

Westview Lodge Limited

# Westview Lodge Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The inspection took place on 13 and 21 September 2018 and was unannounced.

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

The care home accommodates 74 people across four units. At the time of the inspection 65 people were being supported in the home. The service supported up to 20 people who were assessed as requiring rehabilitation with a view to returning home. Over the course of a year up to 400 people access this service.

The service did not have a registered manager in post. '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 had appointed a manager who had submitted their application to become the registered manager and was waiting for their fit person's interview.

Following the last inspection in February 2018, the service was rated as 'Good' overall, with 'Requires Improvement' under 'Responsive'. This was due to risk assessment information not being transferred to care plans. At this inspection we found two breaches of regulations relating to safe care and treatment and good governance. As a result, the overall rating has deteriorated to Requires Improvement.

Risks to people had not always been identified, assessed or managed safely. In some cases, there was insufficient information or guidance in care records in relation to people's care and support needs. The provider's system of assessment and subsequent recording did not give an overview of people's needs. It was difficult to ascertain the primary care needs of people and readily locate key information such as whether people needed adapted diets.

The staff in the rehabilitation service used care templates designed for people receiving respite care and these made it difficult for staff to readily identify what support people needed. Staffing levels did not consider the dependency needs of people in case of an emergency.

Substances, which if ingested could cause harm to people, were not stored securely.

Issues relating to fire safety had not been addressed in a timely manner.

Conditions attached to people's Deprivation of Liberty Safeguards authorisations had not been met.

The provider's quality assurance process had not identified all the concerns found at this inspection.

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

The provider's recruitment process was safe and robust. Checks were made to ensure only suitable people were employed.

Staff were aware of safeguarding processes and knew how to raise concerns if they felt people were at risk of abuse or poor practice. Where lessons could be learnt from safeguarding concerns these were used to improve the service. Accidents and incidents were recorded and monitored as part of the provider's audit process.

Health and safety checks had been completed such as gas and electrical safety checks. Equipment used to support people had been checked and/or serviced.

Medicines were managed by trained staff whose competency to administer medicines was checked regularly. Medicine administration records (MAR) were completed correctly.

Staff felt supported and received regular training, supervision and an annual appraisal.

People were provided with a varied healthy diet. People's health was monitored and when necessary staff ensured people had access to health care professionals when necessary.

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

People and relatives felt the service was caring. Staff provided support in a respectful manner ensuring people's privacy and dignity was promoted. Where possible people were supported to be as independent as possible.

The provider ensured people were supported to attend a broad range of activities and entertainment within the setting. Plans were in place to use the provider's transport to enable trips out.

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The provider had a complaints process in place which was accessible to people and relatives.

Staff were positive about the manager. They confirmed they felt supported and could raise concerns. We observed the manager was visible in the service and found people interacted with them in an open manner. People and relatives felt the management approach in the home was positive.

The provider worked closely with outside agencies and other stakeholders such as commissioners and social workers.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not safe.

Risk assessments were not always completed with up to date information to support people. Remedial work from Health and Safety checks had not been addressed.

Staffing levels did not consider the level of support people may need in the event of an emergency evacuation.

The provider had a system in place to monitor accidents, incidents and safeguarding concerns to identify patterns of themes.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

The provider's system of assessment and subsequent recording did not give an overview of people's needs. It was difficult to ascertain the primary care needs of people. Not all authorised conditions set out in people's DoLS had been addressed.

Staff received regular supervision, appraisal and training necessary to meet the needs of the people using the service.

People received and had access to health care professionals.

### Is the service caring?

**Good** ●

The service was caring.

People and relative felt the staff were patient, caring and understanding.

Staff demonstrated a kind, caring approach when supporting people. Staff had a clear understanding of people's communication needs.

Information regarding advocacy was available to people and relatives.

### Is the service responsive?

The service was not always responsive.

Care plans were not person centred. Some care plans contained historical information which was not relevant to the person's current needs. There was a lack of detail about people's lives.

Relatives had given several compliments regarding the end of life care provided by the home.

Coordinators spent time getting to know people in order to organise a range of activities.

The provider had a system and process in place to manage complaints.

**Requires Improvement** 

### Is the service well-led?

The service was not always well led.

The provider's quality assurance system has not identified some of the issues found at this inspection.

The manager had a development plan in place to drive improvements and had made some changes to processes.

People, relatives and staff felt the management of the service was open and that the manager was approachable. ☐

**Requires Improvement** 

# Westview 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 to planned 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.

The first day of this inspection took place on 13 September 2018 and was unannounced. This meant the provider did not know we were coming. We also visited the home on 20 September 2018 to finalise our inspection.

The first day of the inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second day of the inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed other information, we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are reports about changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We contacted the local Healthwatch team and obtained information from the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with eight people who lived at West View Lodge. We spoke with the manager, regional manager, peripatetic manager, resident experience regional manager, deputy manager, rehabilitation unit manager, two senior carer workers and six care workers. We also spoke with kitchen staff including the chef and the activity coordinator. We also spoke with six relatives of people who used the service. We also spoke with one health care professional.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of five people, medicine administration records of ten people,

recruitment records of three staff, training records and records in relation to the management of the service.

# Is the service safe?

## Our findings

Albeit booklets were in place for each aspect of care and these contained risk assessments they did not address how individual issues were to be addressed. For instance, in one person's care records it indicated in their risk assessment that they were at 'medium' risk of choking. The boxes staff ticked in relation to this were that they overloaded their mouth, stored food in their mouth and drank fluids quickly. No guidance was provided detailing how staff were to manage this potential risk of choking. We noted they ate their meals in their bedroom and this was not supervised. We could not determine how this would prevent a risk of choking.

We found risks were not identified at all in the provider's care records but were detailed in information the placing authorities had provided. For instance, in one person's care records we only found out that they needed to go to hospital for blood tests every 12 weeks, had a stroke and cancer when we got to the end of their care records and found the local authority assessment.

Another person's skin integrity assessment failed to consider an illness they experienced or their current level of mobility. This meant the current score was incorrect and should have been higher therefore putting the person in the "at risk" score.

A third person's skin integrity risk assessment was not fully completed. Their personal risk assessment did not contain up to date information. The oral risk assessment stated 'no' to the question of difficulty with swallowing, however other records indicated the person was at high risk of choking.

We found one person was assessed as being a high risk of falls, records stated, the person needed support and prompts to use Zimmer frame. Their level of mobility needs had not been completed. Records from 15 March 2018 stated, "Issues around [Name] bed, is still of concern". There were three recorded falls in March, however there was no evidence that the risk assessment had been reviewed. The last fall intervention was recorded in January 2018. There were no records of any fall prevention equipment being used or if this had been considered.

We found that PEEPs were in place but these described how people needed to be hoisted into a wheelchair and that two staff were needed. We discussed this with the staff and manager and found no consideration had been given to how many staff would need to be available to complete a full evacuation in the event of a fire or that the equipment might be elsewhere or the lift unusable so what alternative aides could be used such as an evacuation sled.

We found denture cleaning tablets in a person's bedroom, which were not locked away safely. Nail varnish remover was also found in the dining room. Both items were found on the unit which supported people living with dementia. We handed these items to staff and requested they be stored securely.

We found health and safety records pertaining to fire doors which indicated remedial work was outstanding. The maintenance person had recorded on two occasions that the work was still outstanding. This was



discussed with the manager and area manager who advised they would contact the estates department to address this.

These findings demonstrate a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the staffing levels in the home to ensure they were at a safe level to meet people's needs. Several people required two staff to support them with personal care and mobility needs. We saw on two of the units there were only two staff on duty. This meant when the two staff were supporting people there was no one available to monitor the rest of the people, some of whom were living with dementia.

We discussed our findings in relation to staffing levels with the manager who advised they had reviewed the levels and intended to discuss this with the area manager. During the inspection we discussed our concerns with the area manager, who advised that dependency levels had been revisited on the day of the inspection to ensure people's needs were being met by an appropriate level of staff. We asked the area manager to also consider the staffing levels at night to ensure that people could be safely evacuated if necessary.

We spoke to people and relatives about the levels of staff on duty. One person told us, "I have to keep pressing my buzzer to get a urine bottle or if I need help getting on to the commode and find them very responsive." One relative said "You could always have more staff." Another relative said, "There always seems to be enough staff on call when I visit." Everyone we spoke with agreed that the staff were overworked, but did a really good job but another member of staff "would certainly alleviate things."

People and relatives, we spoke with told us they felt the service was safe. One person on the rehabilitation unit said "Yes, I'm safe in every way, I was initially here for 16 weeks but now I am here permanently, I have had no falls, as I had two carers looking after me at all times". Another said, "I completely trust the care staff, I can't walk and they do everything for me. I don't lock my door at night as I feel safer if the door is open and nothing ever goes missing." A third person said, "I'm safe in every way." One relative told us, "Yes, she is very safe here, they pop in every hour and say 'are you alright?' they even look in every two hours on a night time to see how she is."

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS) and two references. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, which helps employers in their decision making when selecting staff.

The provider had systems and processes in place to keep people safe, such as safeguarding policies and procedures. Staff were trained in safeguarding and understood how to report any concerns. Staff knew the signs to look out for such as changes in people's demeanour or unexplained bruising. One care worker told us, "I would report anything to [the manager]". We found the manager understood their responsibilities in relation to safeguarding and had made appropriate referrals when necessary. Where lessons were learnt from safeguarding incidents, these were shared with staff during supervision or staff meetings.

The manager had a system in place to record accidents and incidents. We found the manager analysed the information to look for patterns or trends. The manager had identified one person who had an increase in their number of falls. By reviewing their support, they had provided additional guidance for staff with the result being a reduction in falls. This meant the process used by the manager was effective.

Environmental risks were assessed to ensure safe working practices for staff, for example, to prevent slips, trips and falls and kitchen safety. These were reviewed on a regular basis and were accessible for staff support and guidance.

We spent time in the kitchen and found systems and processes in place to ensure the kitchen and equipment used in the preparation of food was clean and well-maintained. We found records of fridge and freezer temperatures to demonstrate the provider followed food hygiene regulations.

We inspected medicines on the ground floor and first floor of the service. We found the administration of people's prescribed medicines was clearly recorded and non-administration codes were used correctly.

Appropriate checks had taken place on the storage, disposal and receipt of medication. Staff knew the required procedures for managing controlled drugs [these are medicines liable to misuse]. We checked the records for the management of controlled drugs on both floors and found these were correctly and safely administered.

The ground floor unit provided the rehabilitation service and due to the volume of medicines coming into the service each week they had developed a very robust system for ensuring all medications were received and appropriately administered. The unit manager discussed how they had developed the system. Following discussions with the manager they had designed a streamlined approach for monitoring the controlled drugs.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed regular medication audits and had worked to improve the quality of recording and most of actions they identified had been completed. We noted that in March 2018 they had highlighted that the signature sheets needed to contain all the staff names who administered medicines on each unit. These sheets had not yet been updated. We mentioned this to a senior carer who immediately acted to obtain staff's signatures.

Treatment rooms where medicines were stored were clean, free from clutter and items were stored at the correct temperature.

We found up to date records to demonstrate the provider ensured the maintenance of equipment used by people was checked on a regular basis. Certificates were in place to reflect gas safety checks and portable appliance checks.

## Is the service effective?

### Our findings

We found that the provider's assessment tool was a series of booklets that covered each area of care such as physical health, communication, nutrition. These booklets allowed an assessment either via tick boxes and/or some narrative with the care plan and evaluations. This led to the care files being enormous and often information did not link up or provide a rounded picture of the person. There was no document that provide a good overview of people's needs. This led to the care records being extremely difficult to review and determine what was primary needs or general needs of people. For instance, for one person we reviewed the whole file and could not work out if they were married or separated, what impact the stroke and cancer had upon their sense of wellbeing and physical health or why they needed blood tests.

The provider required staff to complete care records designed for people who stayed for respite whilst receiving support with rehabilitation with a view to returning home. These were extremely lengthy and did not allow staff to concentrate on presenting needs and risks associated with the needs. Staff told us that on average 400 people used the rehabilitation unit and could stay from a couple of days up to six weeks. We found staff were completing several sets of respite documents per week.

We discussed our findings with the manager and area manager who advised the provider had documentation relating to intermediate care which could be adapted to use for people who were admitted for rehabilitation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager was aware that when people lacked capacity and were deprived of their liberty they would need a DoLS authorisation. They understood the need to consider 'best interests' decisions however the provider had not supplied the appropriate MCA capacity assessment documentation or 'best interests' decision forms. Therefore, staff were not able to record MCA capacity assessments or the 'best interests' decisions that had been made.

No information was available to show that when people had their relatives act on their behalf this legally supported. Thus, relatives were signing consent forms for people but we could not establish if they had enacted LPA's for care and welfare.

We checked the DoLS authorisations held by the provider and found some people had conditions applied to

their authorisation. This requires the provider to ensure that conditions are met and that staff are aware of the conditions. One of the conditions placed on six authorisations was the use of the Herbert Protocol. The Herbert Protocol is a document to be used in the event of an adult with care and support needs going missing. It consists of a form that contains vital information about a person at risk that can be passed to the police at the point the person is reported missing. We discussed this with the manager who was not aware of the Herbert Protocol.

The manager and area manager obtained a template of the Herbert Protocol and before the end of the inspection all people who required a protocol to be in place had one on their care file in case of an emergency.

The quality assurance system had not picked up the issues we found in relation to assessments and MCA. We discussed our concerns with the manager who advised that care records would be addressed to ensure they were fit for purpose.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke were aware of who had a DoLS authorisation in place and what that meant in terms of people's care and support. Staff understood the need for ensuring people were supported with decision making and any concerns they had in terms of people's capacity would need to be reported to the manager.

We found the dining room on the unit which supported people living with dementia to be bare and uninteresting. The tables were covered with table clothes but with no other items. Staff told us the tables could not be set as people often moved things such as cutlery and placemats. No thought had gone into making the dining room more dementia friendly.

People were seated before placemats were given, no cutlery was laid until the meal was served. Juice was given in flimsy plastic beakers and tea served without a saucer. This was in stark contrast to the other dining rooms in the home which were laid with table clothes, table decorations, placements and cutlery.

We discussed our concerns with the manager in terms of the lack of equality for people living with dementia. The manager advised they were looking at the dining experience for people living with dementia to ensure they were afforded the same meal-time experience as other people living in West View Lodge. They advised monies had been made available by the local authority to support with the improvements.

We reviewed how people were supported with their nutritional needs. People were offered a healthy, varied diet. Observation at lunchtime provided good evidence that the staff were skilled in terms of their approach to supporting the nutritional needs of people. We found appropriately modified textures were provided for each person requiring specialised diets.

Catering staff were given diet notification sheets which were kept up to date with people's dietary needs. The chef told us, "We get information when new people come in or if there are any changes." We observed lunch in two of the home's dining rooms, people had a choice of gammon or steak pie and vegetables followed by apple crumble or yoghurts. Meals looked and smelt appetising and were modified in consistency where necessary. Napkins were provided or where appropriate people were given the choice of protection for their clothes.

Staff constantly asked people, "would you like some more juice" and "are you enjoying that, would you like

some more?". People were encouraged by staff with comments such as, "You are doing really well" and "would you like me to help you cut it up a little with you? ".

People told us they enjoyed the food at West View Lodge. One person told us, "Yes, I like breakfast best, it's beautifully prepared and there are plenty of drinks water, tea and juice." Another said, "Absolutely lovely, but I can't eat much but what I have is good."

The manager kept a training matrix updated to ensure staff's training was up to date. The provider used a mixture of e-learning and face- to-face training. Staff told us they enjoyed the training and that it was appropriate to the needs of the people they supported. One staff member told us, "There is a lot of training, like dementia training, moving and handling and safeguarding." Another told us, "I have NVQ Level 2, we do our e-learning on the iPad."

A program of appraisal and supervision sessions was in place for staff. Staff told us that they received support from the management team both in relation to day to day guidance and individual supervision.

People and relatives told us they thought staff were trained to be able to meet their needs or their family member`s needs. One person said, "Yes, they do everything very well from what I see and I see them every day." They went on to explain, "I have no complaints whatsoever as they are helpful getting me out of my chair, they do everything really ". One relative commented "Oh, they have to be well trained to work here." Another told us "I observe them constantly, they are definitely caring and well trained".

The staff we spoke with could demonstrate a good understanding of the care and support needs of the people using the service and knew people well. We observed that staff had the necessary skills and knowledge to do their job effectively. Staff were supporting people with ease and confidence and they assisted people communication at the person's own pace. Staff knew when to use speech, gestures or body language to communicate with people, and at a level in which they could understand.

People told us they had access to health care professionals when they needed them. One person told us, "If I am not well, then they get the nurse or the doctor in." Another said, "I get to see them every day because I have exercises to do." People who were residing on the rehabilitation unit were supported daily by occupational therapist and physiotherapists. Care files contained records to identify when professionals had been requested by the home. For example, referrals to community nurses, chiropody and GP's.

We spoke with one health care professional who told us, "I have never had a problem, the home is clean and tidy. Staff are helpful and keep records of visits."

People had access to communal areas and to an enclosed garden. We found lots of space for activities and for people to spend time together with relatives and friends. The home had recently been awarded funds by the local authority to assist the provider to make the home more dementia friendly. The unit for people living with dementia was sparse and lacked interactive or tactile items for people. The manager told us, "I want to improve the dementia unit to improve their (people) quality of life. I want to involve families more to help take this forward."

People had access to hand basins in their rooms. Specially designed baths were available for those who required support to access the bath along with showers. Facilities were large enough to accommodate wheelchairs and other mobility equipment.

## Is the service caring?

### Our findings

People and relatives, we spoke with felt the service was caring. One person told us, "Yes, they are good and whilst taking me to the toilet or the shower they are very understanding. I wouldn't like to be anywhere else, other than home of course". Another person said, "Yes, I'm well cared for, they know their duties and jobs, they are very good, they chat away and listen." A third told us, "Oh, they stop and listen when they are not too busy. But if you're poorly they are there, if they can help they will help." A fourth said, "They even allow my dog in."

One relative told us, "It is a lovely home, the girls are caring, always smiling." Another told us, "What is really good is that when you press the buzzer they come straight away- especially during the day". A third said, "No complaints everything is good. They are very helpful staff." A fourth told us, "I do believe the staff genuinely care, it's a lovely atmosphere and they have the patience of saints."

One health care professional told us, "The staff are friendly and people are always well presented and appear cared for."

We observed genuine relationships between people and staff. There was lots of laughter in the home and people reacted in a positive manner with staff smiling and chatting together. It was clear staff knew people well and understood how to communicate using gestures, body language and facial expressions.

We saw one person who was becoming upset a staff member immediately approached them smiling and offered out a hand to hold. Another who was constantly wanting to leave the dining room was supported gently to eat a little more with staff using diversion therapy to redirect them to their meal.

We joined people in the dining room at lunch. People were asked if they wanted to wear protection for their clothes before being served their meals. We observed staff demonstrating respect for people by asking what they preferred for lunch, offering choices and alternatives. Staff supported people to eat and drink in a safe manner and to be as independent as possible. Meals were not rushed, people were given time to eat their meal at a pace of their choosing.

Where people were supported to eat in their rooms we saw staff sitting with them at eye level. People were given food only when they were ready of the next mouthful. Drinks were offered regularly. When the meal was finished, staff made sure people were comfortable before leaving them.

During the inspection we saw staff knocked on people's doors before being invited in. Staff ensured doors were closed when they were supporting people with personal care. People were asked if they wished to go to their room when visitors arrived for privacy.

Staff gave us examples of how they promoted people's independence. One staff member told us, "I always make sure they (people) to do as much as they possibly can for themselves." Another told us, "Helping to get dressed but not taking over." We saw staff encourage people to get up unaided when appropriate and to use

mobility aids. We saw staff members cut up food for people but then encouraged them to eat independently.

Information regarding advocacy services was available to people, relatives and visitors. Advocates help to ensure that people's views and preferences are heard.

## Is the service responsive?

### Our findings

We found that some care records did not contain any information and others provided insufficient information to assist staff understand how to deliver the support. For instance, one person's records merely stated, 'I will need help to get into my wheelchair.' Other people's files contained care plans that were no longer accurate and a mixture of old and new information. One person's assessment stated, " [Person's name] has movement in both arms and legs but they cannot walk. They can lift their legs a little". In an evaluation completed several months later it stated, [Person's name] has recently had a stroke and is unable to weight bare."

The care records lacked information about people's lives. Understanding how people had lived their lives is crucial when working with people who lived with dementia. They were not person-centred, as we could not establish basic information such as whether people were married or how to support individuals. We discussed this with the manager who took immediate action to address all the issues we highlighted. They had identified these deficits in the care records and was in the process of working through records and improving them.

Where appropriate people had end of life care plans in place. These gave staff details of people's wishes and how they wished to be supported. We found staff had received training in supporting people at the end of their lives. Compliment cards demonstrated families had been grateful for the care and support provided to their loved ones who had passed away.

We looked at how complaints were managed in the service. The provider had a policy and procedure in place which provided clear information for people who used the service. We found were complaints had been made the manager had responded. Lessons learnt from complaints were discussed at supervision and at team meetings.

The provider employed two activity coordinators to support people with recreation and leisure. We found the coordinators took time to get to know people and spoke with family members to find out more about their lives. We found a range of activities were available in the home such as bingo, singing, dog and pony therapy, exercise classes, card games, artwork and church singing. A singer was entertaining people at the time of the inspection, 18 people had gone along to listen. Two people were dancing, most were singing along, staff were also dancing and singing. Staff interacted with people saying, "Would you like him to sing your favourite old song" and "Are you singing?".

We found people also access the local community. People visited the Salvation Army Dementia friendly café. The activity co-ordinator organised trips to a dementia friendly cinema which stops the films for comfort breaks. They told us, "We have a sister share with a bus but we don't have a driver- my role is to try and get a driver as the resident`s love going out". During the inspection a staff member was identified as a potential driver for the bus.



## Is the service well-led?

### Our findings

The manager told us that since coming into post they had become aware that the service had not operated in line with expected practice. They had been taking action to make improvements, however felt more were needed.

We found the quality assurance procedures were not effective. For instance, the tool the provider had supplied for monitoring health and safety did not identify the issues with the PEEPs and having sufficient staff to evacuate the building. Or that the respite care records did not meet the needs of the service and that the MCA template records were incorrectly designed.

The quality monitoring systems had not picked up variations in the contents of the care records, that some records contained inaccurate information and that the complexity led to difficulty identifying risks and needs.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had submitted their application to become the registered manager and was waiting for their fit person's interview. We discussed their plans for the service and found the manager was committed to driving improvements in Westview Lodge. A rolling development plan was in place which was monitored regular by the area manager during their compliance visits.

People and relatives were happy with the manner the service was managed. One person told us, "The manager and his staff are excellent". Another said, "They are very approachable". One relative told us, "Nothing is a problem, [manager] is always about." Another told us, "Seems to be nice enough, his door is always open."

The manager was supportive of the staff team and took their responsibilities in supporting staff seriously. Processes were in place to ensure staff were supervised and appraised. To ensure staff were skilled and knowledgeable to support people, mandatory training was planned and refresher training organised when necessary.

We asked staff for their views on the management of the service. One staff member told us, "There is good communication, we have staff meetings." Another said, "It's fine. He [the manager] has not been here long but we are getting to know him." A third told us, "We can always speak to [manager] or [unit manager] if we need anything. We are a good team."

We found minutes of regular meetings held with people and relatives. These were recorded and made available for those who could not attend.

An electronic system was available for people and relatives to leave their views and opinions of the service. These were analysed with results made available to the manager in order to address any concerns or issues.

The manager told us, "I welcome any comments good or bad, I want to work to make the home better." Regular team meetings were held. These were recorded and made available for those who could not attend so important information was disseminated to all staff. The minutes of meetings demonstrated these were open and encouraged discussion with the staff team. Ideas and suggestions were acknowledged and discussed during meetings.

The service worked in partnership with many agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not fully assessed the risks to the health and safety of service users receiving care and treatment.</p> <p>Regulation 12 (1)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured systems and processes were operated effectively to assess, monitor and improve the quality of the services provided.</p> <p>Regulation 17 (1)</p>