Care Quality Commission

Whitmore Vale Housing Association Limited

Westlands

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced. The last inspection was undertaken on the 5 March 2013, no concerns had been identified. Westlands provides accommodation and support for up to seven people who have a learning disability or autistic spectrum disorder. On the day of our inspection there were seven people living at the service. The accommodation is provided over two floors that were accessible by stairs and a passenger lift. There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

Applications for the Deprivation of Liberty Safeguards were in the process of being completed in relation to the key pads used on the front door that restricted people's freedom. The provider had not ensured people had been assessed as being able to give consent to take their medicines.

There was a relaxed atmosphere at the home and we saw staff interacting with people in a calm, polite and caring manner. Staff supported people as and when required and were aware of the communication needs of each person. People were going out to attend external activities. Other people returned from their activities at varied times during the day and made their lunch and relaxed doing what they wanted to do.

Staff told us, and we saw evidence, that they had received training that had enabled them to recognise and report abuse. They told us that they would report all bad practice to the manager and were confident that action would be taken. We saw in the staff training files we sampled that training about keeping people safe had been delivered to staff. Visiting health care professionals said that staff knew the health care needs of people extremely well and staff were very caring in relation to meeting the medical needs of people.

Relatives of people were complimentary about the care their family member received from staff at the service. They told us that they felt their family member was safe and staff knew their family member's likes and dislikes.

People had care and health action plans that ensured their assessed needs would be met. Relatives of people confirmed that they had been involved with the care plans and would be notified of any changes. There were risk assessments in place to enable people to take part in activities with minimum risks to themselves or others.

People received variety of meals that they had chosen. They took part in the weekly shopping and planning of the menus. We saw that people could choose to have an alternative meal if they did not like what was on offer.

Relatives told us they would talk to the manager if they ever had the need to make a complaint. They told us they were very satisfied with how their family member was cared for by staff at the home and they were confident the manager would address any complaints made. This service had not received any complaints since the last inspection.

The provider had a clear set of values that included the aims and objectives, principles, values of care and the expected outcomes for people who used the service.

The service had quality assurance systems in place. These ensured people continued to receive the care, treatment and support they needed. The registered manager was present in the service five days a week and more when required. Staff, relatives and other external health and social care professionals told us that they believed the service was well led by the registered manager.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not fully safe. Staff had received training in relation to the Mental Capacity Act (MCA) and the Deprivation of Liberty safeguards (DoLs). However, we found improvements in relation to gaining people's consent to administer their medicines were required. This was because people did not have the capacity to give consent therefore the requirements of the MCA were not fully met.

Staff spoken to had a good understanding of how to keep people safe, how to recognise abuse and the procedures to be followed should they suspect or witness abuse.

People who lived at the home were safe because there were enough skilled and experienced staff to support them. The service had effective systems in place to manage risk to people's care without restricting their activities.

Requires Improvement

Is the service effective?

The service was effective. People who used the service had personalised care plans that were reviewed on a monthly basis. These included health action plans.

People had access to the health care professionals they needed. For example, GP, dentist, opticians and community learning disability teams. We saw that people had an annual health check undertaken with their GP.

Staff were aware of people's communication needs and how to effectively communicate with them.

People were protected from the risks of inadequate nutrition and dehydration. People had a choice of food for every meal and if people did not want what was on offer they would be offered an alternative.

Good

Is the service caring?

The service was caring. Staff were seen to interact positively with people throughout our inspection. They took time to talk with people and make sure they were happy. Relatives we spoke with told us staff at the service were very caring and committed to the people who used the service.

Care plans were detailed and people had been involved in making them. People who and their relatives were involved in decisions about their care and support. Staff knew the personal histories, likes, dislikes and religious beliefs of people they supported.

People were supported by caring staff who respected their privacy and dignity.

Good

Summary of findings

Is the service responsive?

Good

The service was responsive. People received care and support which was personalised to their wishes and responsive to their needs.

Care plans were regularly reviewed and staff were knowledgeable about the risk assessments and health and care needs of people. Staff responded to the changing health and care needs of people who used the service.

People who used the service were provided with a pictorial complaints procedure to enable them to make complaints if they wished. This showed us that people were provided with information in a format they could understand.

Is the service well-led?

Good

The service was well led. The provider had systems in place to regularly assess and monitor the quality of service people received.

The provider had a clear set of values that included the aims and objectives, principles, values of care and the expected outcomes for people who used the service.

People who use the service, their representatives and staff were asked for their views about their care and treatment through surveys.

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Detailed findings

Background to this inspection

The inspection team consisted of two inspectors. We undertook a visit on the 10 July 2014. We spoke with three members of staff, the registered manager and one person who supported people to attend an external activity. We spoke with two relatives to gather their views about the care, treatment and support provided to their family members who used the service. We also spoke with another member of staff on the telephone after the inspection visit.

Before our inspection we reviewed the information we held about the home and contacted commissioners and other associated health and care professionals to obtain their views about the service. We reviewed the Provider Information Record (PIR) before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern.

We observed people in the communal areas and staff interaction with people. We read care plans for two people, two Medicine Administration Records, audits undertaken by the provider and other external professionals, five staff training records minutes of resident meetings, and a selection of policies and procedures. We were not able to have detailed discussions with people who used the service due to their verbal communication skills. We did, however, undertake direct observations and recorded staff interactions with people. There were no negative interactions noted.

Is the service safe?

Our findings

Assessments for people's capacity to make specific decisions around consenting to medication had not been completed. Because of the higher dependency of the people who live at Westlands the provider told us they had presumed to administer people's medicines without gaining their consent as required by the Mental Capacity Act. This was also not in line with the provider's medication policy that stated, "Medication may not be administered without consent. Where possible, the person should clearly provide informed consent. If this is not possible, but there is a chance that the person can give consent, then the person should be given support to be able to make an informed decision. If it is not possible to obtain consent, key people acting in the best interests of the person can make a decision. This includes a full assessment from a healthcare professional. Documentation of how and why the decision was reached must be made. This meant that staff had not followed the legal requirements of the Mental Capacity Act 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People had not been assessed as to be able to give consent to staff administering their medicines or to understand what their medicines were for. We noted in the care plans information in relation to consent was recorded. For example, it was recorded for one person they were able to make small decisions but not able to make bigger decisions. If the person required treatment or an operation it stated "If I require treatment or an operation I may require a best interest decision or at least assess my capacity to make these individual decisions." It recorded the names of people who should be involved for example, the person's next of kin, GP, care manager and staff at the service. However, this had not been done in regard to seeking consent for medication.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had received training in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. We saw evidence of this in the four staff training records. Staff were able to tell us that if a person lacked the capacity to make decisions then best interest meetings would be arranged. Care plans had a section in relation to consent. Each person had a 'Statement of Capacity and Consent' that recorded their care plans had been discussed with them in simple terms. They documented why the person found it difficult to make informed choices and why they had not signed their care plans. They also informed if the person was able to make day to day decisions in relation to their daily living and the support they would require making major decisions. Care plans informed that staff would need to apply the five core principles set out under the mental capacity act to give the person the opportunity to make major decisions. Care plans also stated that staff may not sign the care plans on the person's behalf.

The registered manager had an understanding about the Deprivation of Liberty safeguards (Dols) and was aware of the recent ruling. As a result of this they told us they were in the process of completing and submitting deprivation of liberty safeguard applications for each person living at the service as they keep the front door locked to ensure people only went out supervised. We saw two of these applications had been completed. No other restrictions were imposed on people.

The registered manager and staff were knowledgeable about safeguarding vulnerable adults and the reporting process to be followed when suspicions of or actual abuse had occurred. They were aware of the different types of abuse and the reporting procedures to be followed. They told us there had not been any safeguarding incidents at the service. This was confirmed in the feedback we received from a social care professional who informed us the registered manager was good at seeking support and guidance. Staff told us they had received training in relation to safeguarding adults. We saw evidence of this in the staff training records. They told us this training also included whistle blowing.

The service had a safeguarding policy and staff confirmed they had read and understood the policy. A copy of the local authority's safeguarding procedures was also

Requires Improvement

Is the service safe?

available that included the contact details for the local safeguarding team. This meant that staff would be aware of the relevant guidance and contact details for the local authority safeguarding team.

Relatives told us their family members were very safe living at the service. They told us staff were caring and knew their family member's needs. One relative told us their family member had significantly improved in their health and welfare since they started using the service.

Risk assessments had been undertaken that ensured people could access meaningful activities. For example, risks in relation to accessing the community, use of the service's vehicle, vulnerability, behaviour and relationships. This ensured that people were able to take risks as a plan to keep them and others safe when undertaking the activity was in place. We saw people leaving the service to attend activities in the wider community. Risk assessments were individual to each person and reviewed on a six monthly basis. The registered manager told us that one person wanted to go to a concert to see their favourite singer perform. The person did not like crowds; however, staff at the service visited the venue and identified a safe place for the person to be during the performance.

Staff told us there were enough people on duty to meet the needs of people. The registered manager told us the duty rota was based around the needs of the people who used the service, not the staff. We saw people were supported by an appropriate number of staff to meet their needs. For example, people were cared for on a one to one basis when needed. Relatives told us that there always seemed to be enough staff on duty whenever they visited.

Staff told us they believed their recruitment process was thorough and fair. They said they had to submit an application form providing a full employment history, two referees and proof of identity. The registered manager told us all staff had a Disclosure and Barring Service (DBS) check undertaken. This is a check on staff's criminal records to ensure that they are suitable to work with vulnerable people.

We looked at medicine management to check if safe systems were in place as there had been three medicine errors at the service during the last twelve months. The registered manager told us only staff who had received the appropriate training administered medicines. This was confirmed during discussions with staff. The registered manager told us she was responsible for the ordering and receipt of medicines and she undertook unannounced observations of staff administering medicines.

We looked at the medicine administration records (MAR) sheets. These recorded the quantities of medicines received. We observed a member of staff had administered medicine and they only signed the MAR sheets after the medicine had been taken. We noted that MAR records were used appropriately This meant that records of medicine administration were accurate and fit for purpose.

We saw the provider had written individual PRN [medicines to be taken as required] protocols for each medicine that people would take. These provided information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. This meant that people would receive their PRN medicines in a consistent way.

Good

Is the service effective?

Our findings

Staff told us they had received all the essential training as required by the provider. A list of this training was posted on the notice board in the staff office. A new member of staff was undertaking induction training. This is training helped them to understand people's needs and gave an introduction to the other essential training. For example, staff knew the importance of providing a healthy and balanced diet to people. Staff told us they had undertaken other training that helped them meet people's needs. This included equality and diversity, nutrition, epilepsy, the mental capacity act and the NVQ level 2. This meant people were supported by staff who had up to date knowledge about how to provide effective care to people.

Staff told us, and we saw evidence, they were receiving regular one to one supervision and an annual appraisal. Staff were provided with the opportunity to review their performance or identify any training needs they may require.

Staff stated they felt supported by the registered manager and they could approach her at any time. Relatives and health and social care professionals told us they believed the staff were well trained. They all stated staff were very knowledgeable about the needs of people and there was always a happy and friendly atmosphere at the service.

We looked at the menus at the service for four weeks prior to our inspection visit. We noted each weekly menu recorded the names of staff and people involved in planning the menu for that week and the methods used. For example, it recorded pictures of foods and cookery books used to plan meals. We saw in the kitchen each person had a document that would help staff provide each person with appropriate help to prepare their meals. These documents were entitled, "I can do, and you may help." The emphasis at the service was on what people 'can do' not what they could not do. We saw staff supporting people in the kitchen to make their lunch. Staff encouraged one person to put their bread in the toaster. Staff then supported the person to butter their toast and gave positive feedback by saying "Very good." The person was smiling and laughing with staff. Staff talked to people when they made their lunch and gave clear explanations of what they were doing, why they were doing it in that way and they gave lots of praise to people. This showed us staff supported people in a way that respected them as an individual and promoted their independence.

There was a choice of food for every meal and if people did not want what was on offer they could ask for anything they wanted to eat. We saw this take place during our inspection visit. One person was becoming distressed and not eating their food. This was very quickly recognised by staff who reassured the person and brought different foods to offer them. When a person required specialist dietary input this was sought for them. For example, one person had been seen by a speech and language therapist to help them with an eating difficulty they had experienced.

Meals provided included meat, fish, pasta, and fresh fruit and vegetables. Foods bought were good quality foods and all salads, vegetables and fruit were fresh. This meant that people were offered a variety of meals to choose from. Fresh fruit and a choice of hot and cold drinks were available throughout our visit. The registered manager told us people took part in doing the weekly shopping. This was confirmed during discussions with staff and relatives we spoke with.

We looked at the care plans for two people. Each included a health action plan. These provided information in relation to people's health care professionals. For example, the optician, dentist, GP, audiologist. They provided information on the current health care needs of the person and all health care appointments were recorded with the outcomes. This ensured people's health needs were met.

Each person had a hospital passport that would be taken with them as and when they required emergency treatment. This provided information to other services about the person, their current medication, allergies, risks and important information about them. For example, how they communicated and their personal care needs.

Health care professionals told us staff knew the health care needs of people extremely well, that all the required documents were readily available whenever they visited the service and staff were very caring in regards to meeting the medical needs of people. Health and social professionals told us staff know people "Very well." One health care professional told us staff were sensible and very caring regarding the medial care of people. A social care professional told us staff treated people as individuals.

Good

Is the service effective?

Relatives told us staff always informed them when their family member had attended any health care appointments. One person told us, “I was informed when my family member had a urine infection. Staff kept him calm and explained everything to him.” This meant people could be assured that staff would support them to maintain good health and to access all health care professionals as required.

Good

Is the service caring?

Our findings

Due to the communication needs of people who used the service it was not possible to get verbal responses. However, we did observe the interaction between staff and people. We saw staff were caring and they spoke to people in a polite and courteous manner. Staff were able to communicate with people using different methods. For example, one person had finished eating their meal and staff were able to tell from the gestures made by the person that they would like more to eat. We noted from discussions and records one person had built a strong relationship with the member of staff who was their key worker. For example, records showed the member of staff had supported the person on a four day holiday. The person acknowledged, through the registered manager, they really liked this particular member of staff who supported them.

Staff supported people to access external activities. We noted staff on duty had a very good, clear knowledge of people who used the service. We asked staff about the personal histories, likes, dislikes and religious beliefs of people they supported. Staff were able to give a clear description that was also in people's care plans. Staff knew the religious beliefs, ethnicity and disabilities of people they cared for. For example, a member of staff told us one person practices their religion every Sunday by attending the church service. They told us this person always went to the church thirty minutes early so they could interact with people before the service began.

We saw staff communicating with people as they returned from activities, prepared their lunch with the support of staff and relaxed. Staff waited for people to respond to their questions using their preferred method of communication. For example, by pointing, making gestures and use of body language.

We observed the staff handover meeting. Staff spoke passionately about people and what they had done that morning. For example, one person attended an activity using a taxi that was paid for by the service because the service's mini-bus was already in use. One person's current health care needs had been fully discussed. The person had been involved in collecting their prescription with a member of staff from the pharmacy. This showed us that staff supported people to be involved in their health care.

Staff told us they showed compassion and kindness through listening to what people had to say. They told us they involved people in their care by talking with them about their care plans every month.

We saw staff asking people for their views about what they wanted to do, where to go and the food they would like to eat. Choices were offered to people throughout our visit. For example, they were offered a choice of leisure activities. We saw records that evidenced people were able to express their views about their care. For example, monthly review notes in care plans recorded the key worker had discussed the care plan with the person, and records of their choices had been noted. We saw records of resident meetings where people had discussed choices of activities, forthcoming events and any concerns they may have had about the service. We noted these had been recorded using pictures and widget symbols. These are symbols that are used to support written text, making the meaning clearer and easier to understand. This meant people were supported to be able to understand what had been discussed at the meetings.

Relatives told us all the staff were caring. One relative told us, "Staff are absolutely lovely." They said staff could not do enough for their relatives or other people. One relative told us, "Staff treat all the people with kindness; it is just like one big happy family." Relatives also told us staff were committed to their work because they would volunteer to take individual people away on holiday. For example, one person had been on a holiday abroad with one to one support from a member of staff. They told us, "Where else would a person be able to have this experience whilst living in a care home?" People chose to go to London and attend musical performances. Staff had made a bound book that included the photographs taken of this holiday so they could look at them and remember their holiday in the future.

Due to people's communication difficulties we spent time observing staff interact with people. Staff were respectful to each person. For example, they called people by their preferred names; they knocked on bedroom doors and would not enter without the person present. People were able to either say yes or open the bedroom doors themselves to let staff enter. Staff would check the whereabouts of a person if there was not a response when they knocked on the bedroom doors.

Good

Is the service caring?

Staff told us they ensured that they maintained people's dignity at all times. For example, they would encourage people to keep themselves covered when walking between the bathroom and their bedroom. We noted people were allowed to spend time on their own and in private. For example, staff were able to respond to one person's request to go into a room that was specific for the person so they could listen and dance to their music. The member of staff supported the person to choose the music CD they wanted and left them on their own in the room. The member of staff told us this person prefers to be on their own so they could freely dance to the music. We found people could have privacy if they needed it. For example, one person had decided to have a lie down in their bed. Staff respected their decision and left the person to rest in their bedroom. Relatives confirmed to us that staff always respected the privacy and dignity of their family member. This showed us staff were able to communicate with people and ensured their requests for privacy were respected.

Good

Is the service responsive?

Our findings

We saw throughout our observations staff had a very clear understanding of how people communicated their needs. For example, one member of staff was in the lounge reading some notes. Two people were present. One person just said, "Tea." The member of staff immediately responded and confirmed with the person they wanted a cup of tea. They also asked the other person if they would also like a cup of tea and then went to the kitchen to make it. We did observe during our visit people were also supported to make hot beverages This showed us staff were aware and responded to people's needs and knew how to communicate with them.

Personalised care plans had been written for each person. Information for the care plans had been developed from the person's assessment of need. They were written about the person for the person. We noted the care plans were well organised and a clear index was at the front. Information recorded included a personal information sheet with details of the person's next of kin, family, friends, GP contact details and health care contacts, ethnic origin and religious beliefs. Care plans included information in relation to the person's care need, likes, dislikes and the way they communicated.

We observed staff following the care plans as they had been written. For example, it was recorded that one person would use one or two words to communicate and they would also use noise and gestures. We observed the person making the noises and gestures and staff responded to the person. The person had wanted to show a member of staff what they had done in the garden. The staff understood their gestures and followed the person. On seeing what they had done they gave the person praise.

Throughout our visit we noted all information in relation to activities, cooking and cleaning was focussed on what the person 'can do' not what they could not do. Care plans included short and long term goals for the person. This meant the provider promoted independence in a way that reinforced positive outcomes for people who used the service.

During our visit a member of staff had reported to the registered manager they had noticed one person's eczema on their elbow that had become inflamed. An appointment was made with the person's GP. One person was not well and had been taken to see their GP. The registered manager and staff were concerned they had not made a full recovery from a recent infection despite completing their course of antibiotics. Action was taken by staff and the person received a further prescription for antibiotics. Staff told us they would respond to all people's needs without delay for example by supporting them to attend all medical appointments. This was confirmed during discussions with people's relatives and health care professionals. This showed us staff at the service were responsive to people's health care needs.

During our inspection we sat in on a daily handover meeting at the change of a shift. All care, treatment and support about individual people were discussed during this meeting. For example, the activities they had undertaken, daily reports from the previous afternoon and night time, and any health care concerns that had been dealt with. This meant staff shared information about people and how their personal needs had been met on the previous shift and any issues or concerns that had arisen.

Staff told us, and we saw, people had access to community activities every day. For example, they attended a local day centre. There was a list of activities people attended on a daily basis, for example, shopping, pubs, cinemas, walks and cooking. These were confirmed during discussions with relatives. This showed us people were not isolated within the home.

We saw copies of the complaints procedure displayed at the service. This made people aware of the timescale of the process for responding to and resolving a complaint. It also provided the details of the local independent ombudsman should they not be satisfied with the outcome of their complaint. People who used the service were provided with a pictorial complaints procedure that was in the service user guide they had in their bedrooms. This meant when someone had a complaint there were processes in place so that the complaint could be investigated in a timely manner.

Staff told us they would follow the complaints procedure should a complaint be made to them. They told us they would listen and record any complaints they received and would pass the information to the manager. The registered manager told us that staff had sat with people and talked through how to make a complaint, and this was regularly discussed during meetings with people. Relatives told us they would talk to the manager if they ever had the need to

Good

Is the service responsive?

make a complaint. They said they were very satisfied with how their family member was cared for by staff and they were confident the manager would address any complaints made. The registered manager told us that they had not received any complaints. She informed us there was an open door policy and all people and their relatives could talk to her at any time.

Good

Is the service well-led?

Our findings

Staff told us meetings with people were held on a regular basis. They told us they discussed the activities people wanted to do, the menu and holidays. We looked at the minutes for meetings. Topics discussed in the meetings included asking people if they wished to go on a boat trip activity, a group of external singers visiting and people could choose their favourite songs to be sung, and having photographs taken of activities undertaken. They also had discussions about identified issues at the service. For example, a ripped table cloth, no fruit in the bowl on one occasion, and their right to make complaints if they were not happy or were worried about anything. This showed us that people were involved in discussions about the service, how it was run and the things they wanted to do.

Staff told us that any accidents would be discussed with them in staff meetings and lessons to be learnt from them would be explored. We viewed the minutes for three staff meetings that had been held at the service. Topics discussed included news from the provider, a presentation around healthy eating, complacency in care which could lead to possible abuse and the importance of the practice of letting people have sufficient time to have their personal care, medicines, breakfast and leisure time in the mornings. Staff meetings also included the results of audits undertaken at the service, which we noted to be positive. For example, cleanliness of the house, health and safety and medicine audits.

The registered manager told us there had not been any accidents at the service since the previous inspection. There had been several incidents that had been recorded by the registered manager. When an incident had occurred the person's care manager and relatives were informed and a debrief had taken place with staff. The registered manager recorded every incident, no matter how minor. None of the incidents we looked at were notifiable incidents to the Care Quality Commission. Staff told us they discussed all incidents that had occurred during staff meetings. This showed us the staff would be included in analysing incidents to see what they could learn from them and to prevent a repeat of the incidents. For example, one person's mobility had deteriorated and had three falls over a period of four months. Input was sought from occupational and physio therapists. As a result hand rails were fitted around the home to aid the person's mobility.

The provider had a clear set of values that included the aims and objectives, principles, values of care and the expected outcomes for people who used the service. For example, we saw in the statement of purpose that the aim was to provide support that is unobtrusive, enabling, person centred and adaptable to the changing needs of people. The principles of care included maintaining people's dignity, respect the rights of people to privacy, choice and equality and diversity. Staff we spoke with were aware of the values of the service. The registered manager told us that she observes practice five days a week and discussions would take place during supervisions to ensure that staff knew and adhered to the values of the service. This meant that people who used the service could be assured they would receive care, treatment and support that promoted their independence and included them in decision making about their lives and the service.

We observed that the registered manager had a very good relationship with people who used the service. For example, she understood their preferred communication method and was able to interact with all the people at the service. The registered manager introduced the inspection team to the people and explained the reason for our visit to the service.

The provider sought feedback from people who used the service, families, day care workers, activity providers and other associated professionals. Comments on surveys that had been returned to the service in June 2014 were positive about the care, treatment and support provided to people. For example, one relative had written, "I am grateful how my relative has control over their daily life and they seem to have access to lots of activities. I am really pleased with what my relative does. Westlands is a very happy place." Another relative had written, "I have great respect for the staff. I feel my son is so lucky living at Westlands. Whenever my husband and I visit my son we are always greeted by the staff with a warm greeting and a cup of tea." A day care worker had written, "As far as we are aware our gentlemen at the service are attended to and involved in the community as they are able or want to. Everyone at Westlands are always friendly, cheerful and very supportive of the residents' needs."

Staff and the registered manager told us that they sought the views of people during their monthly key working meetings. We saw an example of this whereby a person had made it known that they wanted to go on a particular

Good

Is the service well-led?

holiday with a particular member of staff. This was organised and the person had a successful and enjoyable holiday. This ensured that people, their relatives and other associated professionals had the opportunity to inform what they thought about the service.

Relatives told us the registered manager was always at the service and was available to talk to them whenever they visited or telephoned. Staff also confirmed this during our discussions. They also told us the registered manager worked alongside them and they believed the service was well managed. They said they saw a senior person from the organisation every month and that management at the service was very supportive. If they had any issues or concerns they could discuss them with the registered manager at any time.

The deputy chief executive worked closely with the registered manager and they visited the service every month. We saw that monthly quality assurance visits had been undertaken and reports and action plans of these visits had been written. Any actions that had been identified had been completed before the next visit.

The registered manager audited their medication administration records (MAR) charts on a regular basis. The MAR chart is a legal record of medicines administered to people by trained staff at the service. Staff sign these records at the time the medicine has been administered to the person.

We looked at one of these audits. It included an observation of medicines being administered including the washing of hands prior to commencing the administration of medicines. It also included checking the MAR sheets to ensure there were no omissions and looking to ensure that staff explained to people why they were taking the medicines. However, they had not picked up on the consent for people taking their medicines. This meant the registered manager ensured people's medicine was securely stored and they received the medicine that had been prescribed by their GP.

The service had external links with other organisations that acted as developers and sources of best practice. For example, there were links with Skills for Care, Food Standards Agency and the Surrey Care Association. (SCA). The registered manager told us that through the SCA they were kept up to date with changes to legislation, best practice and were able to network with other LD services. For example, the registered manager was aware of the recent changes to the Deprivation of Liberty Safeguards (DoLs). These are regulations that have to be followed to ensure that people who cannot make decisions for themselves are protected. They also ensure that people are not having their freedom restricted or deprived.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.