

Westwood Lodge Ltd

Westwood Lodge Care Home

Inspection report

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Tel: 01912733998

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 3, 5 and 6 April 2018 and was unannounced, which meant the provider did not know we would be visiting.

At the last inspection in January 2017 the provider had not ensured that people were protected against the risks associated with unsafe and unsuitable premises. They did not ensure that robust systems were in place to assess, monitor and improve the quality and safety of the service or to mitigate the risks relating to the health, safety and welfare of people using the service. Records were also not accurate or completed fully. These issues were breaches of regulation 15 (premises and equipment) and regulation 17 (Good governance). Following the inspection, the provider sent us a detailed action plan to explain how they would address these concerns.

At this inspection the provider had made some improvements but we found other issues needed to be addressed. Following the inspection we wrote and invited the provider to attend a meeting with us to discuss the concerns we had found. We will report on this at the next inspection.

The overall rating for this service is now inadequate and the service has been placed in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Westwood Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Westwood Lodge Care Home provides accommodation for up to 44 people with residential and nursing care

needs. People had a range of health care needs, including those with mental health, alcohol misuse related conditions and those living with dementia. At the time of the inspection, there were 31 people living at the service.

The service had a registered manager who had worked at the service for over 10 years, the last two as manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was currently seeking to appoint a deputy manager to support the registered manager in their role.

Although people told us they felt safe living at the service, we found some areas of concern which needed to be improved.

The Registered manager had not maintained clean and hygienic facilities for people living at the service. Staff did not always follow correct procedures to maintain hygiene, including the lack of proper use of aprons and gloves. The provider had not monitored this area which led to poor infection control procedures being followed. After the inspection, the registered manager told us they had addressed some of the concerns we had raised and later sent us an action plan on how they would address this.

Medicines were not always managed appropriately. We found a number of areas which needed to be improved, including giving medicines before food as prescribed, thickeners being stored in unlocked cabinets within one of the dining room areas and ensuring that correct records were kept to support staff.

People's needs had been assessed and individualised care plans and risk assessments developed. Some care records had detailed information for care staff to follow. Other care records lacked specific detail about how to support people, including missing risk assessments and care plans not in place. Reviews of care plans were not always timely, detailed or appropriately recorded.

People said food and refreshments at the service needed to improve and was not always hot. Meals were not always delivered in an appetising way, for example people with pureed meals. We found this not person centred.

We have made a recommendation to the provider in connection with ensuring they follow best practice with the input from dietician teams when necessary.

Quality monitoring systems were not always in place at the service, including for example, those in connection with infection control. We found checks had not always uncovered what we had during the inspection. We deemed that the registered manager and the provider did not have full oversight of the service because of this.

The provider had completed equipment and premises checks at the service, including gas, electric and fire safety. We have made a recommendation to the provider in this area to update their fire risk assessment in light of our findings.

People said staff were kind and caring. Although we found some staff practices were not respectful and less dignified than they should have been. For example, food being left on people's faces after being supported to eat and appropriate bedding not being in place for one person.

Activities took place within the service, but we deemed these were limited and have made a recommendation to the provider to review these and the deployment of staff.

Staff told us they felt supported and had received induction, training, supervision and yearly appraisal. The registered manager knew they were behind in some support sessions and were working through this.

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

People felt that the staff at the service kept them up to date with information and enabled them to be involved with planning and review of their care needs.

The service had responded to the changing needs of people and supported people if the intention was to move on to different living accommodation by helping them with skills they needed to either retain or build upon, for example, completing laundry tasks, shopping or cooking.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, person centred care, dignity and respect and good governance.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Infection control procedures were not robust.

Risks to people using the service were not always assessed and reviewed.

People's medicines were not always managed well.

Recruitment procedures were in place to minimise the risk of unsuitable staff being employed, although some risks had not been assessed.

Staff knew how to protect people from abuse.

Is the service effective?

Requires Improvement ●

The service was not effective.

Care records were in place, however care plans were in need of review to ensure they were up to date and followed.

Staff felt supported although regular supervisions and appraisals needed to be improved.

People were supported to maintain a varied diet, although some areas of kitchen and mealtime practice needed to be improved.

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

Staff supported people to access external healthcare professionals to maintain and promote their health.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Staff treated people with dignity and respect and promoted their independency. However, we saw some instances where this had not occurred.

People felt that staff were kind and caring. People were supported to access advocacy services.

Is the service responsive?

The service was not consistently responsive.

Care plans were personalised but some lacked detail and some practices were not person centred. People were supported to return to life in the community if that was their wish.

Activities were available, but in need of review.

The service had a complaints policy and people said they would use it if needed.

Requires Improvement ●

Is the service well-led?

The service was not well led.

We found the service did not demonstrate good oversight of the service and did not have robust quality assurance systems in place.

There was a registered manager in place who had worked at the service for over 10 years, the last two as manager.

Inadequate ●

Westwood Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 3, 5 and 6 April 2018 and was unannounced on the first day which meant the provider did not know that we were going to inspect. The inspection was carried out by one inspector, one specialist advisor and one expert by experience. A specialist advisor is a person who specialises in a particular area of health and social care, for example medicines, moving and handling or quality assurance. This specialist advisor was a tissue viability nurse specialist. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

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

We contacted the local authority commissioners and safeguarding teams for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We also contacted the community nurse team, the palliative nurse team, infection control lead for care homes in the area, tissue viability nurse for the area, the specialist care home support team and the local fire authority. We also spoke with a visiting care manager. We used any comments received to support our planning and judgement of the inspection.

We placed a poster in the reception area of the service to alert visitors to our inspection and invited them to contact us to offer their experiences of the service.

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

We spoke with 14 people who used the service and one family/friend. We also spoke with the registered manager, two nurses, the cook, an activity/senior carer, two domestics, the maintenance person and seven members of care staff. We observed how staff interacted with people and looked at a range of records which included the care records for eight people who used the service, medicines records for 20 people and six staff personnel files, health and safety information and other documents related to the management of the service.

Is the service safe?

Our findings

At the last inspection in January 2017 the provider was in breach of regulation 15, as they had not ensured the premises and equipment were suitable for the purpose for which they were being used or were properly maintained. At this inspection some improvements had been made, however, we found further shortfalls.

Some new carpets had been fitted and decoration was apparent in parts of the service. The main communal rooms had recently been painted, as pictures and signs had not been replaced. The registered manager told us that this process was continuing on a rolling programme due to the complex nature of some of the people living in the home.

We did find other issues, including for example, one bathroom which had a broken bath panel with sharp and exposed edges. This represented a risk to people who could easily catch and tear fragile skin on the sharp plastic. We brought this to the attention of the registered manager who had said they would have this addressed immediately. They later confirmed this had been repaired.

Some bedrooms were in the process of being redecorated but were left unlocked during this process. We found broken glass and building waste held within the room which posed a risk to people. When we checked the room later in the inspection, it was locked.

Communal bathrooms were unclean and used for storage. We found a range of equipment and laundry stored. In one bathroom we found two hoovers, two wheelchairs and another bathroom had three vacuum cleaners stored within it. Another bathroom had two laundry baskets stored within it. Bins within bathrooms were found, in some cases to be rusty with some soiled by faeces. Two bathrooms had no toilet roll dispenser and others had broken toilet seats or heavily soiled toilet brushes. Extractor fans in some of the bathrooms were not working or were covered in dust. The registered manager, after our inspection visit, confirmed that equipment had been removed from the bathrooms and they had addressed cleaning issues with domestic staff, including the appointment of a housekeeper.

We found one cupboard which stored dirty and wet odorous mops in dirty buckets. The laundry room was not kept clean, this included dirty washing machines and dryer fascia's and the floors of the room.

There were cloth covered commode chairs in use. The cloth covered commode chairs were worn and dated. Urine and faeces can splash onto the fabric and strikethrough to the underlying foam. In the chairs we viewed, the underlying foam on the chair was exposed as the fabric was worn through making them impossible to clean effectively. The registered manager confirmed after our inspection visit that these commodes had been replaced.

Some of the bedrooms we viewed, including used and empty rooms, had strong urine smells. We also saw bedrooms which were dusty and appeared not to have been cleaned for some time, with stained carpets and some redecoration required. After the inspection visit, the registered manager told us that the decorators were currently in the service and that a new carpet cleaner had been purchased.

Two members of staff told us that stained or worn mattresses were replaced. However we did not find this to be the case. A number of mattresses were stained with urine and/or had unclean bedding, including in rooms which were not being used. These mattresses should have been disposed of and replaced, including in readiness for any new people to move in.

We checked the settings of three pressure relieving mattresses that were being used. Of these, one of the three we checked was set incorrectly. Having a mattress pressure set too low means that a person may come into direct contact with the bed base and this could cause pressure injury. Fitted sheets should not be placed on dynamic mattresses, as the close fitting sheet can disrupt the flow of air within the mattress and negate its function. 'Dynamic' mattresses are a type of pressure relieving mattress. We found a fitted sheet on one of these mattresses being used.

Staff were frequently observed walking about in protective aprons and gloves, and moving between people's rooms with the same apron and gloves on. Staff seemed to be unaware of the need to change personal protective equipment (PPE) between contacts with people. We observed staff entering the kitchen area without wearing PPE and using equipment, including collecting food, washing hands or making drinks, this included the registered manager. We also observed staff wearing long sleeved clothing which posed a risk. Not being bare below the elbow makes thorough hand washing difficult as the wrist area cannot be fully washed and dried, and also cuffs can become contaminated when providing personal care as gloves do not cover this area.

Some of the chairs in communal rooms were ripped, some with dried fluid stains. This posed an infection control risk as they were unable to be fully cleaned. Some furniture which was worn meant it could not be cleaned effectively, this included, tables and cabinets.

We found the outside area of the service was cluttered and in need of attention. For example, kitchen staff used a wooden shed to house a freezer which held excess items of frozen food and some fresh food produce. The shed was also extremely untidy and packed full with excess materials, including wood, packaging and other items. We asked the registered manager about this and they told us they had never been in the shed. We passed this information onto the local fire authority for their information.

The provider was not meeting the code of practice in The Health and Social Care Act 2008 Code of Practice on the prevention and control of infection which placed people at risk. After the visit, the registered manager told us that they were in the process of knocking the outside shed down and replacing it with a more suitable storage area. Excess equipment had been removed. She also said they had implemented an infection control audit, and that the infection control lead for care homes had been contacted.

Medicines were not always managed safely. As we observed medicines being administered to people, we saw the nurse in charge had dispensed two people's medicines into 'pots' ready for administration. This included controlled drugs. Controlled drugs are those with more stringent storage measures as they are prone to misuse. These pots had no names on them and meant there was a risk people may have received the wrong medicine which may have caused them harm. Medicine administration records (MARs) did not always have pictures of the people the record referred to. After our visit the registered manager told us that they had spoken with all staff about the administration issues and that photographs of those people missing had been taken.

'As required' medicines were available to people. These are medicines which are not taken regularly but used when the need arises, for example, for pain relief. However, we found that there were no protocols in place to inform staff of the details of, for example, what the medicines were used for, when they should be

administered and what the dose should be. Protocols are particularly important for people who are unable to communicate their needs as they help staff to understand how they can better support people. Topical medicine administration charts were not in place. Topical medicines are generally creams and ointments applied to the body. Topical charts have details of where and how the medicine should be applied and without these, people were at risk of not having the medicine applied correctly as prescribed. The registered manager later informed us that they had received protocols and topical charts from the chemist and were in the process of implementing these.

We found five tubs of thickener granules stored in an unlocked cupboard in one of the lounge areas. Thickeners are usually powders added to foods and liquids to bring them to the right consistency or texture for people with swallowing difficulties. NHS England issued a patient safety alert in February 2015 advising of the risks of death from accidental ingestion of food thickening powder after a person died, and advised these products needed to be securely stored. We also found in the same cupboard two tubs of Hydromol topical application, one for a person living at the service and the other with no name on it.

We found that medicines which were due for disposal were not stored in the medicine room in line with the NICE guidance as they were not in a tamperproof container within a locked cabinet.

The medicines policy was not fully in line with best practice and was not up to date with the National Institute for Health and Care Excellence (NICE) guidance. NICE provide national guidance and advice to improve health and social care. Just after our inspection visit the registered manager told us the policy had been updated, including in connection with 'as required medicines and topical application charts.

Some people had been prescribed medicines which needed to be taken at least 30 minutes before food. We saw staff administering these medicines either when a person was having their breakfast or after breakfast. The registered manager told us they would change their procedures to ensure that medicines were given at the correct time.

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

Fire exits were clearly marked throughout the service. We found one garden area was securely locked at each exit point. Staff had the codes for these areas. We asked staff how they would get out of the area and they were able to tell us about the fire evacuation process. Staff had performed fire drills and these were recorded and fire extinguishers had been checked regularly. One person said, "I feel safe here, and they test the fire alarm regularly. There is always someone close by to help us." After the inspection visit, we further examined the providers fire risk assessment and this detail had not been included. The local fire service had visited in January 2018 and had no issues in this area.

We recommend the provider review fire risk assessments in line with best practice.

People told us they felt safe, "I feel safer here with my mobility issues"; "It's marvellous here, comfortable, first class"; "I feel very stable here"; "Very comfortable here, more secure than the last place" and "It's nice living here, I prefer to stay here". We were made aware of a number of altercations between people who lived at the service. Some people had complex mental health needs and when we looked into these incidents, we found the provider had addressed them appropriately, including additional referrals to healthcare professionals if required. Staff had received safeguarding people from abuse training and told us they would report any concerns they might have.

Risk assessments had been completed for people in connection with their daily living to mitigate any potential harm occurring. Including for example, in connection with the use of alcohol and risk of falls. One person had asked if they could do their own washing and ironing and staff had supported them, which included a risk assessment to help avoid any harm.

Risk with regard to the premises and environment of the home were mitigated. We saw copies of the services gas safety certificate and portable appliance testing (PAT) certificates. Hoists and lifting equipment in the home had been subject to a six monthly Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) check. Staff undertook regular checks around the home, including checks that water temperatures were sufficiently hot to limit the risk of Legionella and that window restrictors were in line with guidance. We noted however that the five year electrical check was out of date. The registered manager confirmed that the provider was in the process of having a new monitoring check organised and confirmed after the inspection that this had been completed by sending us copies of the certificate.

The location of the smoking room at the last inspection had caused some concern. The provider had moved the room from one of the main lounge areas to a smaller more suitable room. One person said, "The smoking room has made a bit of a difference (for the good)."

Accidents and incidents had been recorded and monitored for any trends. We have further discussed this in the well led domain.

During the inspection we deemed there were enough staff on duty throughout the service to meet people's needs. We viewed staff rotas which also confirmed this at other times. We were told that many of the staff at the service had worked there for many years, some over 20 years. Recruitment procedures were in place. We checked the records of six staff, including those recently employed. References had been applied for and received. Application forms had been completed with full details of employment history. When staff had been offered positions, the provider had carried out pre-employment checks to ensure they were suitable to work with vulnerable adults. These checks included vetting checks by the Disclosure and Barring Service (DBS). We found that positive disclosures had not been risk assessed to confirm staff were still suitable or did not require additional support. Although the registered manager told us that this had been discussed with staff and they were satisfied there was no risk, there was no recorded evidence of this.

We found that the registered manager had not checked any of the PIN numbers of nursing staff recently, including those from an agency as five of the records they had of previous checks were out of date. All nurses who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN. However, during the visit this was completed and everyone's PIN was found to be in order.

Is the service effective?

Our findings

People had their needs assessed before they came to live at the service. Once people had moved in, more detailed care plans were completed and reviewed to ensure that people's needs continued to be met.

People's care planning was based on the best practice model 'Roper, Logan and Tierney's Activities of Daily Living'. The model looks at 10 activities of daily living as a minimum, including, communication, hygiene, work and play, elimination, safe environment, breathing, eating and drinking, controlling temperature, mobilisation and sleeping. Death and sexuality is also often considered. We found that the whole model had not been considered as part of the initial assessment and care planning process for people. Some people required care plans for example, sleeping, skin integrity or medicines, where additional support was required but these were not always in place. For example, one person had behaviours which challenged the service, however there was no care plan in place for this. One person had risk assessments completed to show they were at risk of skin damage, however, there was no care plan in place to support this. Another person had a risk assessment in connection with their finances but no care plan in place to support this. The registered manager told us they were in the process of updating their care planning documentation and all records were being reviewed.

Some people's care records had not always been reviewed fully every six month as required by the providers own policies. For example, one person's care had not been fully reviewed since October 2016, although monthly updates of their care plan and risk assessments had taken place.

One person's risk assessments stated daily skin checks should be made, but we found no written evidence this had been completed. Reposition charts which should be used at night to show staff had moved people, were not always in place.

One person had developed a pressure area and staff had been quick to contact the local tissue viability nurse for the area to support them. We reviewed this person's records and it lacked detail. This included no evidence of wound measurement since the beginning of March and lack of detail of the description of the wound and its progress. This is important to allow staff to closely monitor the progress or deterioration of any wound. We spoke to the local tissue viability nurse involved with the care of this person. They told us that staff had followed the care plan which they had left and were satisfied with the care staff had given. They said, "Staff are absolutely fantastic." Following the inspection visit, the registered manager confirmed that the person's wound had greatly improved.

Staff used a recognised assessment tool called 'Braden' to measure the risk of people developing skin damage. This tool should be used to support any decisions regarding if pressure relieving mattresses are required. However, when we asked the registered manager how they decided who needed these special mattresses, they said, "If our clients are frail, then they get an airflow mattress." Identifying people at risk of skin damage just by judging their frailty will not give an accurate assessment of risk. One person was on a high specification foam mattress indicating staff had identified they were at risk of developing pressure ulcers. However, this person did not have a care plan in place for maintaining their skin integrity. The

person's Braden score was also only being reviewed once every 6 months. If someone is at risk of developing pressure damage or there are concerns about skin integrity a risk assessments such as Braden should be completed at least monthly. We contacted the tissue viability nurse involved with the service. Although they could not comment on paperwork, they told us that the service was quick in responding to skin integrity issues and they had no concerns about the staff acting inappropriately. This meant that not everyone had an accurate record of care.

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

We received mixed views about the food and refreshments provided at the service. People's comments included, "Food has ups and downs, depends on the cook. There is a choice of food, if I want a lie in they will still cook me a breakfast later on, or if I go out they will make me a sandwich if I have missed dinner. There is plenty of orange juice, tea and coffee"; "Its only just palatable, it's not hot"; "Food could be better at times, beggars cannot be choosers though"; "I don't eat much, but the foods okay"; "The food is beautiful" and "The foods okay, it has its ups and downs, I live on takeaways mostly."

We observed the lunch time experience in various parts of the service. One person had baked beans and fishcake. The meal did not look appetising. The person said they did not like baked beans. They were asked if they wanted something else but as they could not decide, they were offered and accepted strawberries and cream. Sandwiches were on offer as a second choice, and we found the plastic plates they were served on were scratched and worn.

People had special dietary requirements and received them as they should. Some people received pureed meals as part of their special dietary needs. These meals were all pureed together and were not separated into different food types to improve taste and appearance. We had no evidence to suggest people preferred their meals in this way. When we asked staff what these meals consisted of, they had no idea and could only guess. One staff member said, "I am not sure, to be honest."

Covered meals were brought into dining areas on trolleys. We found meals were not always delivered hot. One person said, "The food can sometimes be warm but never hot usually." Another person said, "Its rarely hot....but it's okay I suppose."

One member of care staff said, "We have regular theme nights, Pizza, Chinese, Indian...whatever the residents wants. They all join in with this and we deliver the food to the rooms of those who don't want to come to the lounge." We were told this was paid for by the service.

We spoke to the registered manager about the comments people had made and after the inspection visit they told us that they were meeting with the provider to discuss this further, including the possibility of a hot trolley to be used to service meals. They said they had spoken with staff in the meantime and reminded them of the need to get people's meals out as quickly as possible. They also said they had spoken with people and they had reported some improvements in the temperature of meals. The registered manager also told us that moulds had been ordered for people who received pureed meals in an aim to make them look more appetising. However, this meant people's individual food choices and preferences were not always being met.

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

We asked how the registered manager assured themselves, for example, that people did not suffer any pressure damage or skin problems that went unseen. We were advised, "I work hands on, so I would notice myself." They also said, "There is a handover at the beginning of each shift; all staff attend and we would discuss any incidents of skin changes." We checked the handover records and found them to contain good detail.

People told us that staff at the service provided them with effective care and treatment. One person said, "I think the staff here have given me the confidence to go forward, they helped me to improve" and "There is never a problem when I ask for help."

An induction programme was in place. The staff we spoke with told us they had received an induction when they started to work at the service. Staff told us they had just been 'shown' what to do. One staff member said, "I shadowed staff until I knew where everything was and what I needed to do...I thought it was okay and helped me to settle in."

Staff told us they felt supported by the nurses, the registered manager or by each other. One nurse said, "The staff and the manager is supportive" and "Even if I call the manager at home she is fine with this." One staff member said, "I like working here, it's not far to come, I just do my job and go home." Staff had received supervision and yearly appraisals. We viewed staff records and found some gaps in the timescales between staff support sessions. However, the provider contacted us after the visit to confirm that all staff had received supervision within the provider's policy and procedures timescales. We concluded that these records had not been placed on the staff personnel files and we will check these at our next inspection.

One community nurse told us, "The manager supports her staff really well and is always available and very approachable."

Staff had completed a range of training to maintain their skills. We looked at staff records and confirmed this. Training included, for example, nutrition and hydration, moving and handling and first aid. One nurse told us, "I have had all my recent training, it is delivered either here or we go to a separate training venue for it." The registered manager confirmed that they completed competency checks on all staff. However, records we viewed did not include the detail in connection with these checks and were merely signed to say they had been done.

The service was involved in the 'Enhanced Health in Care Homes Vanguards' project. This is a project to improve the care of people living in care homes and involves, for example, regular visits by GP's to the service. The registered manager told us they had recently been given two hospital transfer bags from their local link nurse. She told us that these would be used for anyone going into hospital with the aim of having all the important information about them in the bag, including medicines information.

Records we reviewed showed that people had good access to a range of healthcare professionals this included from tissue viability nurses and palliative care nurses. One nurse commented, "The carers know their jobs, they report back to me. If someone wasn't eating or drinking we would know, and we call out the GP if we are worried."

The registered manager and staff were aware of their responsibilities and followed correct procedures regarding the Mental Capacity Act 2005 (MCA). 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any applications had been made to deprive a person of their liberty. 26 people were subject to a DoLS which had been applied for and authorised (or awaiting approval) via the local authority. These were all in order and correctly applied for and monitored.

People told us they had choice in their daily life. One person said, "I get on well with all the staff here, the food is okay. I chose my food yesterday, and I get my choices today." There was a choice of hot and cold drinks for lunch and some people had chosen milk to have. One person had signed a disclaimer stating they did not want to be disturbed between the hours of 10pm until 7am.

People's bedroom doors lacked numbers or information on who lived there. The registered manager contacted us after our inspection visit and told us that new door numbers were on order for some people who had told her they preferred this method. They also said they had been in touch with their visiting optician who was helping with possible door name templates they could use to better support people with vision issues.

We also noticed that some other rooms, including toilets and bathrooms did not always have signs on them. This again was something that the registered manager told us they were putting in place.

Is the service caring?

Our findings

We observed three people who required support with their meals. Two care staff were from an agency and had little interaction with the two people they supported. The other member of care staff who was a permanent member of the team supported the third person very well and some positive interaction took place which showed they had a good understanding of the person's background and their needs.

People were generally treated with dignity, although we did see two examples where people's dignity was compromised. We visited one bedroom and found the person lying on their bed covered with a duvet. There was no duvet cover, no sheet and no pillow case. We brought this to the attention of the registered manager who immediately dispatched staff to check and have this addressed and find out why this was the case. We observed one example of a person who had food debris on their mouth after they had finished breakfast, including food on a clothes protector they wore. We asked staff to attend to this person and on return over half an hour later, the food remained although staff had performed personal care tasks with the same person.

We viewed the minutes of a staff meeting from January 2018 where the registered manager had recorded, "She [registered manager] finds time after time when she comes onto the floors, staff sitting chatting amongst themselves giving no regard to the residents." This meant staff had not always provided people with dignity and respect.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were "very nice to them, very caring."; "It's okay here, there is someone to talk to when I want help"; "I am well looked after"; "They are good people I get on with them all" and "The staff are canny (nice), they are down to earth and do care about us. It's hard for them to look after some of us though...we like to work our ticket (unpredictable/annoying) at times."

One person said, "The carers sometimes take time to talk, but they are very busy the majority of the time." Although continued to say, "It's homely, caring always someone to talk to about problems."

A community nurse told us, "The staff are also extremely helpful and manage their residents really well. They have a lovely attitude towards their residents and are always visible in all of the resident's lounges." A Tissue viability nurse said, "Staff are absolutely fantastic and put service users at number 1. People really trust them (all staff)."

We were shown a number of compliments from relatives and healthcare professionals which showed they were happy with the care provided by all staff at the service.

People felt that care staff treated them with respect and were able to offer examples of how they had shown this. One person said, "They knock on my door before they come in."

We observed one person helping at lunchtime to set the dining room tables. Including, for example, placing cutlery and napkins.

Staff gave explanations to people. We observed positive examples of this. For example, while administering medicines or when about to complete a personal care task with them. Staff bent down as they talked to people, so they were at eye level as maintaining eye contact helps enhance effective communication.

'Resident' meetings took place. For example, in October 2017 six people attended the meeting which lasted 45 minutes and there was another meeting held in January 2018. We saw from minutes, for example, that menus, activities, décor and Christmas outings had been discussed. Comments from people were noted, including requests for more sauce on some foods, alternative options for Christmas and a request for gaining the views of people on colour schemes for some redecoration taking place. The registered manager agreed she would take all views forward. We confirmed with some of the people in question that the requests had been fulfilled.

People generally had the perception of feeling included in their care planning. We saw people (where possible) had signed to say they had seen and agreed their care plan documentation and risk assessments. Another person said that staff asked them "all the time about how I am and if things are going okay".

People had been involved with advocacy services from the records we viewed. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. We saw that one person had been previously involved to help with support in their Tenancy and a DoLS application. The registered manager was aware of services in the local area to support people should they need the use of this type of service in the future.

Is the service responsive?

Our findings

People were weighed weekly regardless of whether they needed this level of monitoring. The registered manager said that "If we say one's weekly and one's monthly people will get missed so they all get weighed weekly." The registered manager said that people were happy with this, although we saw no written evidence to confirm this.

People's records lacked evidence that care procedures had been fully carried out. For example, some people's records showed they had only been washed or bathed once per week. We asked staff to confirm if any other records were available and they said no. We asked people about bathing in particular and some were able to confirm that washing or bathing occurred regularly and not only once per week. However, when we checked records this was not always recorded fully. We were therefore unable to always confirm that people had received care in this area which was person centred.

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

One person said, "I get lots of support from these guys here. The staff here helped me challenge a decision about the location of a flat for me. They helped me to overturn this [offer of flat] and now I have been offered a flat in a nicer location." Another person said, "It's nice living here, I have been here 10 years in the same room, I prefer to stay here."

Some people at the service did not intend to stay there permanently as it was hoped they may be able to move back into the community at some point in the future. We discussed how the service supported people to do this. Some people were able to do their own laundry and some cooking to encourage these skills. Others were supported to complete shopping. We discussed the possibility of people completing some of the same training courses as staff, for example, food hygiene or first aid related courses. The registered manager said this was something they would look into. One person explained how they had asked the manager if they could do their own laundry. They told us, "They said I could use the laundry room, they showed me how to use the machines and now I can do my own washing and ironing." Some people had kettles in their bedrooms to use which had been fully risk assessed for safety.

People could receive visitors when they wanted. The registered manager told us that visitors were important to maintain relationships and they were allowed to stay over, although this had not currently occurred. One person was supported to stay at their partner's home from time to time.

Care records contained personal history, life experiences and interests which were very detailed in many cases but not all. For example, one person had previous interests in painting and another person liked the music of Elvis Presley.

One person told us that staff cut their hair for them which they said they preferred to a hairdresser. Other people looked clean and their appearance was how they wanted it to be.

On the second day of inspection one person received a new chair in the lounge area to use which was more appropriate to their mobility needs. The delight on their face was noticeable. They spent the next 10 minutes smiling to themselves. The registered manager at the service had helped to source this equipment to better support the changing needs of this person. We were told that other chairs were in the process of being replaced also.

There was no dedicated full time activity staff member. One staff member told us they were both a member of care staff and someone who organised activities for people. The staff member told us they found it "difficult to get the residents to join in." They said they encouraged people to join in by starting an activity (game etc.) with other staff and then sometimes people would then join in. One member of staff told us that they were expected to encourage activities and spend time talking to people, but said, "Sometimes it's hard when you have to do your usual tasks."

An activity record book was kept to record events or activities completed by people, however, there were only 19 records for individuals, which meant there was no evidence that the remaining people had participated in any stimulating activities. Some of the activities recorded included, "Interaction with staff and other residents"; "Watching TV"; "Going to the betting shop"; "Spending relaxing time in room"; "Visiting local shops"; "Going into the garden." We deemed that these activities were either not fully recorded to show the exact stimulation which had taken place or were not providing people with opportunities to develop interests or pursue various pastimes. Including pastimes which they used to enjoy, for example, one person who used to enjoy painting according to their care records.

We recommend the provider review their activities programme and deployment of staff to ensure that people receive enough stimulating activities.

People told us they knew how to complain. One person said they had made a complaint (but could not be sure when that was) about a torn item of clothing and said, "They compensated me for it, they said it was a faulty washing machine." Staff understood how important it was to listen to and act upon people's complaints. They told us if they received a complaint, they would immediately inform the registered manager. There had been no complaints recorded since the last inspection or since 2015.

A nurse specialist from the palliative care team told us, "Nurses have attended education offered in palliative and end of life care to support caring for the dying patient assessment and documentation." They also said, "I visit Westwood Lodge about once a month. We have an MDT (multi-disciplinary team) meeting where we discuss residents on the palliative care register. In my opinion the care home engages well with this process. I feel they know their residents very well and always strive to identify and meet their needs." At the time of the inspection, there was no person at end of life care.

Is the service well-led?

Our findings

At the last inspection in January 2017 the provider was in breach of Regulation 17, Good governance, as they did not have robust governance systems in place and records were not always up to date. At this inspection we found some improvements had been made but there were further issues found which meant the provider continued to be in breach of this regulation.

There was a lack of full oversight of the service by the registered manager and audits were not robust as they had not found the issues we had during our inspection, including in connection with medicines and infection control. Provider visits had also not seen the issues we had and we noticed on checking three records that no people had been spoken with to gain their views.

The provider was in the process of seeking to appoint a deputy to support the registered manager in her role.

We saw documentation from a visit from the local pharmacy team to the service in December of last year had found some of the issues we had, for example, lack of 'as required' protocols and that the medicines policy needed to be updated. These issues had still not been addressed.

Care records, including care plans and risk assessments were not fully maintained as they should have been and as discussed in other domains.

Mattress checks were not in place. We found one mattress set at a lower setting than it should have been and the staff we asked were unaware of this. Mattresses need to be cleaned and inspected on a continual basis and there needs to be a process to follow to ensure mattresses can be effectively cleaned. We found there was no decontamination processes in place for cleaning mattresses. Since the inspection visit the manager has told us that they have implemented checks on mattresses.

One domestic said, "There are cleaning procedures written down for us to follow to make sure the home is kept clean." However, we found infection control procedures were not monitored thoroughly and an infection control audit was not in place. Although the registered manager told us after our visit that they had implemented an infection control audit and improved cleaning regimes in the service.

Hazardous substance data sheets were not up to date in the kitchen area. These sheets provide staff with information on how to deal with spillages or accidents should they occur. We found that the sheets in place had chemicals on them which were no longer used or the sheets needed to be updated as they were from a number of years ago. Since our visit the registered manager told us these had been updated.

Older care records were not archived well and we found boxes of older records held in one of the offices. We were told by the registered manager, "We don't have a lot of storage space so we just keep notes where we can." Archived records should be stored in logical order, safely and securely in case of recall by, for example, the coroner.

We asked the registered manager if there was a policy regarding incident and accident reporting and they said there was not one. They later sent us a 'falls policy' which was in connection with falls and accident prevention and contained minimal information and was not robust to support staff. A monthly accident returns form was completed to monitor the number of accidents over the course of a month. This did not show enough information, including times, staff on duty and where the accident occurred. The way the information was recorded did not clearly show any correlation in figures and made it more difficult to monitor any trends forming.

Some policies had not been recently updated from the information we were given by the registered manager. This included the complaints policy from April 2011. We noted that no complaints had been recorded since 2015 and reminded the registered manager that all complaints should be recorded.

The registered manager had not maintained suitable checks of PIN numbers of nursing staff as the ones we found were out of date, although they were checked during our inspection and found to be in order. Risk assessments had also not been undertaken when the provider had received employment checks with less favourable disclosures that could have potentially put people at harm. Competency checks were not fully recorded to confirm what had been checked and monitored.

Some people had their finances supported by the provider. We completed a full count of the money held in the service and found this to be excessive and in the region of £6000, with some people having more than £1000. The money did not fully reconcile on the day as there was more money counted than there should have been according to the records we checked. We viewed a sample of receipts to check appropriate transactions had taken place and found they had. The registered manager told us they were going to keep people's money in separate zip wallets in the future instead of being all together.

Storage of records was not always in line with confidentiality and data protection procedures and meant that the privacy of people's personal data could be compromised. Daily charts were kept in the lounge areas of the building but were not in locked and secure storage. We also noted that rooms which held people's care records or other private documentation were not always locked when not in use, including the registered manager's office and the nurse's office on the ground floor.

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

There was a registered manager in post. They had worked at the service for over 10 years after qualifying as a registered mental health nurse in 2007, the last two years as the registered manager of the service.

The registered manager was well thought of by healthcare professionals. One community nurse told us, "The manager knows all of her residents extremely well and is always very prompt in requesting support from other health care professionals if required." The provider worked in partnership with other agencies, including a local GP who completed regular visits to the home and other providers by attending local provider forums.

A staff member told us, "The manager is approachable." Another member of staff said, "[Manager's name] is lovely, very supportive...you can go to her with anything and she will help how she can. I like working here."

Staff meetings had been held, albeit not very regularly and not all staff had attended. One staff member said, "I haven't attended any of these meetings." We saw records of staff meetings which covered a range of topics, including staffing, people's care and activities for people. Staff clearly had a chance to raise any

issues. We saw recorded that staff had raised an issue over nursing staff not supporting them as much as they felt they should, particularly in a morning. We saw that the registered manager had raised this issue with nursing staff at their meeting and reminded them of their responsibilities.

People were involved in the running of the service by meetings held for them, through individual conversations with management and by the reviews which took place. For example, we saw one person speaking with the registered manager about organising how a visit which was going to be managed. The registered manager listened and took actions to support this.

The provider had sent in notifications of incidents or serious accidents and had displayed previous ratings on their website and within the service which are legally required. One very recent notification regarding pressure damage had not been sent, but the registered manager sent this in immediately after the inspection visit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	Care and treatment was not always appropriate to meet people's needs or their preferences. This included during meal times, bathing and when performing monitoring checks on people.
Treatment of disease, disorder or injury	Regulation 9 (1)(a)(b)(c)(3)i

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Diagnostic and screening procedures	People were not always treated with dignity and respect
Treatment of disease, disorder or injury	Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Medicines were not being managed safely. Infection control procedures were not being followed.
Treatment of disease, disorder or injury	Regulation 12. (1)(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Systems and processes were not always in place to assess, monitor and improve the

Treatment of disease, disorder or injury

quality or the service or mitigate risk. Accurate and complete contemporaneous records were not always maintained or stored securely.

Regulation 17 (1)(2)(a)(b)(c).