Barchester Healthcare Homes Limited

Werrington Lodge

Inspection report

Baron Court
Werrington Meadows
Peterborough
Cambridgeshire
PE4 7ZF

Tel: 01733324252
Website: www.barchester.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Werrington Lodge is registered to provide nursing and personal care for people for up to 82 people. People living at the home have physical needs and some of the people live with dementia. Long and short-term stays are offered. At the time of our inspection there were 58 people being looked after at the home.

This comprehensive inspection took place on 19 September 2016 and was unannounced.

The provider is required to have a registered manager as one of their conditions of registration.
A registered manager was not in post at the time of the inspection although the provider had recently appointed a new manager who was yet to start in their new post. The provider told us on 22 August 2016 that it was their aim for the new manager to become registered with the Care Quality Commission (CQC) A registered manager is a person who has registered with the CQC to manage the home. 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.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. The provider aimed to reduce the number of agency staff by recruiting permanent staff into vacant positions. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed. The provider was taking action to improve some deficiencies in the management of people's prescribed medicines to reduce the risk of any harm.

People were supported to eat and drink sufficient amounts of food and drink. They were provided also with choices of food and drink to meet their individual dietary preferences and requirements. People were helped to access health care services. This was to ensure that their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and people were able to make decisions about their day-to-day care. Staff were knowledgeable about the application of the MCA.

People were looked after by staff who were trained and supported to do their job. The provider was taking action to increase the level of individual supervision for all staff members.

People were looked after by kind staff who treated them with respect and dignity. They and their relatives were given opportunities to be involved in the setting up and review of people's individual care plans.

Care was provided based on people's individual needs and helped to reduce the risk of social isolation. There was a process in place so that people's concerns and complaints were listened to and action was

taken to address them.

There were interim management arrangements pending the start of a new manager. The manager was supported by a team of management staff, ancillary staff and a team of nursing and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which ensured they were looked after by suitable staff.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual health and social care needs were met.

People's needs were kept under review to ensure their planned

care was appropriate to their needs.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns. These were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Management systems were in place to ensure that staff were aware of their roles and responsibilities in providing people with the care that they needed.

Quality assurance systems were in place which continually reviewed the quality and safety of people's care.

Werrington Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 19 September 2016 and was unannounced. It was carried out by two inspectors, an inspection manager and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a provider information return (PIR) and sent this to us before the inspection. 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.

Prior to the inspection we made contact with a local authority monitoring officer and a social care commissioner, who was responsible for the placement of some of the people. We also made contact with a speech and language therapist; a community dietician and a tissue viability nurse. This was to help with the planning of the inspection and to gain their views about the management of the home.

During the inspection we spoke with the manager; deputy manager; operations manager and regional director (referred in this report as the 'senior management team'.) We spoke with an activities co-ordinator; one member of the catering staff; a senior member of care staff; seven members of care staff; one registered nurse; a company trainer and a divisional clinical lead nurse. We also spoke with a community assistant dietician; eight people and three people's relatives.

We looked at five people's care records and medicines' administration records. We also looked at records in relation to the management of staff and management of the service, including audits and minutes of meetings. We attended a daily staff meeting to see how information was shared between different internal departments.

We observed how people were being looked after. In addition, we also used 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.

Good

Is the service safe?

Our findings

People's relatives told us that their family members were kept safe. One relative said, "I have confidence in them [staff] all. We know that [family member] is safe and we don't have to worry." We saw that people engaged freely with staff members which told us they felt safe to do so. We also saw how staff helped one person with their moving and handling needs via means of a hoist. We found the person was comfortable and at ease throughout this procedure.

There were arrangements in place to keep people safe from the risk of harm. Staff were trained and able to demonstrate their knowledge about safeguarding people from harm. They were able to describe the different types of harm. They were also able to describe the signs and symptoms of when a person may be being harmed. One member of care staff said, "They [person] could become withdrawn. Have bruising. Loss of appetite." Another member of care staff said, "There could be a change in their mood." Members of staff, which included ancillary staff, were aware of their roles and responsibilities in reporting such untoward incidents. This was reporting to their manager or to external safeguarding agencies, which included the police and the local safeguarding authority.

Information detailed in notifications also told us that the provider was aware of the correct reporting procedures for safeguarding incidents. This included sharing safeguarding information with both the CQC and local authority. The notifications also provided the information regarding the measures taken to reduce the likelihood of a similar occurrence. This included, for instance, involving GPs to review the time of when people were to receive their prescribed medicines. The aim of this was to reduce the risk of people not having their medicines at the prescribed time.

In their PIR the provider told us how people were kept safe from employing unsuitable staff. They wrote, "From application all candidates are screened to a high standard without exception." Staff members confirmed that they had all the required checks before they were allowed to work. One member of care staff said, "First I had a DBS [Disclosure and Barring Service police check] and they [provider] asked for two references from where I used to work. And an application form and an [face-to-face] interview." The deputy manager also described their recruitment experience. They said, "I had a DBS. References; I think two or three; my NMC [Nursing and Midwifery registration] check. Employment history. And two interviews. All before I started."

We found that people were looked after by sufficient numbers of staff. The home had a calm atmosphere because people were being cared for by unhurried staff. We also saw the people, who were living with dementia, had a member of staff present at all times when in the communal lounge. This was to keep them safe. Staff members told us that there was usually enough staff. The deputy manager said that there had been a recent increase in numbers of care staff to meet people's increased level of needs. The manager told us that a staffing tool was used to assess people's needs and matched these against the required staffing numbers.

The provider told us in their PIR that agency staff were used to supplement the 11 staff vacancies. We saw

that agency staff were working and who had worked at the home on a number of occasions. One member of permanent care staff said that when experienced agency staff worked, this was not an issue. However, when less experienced agency staff were used, they had found their work became more difficult and stressful. The senior management team told us that there was on-going recruitment of permanent staff. This would result in the reduction of agency staff. The manager said, "We have increased permanent staffing [numbers]. To get a good team of stable team of staff, we've recruited four registered nurses." One member of care staff said, "Staffing is alright at the moment. When we were a bit short [of staffing numbers] we used agency [staff]. It's much better now as there is less [fewer] agency [staff]."

The local contracts monitoring officer also told us that there was a high use of agency and bank staff due to not only staff vacancies but staff absences. They added it was unclear how staff absences were being managed and monitored. Because of this information we decided to explore this further. The senior management team described the procedures in place for managing staff sickness. This included reviewing frequencies of staff absences and monitoring improvements in staff attendance. The provider's staff disciplinary policy and procedures were in place and were used, if needed. The manager told us that this system was "working" to reduce the levels of staff absences. The senior management team advised us that there was an incentive award to motivate staff and reduce the numbers of staff leaving.

People's risks were assessed and these were managed to mitigate the level of risks. Staff demonstrated their knowledge about people's risks. One member of care staff said, "Assessing risks is really important. There are risks for choking and knowing what type of diets people are on [and need]." Another member of care staff described how they looked after people who were assessed to be at risk of choking. They said, "I use a teaspoon to measure the amount of thickener I add to their [people's] drinks. And they have pureed food. We also have to make sure they [people] are sitting up and not slouching, when they are eating or drinking." The registered nurse told us about the management of people's risks of developing pressure ulcers. They said, "We use the [name of assessment] tool. We also do head-to-toe skin inspections to assess the risk of skin breakdown. And we use equipment, such as pressure-relieving mattresses and cushions. We also help people reposition. Repositioning depends on the person's skin integrity and their ability to move themselves. If they are very frail they are repositioned every two hours." One member of care staff told us that they would inform the registered nurses if they found people's skin was marking. They also said that people who were at high risk of pressure ulcer development were repositioned "every two hours."

People's prescribed medicines were managed safely with the provider taking actions to increase the safety of this care practice. We saw that people were helped to take their medicines by registered nurses in a patient and caring way. The senior management team advised us that the registered nurses had or were being assessed to be competent with the management of people's medicines. The storage and security of people's prescribed medicines were satisfactory. We found, however, shortfalls in the recording of some people's medicines administration records [MARs]. The use of codes for the application of prescribed creams and thickening agents for drinks was confusing. It was unclear if people had their creams applied as prescribed and if the creams and thickening agents were added together – which they should not be. However, the deputy manager assured us that people had their creams and thickeners as prescribed although the MARs failed to support this. Furthermore, the 'as required medicines' [PRN] protocol for the use of sedation, lacked detailed guidance to enable registered nurses. This would enable them to know at what stage this PRN medicine should be given to the person. Nevertheless, the provider had carried out audits on people's medicines. An action plan had been developed to rectify these and other shortfalls. The regional director told us that the action plan was on-going as not all of the remedial actions had yet been completed.

Good

Is the service effective?

Our findings

We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 [MCA]. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider told us in their PIR that applications to lawfully deprive some of the people, in the least restrictive way as possible, was lawful. We found that people were being looked after in the least restrictive way and based on assessment of their risks. This included, for example, the use of recliner chairs and bedrails.

Members of staff were trained in the application of the MCA and demonstrated their knowledge about this piece of legislation. One member of care staff told us how they looked after people, who were assessed not to have mental capacity. They said, "[The MCA] is when a person does not have the ability to make a choice, then we help make their choice [for them]." The deputy manager expanded on this and said, "The MCA is about any cognitive impairment that impairs people's judgement and decision making. If they are not able to retain or understand information. Any inability to make complex decisions about their health and well-being. We put in risk assessments and we also act in people's best interest. We involve the GP, the person if possible and their relatives to make best interest decisions." Care records demonstrated that people's mental capacity was assessed and best interest meetings were held with a GP and people's relatives. This included, for example, end-of-life treatment in relation to resuscitation. The manager was aware of the need to review these specific documents in line with a recent court judgement ruling.

The manager said, "We are on a programme of reviewing all of the DoLS." They had found that some of the authorised DoLS were out-of-date, or DoLS applications had not been made. The manager told us that they had taken remedial action to rectify this issue. This included making further and new DoLS applications to the appropriate authorising agencies.

We found that staff were trained to do their job. The provider told us in their PIR that, "Our staff team are trained, by an in house trainer who delivers a wide range of training in order for the staff to be able to meet the needs of the residents [people who use the service]… The home [company] trainer has a robust plan to ensure that staff are trained." The PIR also provided information about the induction training of new staff. This included completion of a nationally recognised training programme known as The Care Certificate. Staff told us that they had attended a range of training which included health and safety; moving and handling and infection control. The home trainer said that on the day of our visit, sixteen members of staff

had attended induction and refresher training, as appropriate.

The induction also included dementia training and, once staff had attended theoretical training, they 'shadowed' more experienced members of staff. The manager said, "We had two staff on induction last week and they will be doing 'shadowing' this week." Training records showed that staff attendance was recorded and reviewed. The company trainer told us that arrangements were in place to increase the numbers of staff attending training in dementia awareness. This included some staff who will be attending train the trainer training in dementia care during October 2016. They will then be able to cascade this training to other staff members.

We checked to see how well staff were supported to do their job. The local contracts monitoring officer told us that there was insufficient evidence to show how staff were being supported. They also told us that there was a lack of records to demonstrate that staff were supervised and had an appraisal of their work and development needs. The provider told us that, "Supervisions and appraisals had not been managed as robustly in the last year, partly due to a number of leadership changes within the home." However, the information recorded in the PIR provided us with assurances that such deficiencies were being dealt with. The PIR read, "A stronger more robust management of appraisals and supervision's across the staff team." The PIR also told us about how the development and management of registered nurses [RNs] was to improve. The PIR read, "The RNs have historically been micro managed to a point where some of the autonomy has been removed. We now have a deputy manager in post who has the skill set to train and develop our nursing and care team which will empower them and help take this service [home] forward." Records showed that some but not all members of staff had attended a one-to-one supervision. The deputy manager advised us that they were aiming to carry out such supervisions and said, "Staff support and supervisions are very important to me." They added that they were to attend training in supervision before they started to provide one-to-one staff supervision.

Staff members told us that they felt supported to do their job although this sometimes varied. One member of care staff said that working with less experienced agency staff was stressful. However, they added that their support came from the manager and permanent staff members. The divisional clinical lead nurse said, "The staff here are all very caring and pull together as a team."

We found people's nutritional health was being maintained. A community dietician, who specialised in improving overweight people's health, prescribed intentional weight loss programmes. They told us that staff had followed their prescribed advice. This resulted in the person losing weight as part of their planned care and with their consent. The member of catering staff described how they baked, rather than fried, hash browns as a healthier way of cooking this type of food. The community dietician also confirmed that they had no concerns about how people's nutritional needs were being met. A visiting community assistant dietician told us that the staff followed their advice in relation to maintaining or improving people's nutritional intake.

People's weights were monitored and the frequency of these was based on the person's nutritional risk assessment. We found that when people had experienced unintentional weight loss, they had been referred to the community dietetic service. The community assistant dietician told us that in between their visits, a named registered nurse had telephoned them for additional dietary advice.

If needed, and based on people's nutritional risk assessments, people's food and drink intake was monitored. When people were not able to be independent with eating and drinking, members of care staff helped people with their food and drink. We found that people were given enough to eat and drink throughout the day. The catering manager told us that there was a twenty-four hour food service available,

which included snacks and sandwiches during the night. They told us also that they prepared food which was fortified with added butter, for example. We saw 'buttery' creamed potatoes served to people during the lunch time. The member of catering staff told us that information about people's food and drink likes and dislikes was obtained during the pre-admission assessment. Information for staff in relation to these people's preferences was available in their care records and in the main kitchen area.

People's choices and dietary preferences and needs were catered for. During lunch time we saw that people were offered choices of what they liked to eat and drink. The member of catering staff told us that people were able to have alternative menu options. They gave examples of this, which included scampi and sweet jacket potatoes.

We checked and found that people's health was being maintained. The provider had submitted to us notifications in relation to some people who had developed pressure ulcers before their admission or when they were living at Werrington Lodge. Information in the notifications told us about the effective management of the pressure ulcers with evidence of healing.

Before our visit we had been informed by members of the local authority that members of staff had not followed the prescribed care plan guidance provided by a tissue viability nurse [TVN]. Nonetheless, since that time, we received positive comments from a social care professional who told us that they had observed improvements in how people, with this risk and condition, were being looked after. The TVN also had similar positive comments to make. They told us that they had no concerns and that staff were operating and using pressure-relieving equipment correctly. Our observations told us that people were supported to maintain their skin integrity with the use of pressure-relieving aids. We also saw people were helped to move from their wheelchairs to more comfortable seating. At the time of our visit there was no person who had acquired a pressure ulcer whilst living at the home.

We received less than positive comments from a community speech and language therapist [SALT] in relation to staff not previously following their prescribed planned care. Because of these comments we explored this area of care further. We found that people's care planned by the SALT was being followed. Members of care and catering staff were aware of people's individual dietary needs. This included the use of thickening agents added to people's drinks and food made into an easy-to-eat consistency.

People were supported to access other health care services. These included diabetes services; podiatry and psychiatric services. We found that people's diabetes was being managed well. For example, in one person's care records we found that their blood sugar was monitored and their prescribed amounts of administered insulin kept these within a healthy range.

Good

Is the service caring?

Our findings

People's relatives told us that their family member was treated well by kind staff. They told us also that they felt "welcomed" by staff when they visited. We saw some good examples of how well people were cared for. For instance, one member of care staff was making sure that a person was comfortable whilst sitting in their wheelchair. We also saw two members of care staff talking continually to a person, in a reassuring way. This was during a moving and handling procedure by means of a hoist. Other examples included members of care and nursing staff holding hands and talking to people in a patient and social way, during and between times they were looking after them.

Members of staff were aware of the principles of good care. One member of care staff said, "We don't have to treat everyone the same. It's about making a difference to people's lives. Making it like people's homes. To be a friend and for people not to feel alone." Another member of care staff said, "My job is to look after people. To make sure that they are as independent as possible. Give them a lot of choices. When they want to get up, go to bed. What they want to wear. To have a shower or a bath." The staff member confirmed that they were able to offer people such a range of choices. The activities co-ordinator also demonstrated a caring attitude in looking after people. They said, "I'm privileged to have a job like this."

The premises maximised people's independence, privacy and dignity. We saw that there was a call bell system in place for people to call for help, if they were able to use this equipment. Relatives told us that their family member was not able to use this piece of equipment. However, they said that staff were "always popping in and checking" their family member, to make sure they were comfortable and safe. All rooms, which included the one double room, were used for single occupancy. Communal and bathing facilities were provided with lockable doors to ensure that people's personal care was provided in private. We saw that when people were having help with personal care, staff ensured that this was carried out behind closed doors. We also saw members of staff knock on people's doors, wait for a response if appropriate, before entering.

People's right to independence was valued. This included when eating, drinking and walking about. Care plans demonstrated that people were encouraged to be independent with their personal care. This included, for example, washing their hands and face and for men, shaving their facial whiskers.

People's choices and how they wanted to spend their time were valued. People were offered choices of what they wanted to eat, drink and the recreational activities they wanted to take part in. We saw that people's dignity was upheld because people were dressed in clean clothing. In addition some of the people were provided with protective tabards when eating and drinking.

Care records showed that people were able to maintain family relationships. The daily records provided evidence of when people received their guests. This was in the quiet and privacy of their room or in communal areas. We saw people had visitors during the lunch time. We saw relatives helping their family member with eating and drinking. Respite care was also provided. This was to enable the person's main carer [often a family member] to have a break. This type of care enabled people to continue to remain living

at home.

Advocacy services were used and information about these independent services was publicly available for visitors and staff to access. Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's individual needs were met. Relatives told us that, although sometimes there was "a bit of a delay" they were satisfied with how their family member's continence needs were met. The deputy manager told us that at times they had been some delay in meeting people's needs due to staffing numbers. However, they told us that this issue was resolving due to an increased number of permanent staff and reduction of agency staff. This, they said, forged more organised, team working in order to meet people's needs in a timely way. One member of care staff told us how they looked after one person who had a high level of complex mental health needs. They said, "You have to talk quietly and keep talking to [name of person]. The calmer you are, the calmer [person] is. They [person] will let you do it [personal care]. It works."

We found that that there was an assessment and review process in place to ensure that Werrington Lodge was a suitable place for prospective people. Pre-admission assessments were carried out, with care plans being subsequently developed based on the initial assessments. The records showed that the planned care was kept under review and action was taken in response to people's changing needs. The manager told us that some of the people's needs were being reviewed. They said, "It has been a thing we have looked at. We have been finding out about people's needs. We've been talking to staff and visiting health care professionals. We are looking at how we can look after people." They gave examples of reviews of people with high levels of complex mental health needs. They said that these were being carried out in collaboration of external health and social care professionals.

Internal reviews of people's planned care were carried out during monthly evaluations of people's needs and risks. These were kept up-to-date to ensure that the planned care was meeting people's needs. When changes in people's condition were identified, action was taken to ensure that the person was provided with care that met their changed needs. This included the involvement of external health and social care professionals to guide staff in how to meet people's changed needs. It was unclear, however, if people and people important to them, were actively involved in more formal reviews of people's planned care. In only one out of five people's care records we found evidence that the person's relatives were involved in the formal review process. The senior management team advised us that they were aware of this deficiency when people's care records were audited. They assured us that remedial action was to be taken in relation to this issue.

We checked and found people were treated as unique individuals. Information about people's life histories was recorded and staff were aware of these. One member of care staff said, "We have their [people's] life histories. So we know what they used to like doing and what they liked to eat and drink. We get this information from their relatives." The senior member of care staff told us the level of support individual people needed to eat and drink. We also heard them talking to one person about their lunch and it was clear that they knew about the person's dislike of eating fish.

To promote people's sense of well-being they were provided with a range of recreational activities which were meaningful to them. The activities co-ordinator told us that they spoke with people to find out what interested them. The also said that some of the people were, due their frailty, unable to leave their room.

They were, therefore, provided with a one-to-one activity. The activities co-ordinator said, "Sometimes just holding hands and talking to them." They told us also that group activities took place which included visits from external entertainers and individual activities of hand massages and colouring. The activities co-ordinator gave an example of how one person's well-being increased as a result of the activities they had taken part in. They said that the person was happier and enjoyed spending time in this recreational pursuit. We saw that some people, who were living with dementia, were holding dolls and gaining some comfort from this activity.

We found that the provider had a complaints policy and procedure in place. Relatives told us they knew who they would speak with if they had a concern or complaint to raise. One member of care staff told us that if any person, including visitors, wanted to complain, they would listen and take the concern to the manager. The record of complaints showed that people's concerns and complaints were responded to. Remedial action was taken, if needed to improve the quality of people's care. This included, for example, putting arrangements in place for staff to attend further training in dignity in care.

Good

Is the service well-led?

Our findings

There was no registered manager in post when we visited. The last registered manager left their position on 23 March 2016. The SALT told us that, "We are attempting to develop positive working relationships with the care home and foster good practice, but unfortunately have not had a positive experience this year." Since 23 March 2016 there has been interim management arrangements put in place. This included a temporary manager who was experienced and a registered nurse. This was until the start of a new manager. The regional director advised us that once a new manager has started it was their expectation that the registered manager's vacancy would be subsequently filled. Some members of staff told us that they had experienced a number of management changes. One member of care staff said, "Work is okay as long as you don't keep having different managers. There's been a lot of [manager] changes. They don't stay long. It's difficult."

We received positive comments about the interim manager, who was frequently described as "approachable". Members of staff said that the manager was often seen walking around the home. This was to ensure that staff felt supported and were providing people with appropriate and safe care. One member of care staff said, "You see [name of manager] on the floor [walking around the home] and asking how things are going." Another member of care staff said, "The manager makes us feel worthwhile. We feel valued."

The provider submitted their PIR when we asked for it. The management team of the home had also sent in required notifications, which included notifications to let us know of authorised DoLS applications. In addition, information detailed in the notifications showed the remedial actions taken to reduce the likelihood of similar, preventable events. This included for instance, medicines errors and the reassessment of responsible staff's competencies. This told us that they were aware of their legal responsibilities as a registered provider and that remedial actions were taken, respectively, to improve the safety of people's care.

There were systems in place to improve the quality and safety of people's care. This included, for instance, audits carried out in relation to people's care and medicines. Remedial actions were taken or being taken to improve the quality and safety, respectively, of people's care. Another quality assurance audit was to ensure that staff were up-to-date with their training. The provider told us in their PIR that in the event that trained staff failed to fully apply their training into practise, they were required to attend further training. For instance, they attended moving and handling refresher training. Information in the PIR told us that it was the provider's aim to improve the management of staff; to increase the staffing numbers and reduce the use of agency staff; and to have a permanent manager in post.

Other quality assurance systems included asking people for their views about the food. The member of catering staff told us that they had consulted with people about menu choices. In response to the suggestions people had made, changes were made or being made to the menu. This included, for example, providing seasonal menus in response to summer and winter times. The winter menu was planned to have "bulkier" foods which would be in keeping with the colder weather.

Staff were consulted about their working conditions. This was by means of a survey which the provider

carried out during 2016. Actions points were made to improve staff morale and their working conditions. The actions included, for example, the introduction of award incentive schemes and holding staff meetings. Staff told us that they attended monthly staff meetings during which they were able to make suggestions to improve the quality and safety of people's lives. One member of care staff told us that the manager had approved their request to have replacement recliner chairs for people. The member of catering staff's suggestions to change the times of when lunch was served on one of the units was supported by the manager. As a result of this changed time, there was more time for staff to ensure that people had their lunch in an unhurried and calm atmosphere.

Another staff meeting was held each day when a range of staff attended to report back to the manager. Those attending included representatives from catering, nursing, care and maintenance departments. We saw that staff reported, to the manager, on progress of their work, which included, for instance, maintenance and health and safety issues. We saw that the meeting provided staff time to share information between each other and fostered a sense of team spirit. One member of care staff said, "At team meetings we have really nice conversations. The manager asks us how they can help us. People [staff] were just not working together. Now we are."

We checked and found that people and people who were important were asked for their views and suggestions. The PIR read, "Werrington Lodge hold (sic) regular meetings for service users [people who use the service] [and] families… These meetings provide valuable feedback and initiate necessary changes into our service. At a recent relative meeting it was decided that we have a suggestions box in the entrance for communications/ideas about the service [home]. This was actioned the following day…"

Staff were aware of the whistle blowing policy and when this would be used. One member of care staff said, "If there is anything I see out of order or a member of staff doing something wrong we have a 'phone line we can use to get it rectified." Another member of care staff said, "Whistle blowing is when you actually see a resident [person] being harmed. First you have to make them safe and then report it. We have a 'hotline' we can use." Staff told us that they would have no reservations in raising such concerns. This showed that there was an open and transparent culture in the management of the home.

To promote links with the community, a volunteer supported people with their recreational activities. The operations manager described their recent experience of making contact with pupils from a local college. The aim of which was to forge more links with a community based facility. This showed that the provider aimed to improve upon it's ethos of open and transparency.