from a relative. This read, "I am humbled and have nothing but total respect for all the staff and the manner in which my [relative] was cared for…it was a blessing she passed in a place of care, love and comfort". The author thanked all the staff for, "Care and compassion in a difficult and challenging few months".

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Werneth Lodge is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since the start of the year, having previously worked at the service for eighteen years. The registered manager was present throughout the inspection.

Everyone we spoke to held the registered manager in high regard. A visiting professional said "She does a grand job!" and a care worker told us that, "She's fantastic. I've struggled at times, but she's been there like a rock! We have had our cross words but she's there for the people who use the service] and for the staff too. When she needs to, she'll make sure that we do things the right way for the right reasons." We spoke to the area manager, who told us the registered manager was extremely knowledgeable about all the residents and believed she demonstrated a passion and commitment to all the people who lived in Werneth Lodge.

When we asked people who used the service, they agreed that she was a "good and caring" manager. They told us, and we saw that the registered manager was visible around the home every day when on duty. She showed a clear understanding of her role and was aware of her responsibility to pass on any concerns about the care being provided, including notifications to the Care Quality Commission (CQC) and local authority commissioners.

Staff at Werneth Lodge understood their role and function. One care worker said to us, "This is their home and we respect that. People are here because they need some help and support, but there are things they can do for themselves, we are here to assist, not to do". Another agreed, telling us, "It's our job to make sure [people who use the service] are comfortable, and they are here. Their needs are paramount." The positive culture of the service was reflected in the interactions we observed to encourage people who used the service to maintain their independence and listen to them as well as providing support.

We saw staff were highly motivated and worked together as a team, and the people who lived at Werneth Lodge were supported by staff who understood their needs and wishes. The staff we had discussions with spoke positively about working at the home. One care worker told us "It's a good atmosphere [to work in], and we can get close to the people we support. It can be difficult at times but there is no pressure on the floor. We can take a break when we need to, working as a team means we can get the jobs done well".

We looked at minutes from resident meetings which were held on a regular basis. These meetings gave staff an opportunity to feed back to all people who used the service any actions that affected the service and allow for consideration of their views, and to listen to suggestions for improvement. For example, following a discussion about communal activities and a suggestion from a person who used the service, the registered manager agreed to buy a Karaoke machine, which had proved popular. The registered manager had also responded to a request to set up a letterbox by the entrance to allow people who used the service to post letters, which could then be forwarded via Royal Mail.

The relatives of residents we spoke to told us that they were kept informed of any changes in their relative's

condition and felt comfortable about contacting the service. We saw any communication with relatives was recorded in care files. The service also produced a general newsletter which informed relatives of any recent issues about the care home in general.

The Area manager was supportive and made regular visits to the service. In addition to providing supervision to the registered manager she was familiar with and to the people who used the service. Staff told us she was approachable and would respond to any concerns. When we spoke with the Area manager they told us that the owners would respond to any reasonable requests for resources, for instance they had agreed to fund improvements to redesign and upgrade the kitchen and dining area.

At our last inspection we found that the auditing systems in use at Werneth Lodge were not always effective, and systems in place at the time did not always guarantee that people's needs were accurately reflected in their care plans. Since that inspection the service had reviewed all care plans and introduced a new recording system so records would more accurately reflect any changes in need. Additionally the service had produced a regular calendar of audits, and ensured that care plans were evaluated monthly. The registered manager produced a monthly report for the Area manager, and reported on any quality audits completed. The Area manager also completed regular spot checks and audits, including checks out of office hours. We looked at the record for the two most recent spot checks from the previous month and noted that issues identified were promptly responded to and actions reported as complete.

The registered manager showed us the systems in place to monitor the quality of the service to ensure people received safe and effective care regular audits/checks were undertaken on all aspects of the running of the service. She completed regular audits and provided a monthly internal report for the provider. Reports covered staffing, training, resident issues, audits of reviews and care plans, activities, nutrition, incidents, and medicines.

The registered manager monitored cleaning schedules, weight charts, and food and fluid charts to ensure that these were completed in accordance with good practice guidelines. Where mistakes occurred these were addressed.

We also saw that the service worked well with local stakeholders and actively sought support and collaboration with relevant external agencies. It had responded to constructive criticism; for example recommendations following a recent quality assurance visit from the local authority had been followed up, and the service had completed an action plan and responded to the last CQC inspection findings. Before our inspection, we checked with the local authority commissioning team and safeguarding team, and they informed us that they did not have any concerns about Werneth Lodge.

The registered manager regularly sought feedback from staff, people who used the service and their visitors. There were regular staff meetings and residents meetings. A staff survey was conducted on a yearly basis; the results analysed and used to improve the quality of the service for staff and people who used the service. For example following the most recent survey in April 2017 the service reviewed the complaints and grievance procedures to make these more accessible. People who used the service, their relatives, and visiting professionals were encouraged to complete questionnaires. We saw when we reviewed these that the responses were all positive.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.