Meridian Healthcare Limited

Westwood Lodge

Inspection report

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Ratings

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

Overall summary

This unannounced inspection was carried out on the 17 March 2015 with a further announced visit on the 16 April 2015.

Westwood Lodge Care Home is a purpose built home with three units, which provides nursing and personal care for up to 76 people. It is situated in a residential area of Wigan and is about five minutes drive from Wigan town centre. All rooms are for one person and they all have a toilet and a hand wash basin. The home is situated in its own grounds and has gardens with car parking spaces at the front of the home.

There was a registered manager in place at the time of our inspection. 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.

At the last inspection carried out in September 2014, we identified concerns in relation to staffing levels and the management of medication. As part of this visit, we checked to see what improvements had been made by the home to address these concerns.

Summary of findings

During this inspection, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to new regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

During our last inspection in September 2014, we judged the provider to be in breach of Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, because the provider did not have appropriate arrangements in place to manage the administration of medicines. We found that people were still not protected against the risks associated with the unsafe use and management of medicines.

We found the home had processes in place for all aspects of medicine handling, however we found some staff were not consistently following procedures.

We saw evidence that medicines which needed to be taken before food being given after breakfast and lunch time meals. Failure to administer medication as directed could affect how the medicine worked or cause unwanted side effects.

From looking at records, we found that two people had run out of their medicines. We found the procedures for reordering medicines had not been followed. We also found that on one unit, staff were failing to store insulin pens that were currently being used at the correct room temperature.

Nurses told us that they felt the medicines round was difficult particularly in the morning when there were often various other disruptions. The use of 'do not disturb' tabards had not made any difference and that they did not have time to spend with people that required support with their medicines. We were also told that nurses felt unable to plan the medicines around people's needs due to the volume and other tasks that were required.

We found the registered person had not protected people against the risk of associated with proper and safe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

During our inspection, we spoke with one person who was living in the nursing unit known as 'The House,' who was suffering with a contagious infection. The care plan for this person clearly stated that 'barrier nursing of the patient' should be put in place. However, we could see no visible evidence that this was the case.

We were also unable to see any hand sterilising gel or guidance advising other people or visitors that 'barrier nursing' was in place and the actions that they were required to take in order to reduce the risk of cross infection.

We found the registered person had not protected people against the risk associated with spread of health care associated infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

When speaking with relatives and people who used the service we were consistently told that there was a problem of understaffing throughout the home. We noted that a student on work experience had been left alone with between nine and eleven people during this period. Our observations indicated the student was being used by staff as a 'minder' for people in the lounge which was unsafe practice.

Both nurses and care staff told us they believed there were insufficient numbers of staff on duty. Care staff felt that the care staffing levels were very poor and felt that management planned staffing on the numbers of people who used the service as opposed to individual dependency needs.

At 10.25am a person who used the service asked to go to the toilet just as two care staff were transferring another person who wanted to use the bathroom. The student who was present in the room spoke to the person and said that as soon as the care staff had finished they would attend to their needs.

Summary of findings

At 10.40am the two members of staff returned to the lounge. However we found the person had to tolerate the indignity of wetting themselves as there were no qualified staff to support them using the toilet when they required it. One member of staff told us; "We usually have two carers on each corridor which is not enough. People have to wait to be toileted, turned or sat up in bed, it's not good enough."

In relation to providing planned care, we looked at the Service Communication Book for week commencing 09 March 2015, which showed that seven people who were living in nursing unit located in The House, did not have an assisted bath/shower that week. We spoke with staff about this concern. Staff told us this was not due to the person's preference, but due to the lack of time available to them. They found it frustrating that they were not able to meet the hygiene needs of these people.

We found staffing arrangements did not protect people from the risks associated with inappropriate or unsafe care, because care was not delivered in such a way to meet people's individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care.

Westwood Lodge provided care for people coming to the end of their lives due to deteriorating palliative illnesses. The home was part of the National Gold Standards Framework for end of life (EoL) care, which enabled people to have a comfortable, dignified and pain free death.

We could not find any evidence that confirmed training or a competency measurement framework around safely caring for a person who was attached to a syringe driver during EoL care. We spoke to management team and nurses about end of life care and were unable to obtain assurances that safe and consistent syringe driver care was being delivered by the service. We found the service could not provide us with a policy or procedure that would support staff to deliver a safe and consistent level of care. When we spoke to staff we received conflicting responses about EoL care.

Both management and staff confirmed individual nurse competencies around managing EoL care was not measured by the service.

We found the registered person had not protected people against the risk of associated with the safe delivery of EoL care, . This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. However, as a result of the concerns we identified around medication, infection control, meeting people's individual needs and EoL care, it was apparent the service was not effectively assessing and monitoring the quality of service provision.

We found the registered person did not effectively monitor the quality of service provision. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We reviewed a sample of recruitment records, which demonstrated that staff had been safely and effectively recruited.

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. On the whole, staff told us they felt fully supported in their roles and were valued by management. One registered nurse told us; "I feel we get plenty of support and training. I do feel valued. The management are like friends to us so we can speak easily about any concerns we have." We looked at training records to confirm what training staff had received. This included; National Vocational Qualifications (NVQ), manual handling, health and safety, infection control and safeguarding adults.

We spoke to a senior visiting health care professional from the local hospital, who spoke very favourably of the services provided by the home. They told us the model of

Summary of findings

care at the home had been excellent and they were very pleased with the services they received. They had a large team that visited the home to support patients and they had never received negative feed-back about the service.

We saw there were procedures in place to guide staff on when a Deprivation of Liberty Safeguards (DoLS) application should be made. We spoke to the registered manager, who was able to demonstrate that the service had submitted a number of applications in line with guidance from the local authority. We spoke with staff to ascertain their understanding of the Mental Capacity Act (2005) and DoLS. We found that they all demonstrated an underpinning knowledge regarding this legislation.

We found the home did not have signage features that would help to orientate people living with varying degrees of dementia. We have made a recommendation about environments used by people with dementia.

We observed staff offering a choice of hot and cold drinks to people and asking them whether they wanted to wear an apron to protect their clothing. We saw that a three week menu was displayed on the dining room wall though it did not represent what was being served on the day of our inspection.

On the whole, people who used the service told us that staff were kind and considerate. One person who used the service said “The staff will do anything for you, but there’s not enough of them.” Another person who used the service said “Bless them, nothing is too much trouble for them.” A visiting relative of a person coming to the end of their life said “We have never had any concerns regarding the care. The staff are great and also update you on any changes.”

We looked at one care plan which documented that one person who used the service had five Grade 4 pressure sores on various areas of their body. The documentation advised that these were present on the transfer of the person from another care provider. We found that these were safely documented within the care plan and suitable wound management plans for each area had been completed.

We were told by the registered manager that the service employed an activities coordinator who was currently on leave. On the day of our inspection we saw limited physical and mental stimulation for people who used the service.

We looked at minutes from family and residents meetings that had taken place. People had also completed a customer satisfaction survey in 2014. The result of which had been analysed by the provider and included areas such as overall satisfaction with service and likelihood to recommend.

Staff told us they believed there was an open and transparent culture within the home and would have no hesitation in approaching managers about any concerns. However, some staff stated that while the managers were very approachable, they were not proactive in dealing with issues or personal problems.

We looked at minutes from staff meetings. These included external professionals meetings, nurses and housekeeping. We found minutes to be detailed and included topics such as medication, internal audits and handovers.

We found the provider had been accredited with a Gold Award for Investors in People recognition.

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?

Inadequate

The service was not safe. As part of this inspection we checked to see what improvements had been made with the management of medication. We found that people were still not protected against the risks associated with the unsafe use and management of medicines.

Infection control systems were not effective for managing the spread of infections. One person, with a contagious infection required barrier nursing and we found no evidence of this being in place.

When speaking with relatives and people who used the service we were constantly told that there was a problem of understaffing throughout the home. We found staffing arrangements did not protect people from the risks associated with inappropriate or unsafe care, because care was not delivered in such a way to meet people's individual needs.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective. We found that the registered person had not protected people against the risk of associated with the safe delivery of end of life care. This was in relation to ensuring staff had the necessary qualifications, competence, skills and experience to do so safely.

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. On the whole, staff told us they felt fully supported in their roles and were valued by management.

We found the home did not have signage features that would help to orientate people living with varying degrees of dementia. We have made a recommendation about environments used by people with dementia.

Is the service caring?

Requires Improvement

Not all aspects of the service was caring. On the whole, people who used the service told us that staff were kind and considerate.

People told us that though staff were caring they were often too busy develop positive caring relationships.

We observed where a nurse approached and communicated with a person in a manner that resulted in the person becoming upset and agitated.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive. We looked at a sample of nine care files. All care plans provided instructions to staff on the level of care and support required for each person.

Summary of findings

We were told by the registered manager that the service employed an activities coordinator who was currently on leave. On the day of our inspection we saw limited physical and mental stimulation for people who used the service.

We found the service did listen to people's concerns and experiences about the service. The provider had effective systems in place to record, respond to and investigate any complaints made about the service.

Is the service well-led?

Requires Improvement

Not all aspects were well-led. The service undertook a range of audits, however it was apparent the service was not effectively assessing and monitoring the quality of service provision.

Staff told us they believed there was an open and transparent culture within the home and would have no hesitation in approaching managers about any concerns. However, some staff stated that while the managers were very approachable, they were not proactive in dealing with issues or personal problems.

We looked at minutes from staff meetings. These included external professionals meetings, nurses and housekeeping. We found minutes to be detailed and included topics such as medication, internal audits and handovers.

Westwood 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 checked 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 unannounced inspection took place on 17 March 2015 and was followed by a further announced visit on the 16 April 2015. The inspection was carried out by one adult social care inspector, a Specialist Advisor who was a pharmacist and another Specialist Advisor in nursing. The inspection team also included 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.

We also reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority quality assurance and commissioning teams. We reviewed previous inspection reports and other information we held about the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

At the time of our inspection there were 68 people who were living at the home. There were 20 people who were living on the Community Nursing Beds Unit, situated on the ground floor. There were 25 people living on the nursing unit located on the first floor and 23 staying in the nursing unit known as The House. We spoke with 16 people who lived at the home, 11 visiting relatives, one visiting health care professional and a member of the clergy. We also spoke with seven nurses, 11 members of care staff, two cleaners and a student on work experience. We also spoke to the registered manager, the deputy manager, the regional manager and the service bed manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Throughout the day, we observed care and treatment being delivered in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and laundry rooms. We looked at the personal care and treatment records of people who used the service, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the service.

Inadequate

Is the service safe?

Our findings

On the whole, people told us they felt safe and secure at Westwood Lodge. One person who used the service told us; "I feel completely safe knowing that there are many other people here. I don't feel insecure in anyway." Another person who used the service said "I feel totally settled in my room at night and feel confident that someone will come if I press my bell."

During our last inspection in September 2014, we judged the provider to be in breach of Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, because the provider did not have appropriate arrangements in place to manage the administration of medicines. As part of this inspection we checked to see what improvements had been made. We found that people were still not protected against the risks associated with the unsafe use and management of medicines.

We looked at 15 medication administration records (MAR) and seven care plans and observed medicines being given on all three units at the home. We found management had taken actions following our last inspection. Staff had received training and their skills had been assessed by the service. We saw the service medicine's policy had been reviewed and all staff had been given a copy together with their professional Nurses and Midwifery Council (NMC) guidance.

We found the manager had implemented audits and bi-monthly checks, some of which were undertaken by an external person from within the company. The management team had implemented an action plan to address the previous concerns we identified from our last inspection.

We found the home had processes in place for all aspects of medicine handling, however we found some staff were not consistently following procedures. For example, recording the date of opening eye drops to ensure the medicine is not used past its 28 day shelf life and clearly recording variable dose medication when often a dose of one or two is prescribed. We looked at memos sent to all staff reminding them of correct procedures to follow. We found that improvements had been made in respect of topical cream administration and handwritten entries on MAR charts which had been checked. The MAR charts we looked at had been completed accurately with no gaps.

Improvements were required to ensure medication was administered in line with specific warning information found on the label of medicines. For example, the medicines Lansoprazole and Flucloxacillin should be taken 30-60 minutes before food. We saw evidence of these medicines which needed to be taken before food being given after breakfast and lunch time meals. Failure to administer medication as directed could affect how the medicine worked or cause unwanted side effects.

Two nurses we spoke with could not describe their resident's needs as they did not know the people on the unit and records did not show enough consideration of peoples' needs around medication. One person was prescribed two pain relief medicines for 'when required'. There was no information about the person's condition or treatment plan for the 'when required' medicines. Another person was prescribed two emollient creams and the nurse had to ask the person where each cream was for as there was no supporting information.

The home had processes in place to support people taking their own medicines, but we found people with their own inhalers in their rooms without any risk assessment in place. We found that nurses were also signing administration records for these people, though it was unclear to us how often the inhaler had been taken. We found treatment creams were stored in people's rooms without consideration of a risk assessment in place.

From looking at records, we found that two people had run out of their medicines. We found the procedures for reordering medicines had not been followed. We also found that on one unit, staff were failing to store insulin pens that were currently being used at the correct room temperature. These insulin pens were stored incorrectly in the fridge and we found the fridge temperature on the day was minus two degrees. Administering insulin that had been stored at this temperature could make the injection painful and make it less effective.

Nurses told us that they felt medicines round were difficult particularly in the morning when there were often various other disruptions. The use of 'do not disturb' tabards had not made any difference and that they did not have time to spend with people that required support with their medicines. We were also told that nurses felt unable to plan the medicines around people's needs due to the volume and other tasks that were required, such as insulin injections and PEG feed administration. Staff also told us

Is the service safe?

that these concerns had been previously raised with management but nothing had changed. One agency nurse told us that they felt the volume of the round was challenging and was too much for one nurse, especially when they didn't know the people who used the service.

We found that the registered person had not protected people against the risk of associated with the safe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

During our inspection, we spoke with one person who was living in the nursing unit known as 'The House,' who was suffering with a contagious infection. They had come to live at the home six days prior to the inspection. The care plan for this person clearly stated that 'barrier nursing of the patient' should be put in place. However, we could see no visible evidence that this was the case. We could not see near to or in the person's room any of the standard Personal Protection Equipment (PPE) required to promote effective barrier nursing. Nor could we see a clinical waste bag or a red infected linen skip. We were also unable to see any hand sterilising gel or guidance advising other people or visitors that 'barrier nursing' was in place and the actions that they were required to take in order to reduce the risk of cross infection. We discussed this matter with management to ensure immediate action was taken to address our concerns.

We found that the registered person had not protected people against the risk of associated with spread of health care associated infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

During our last inspection in September 2014, we judged the provider to be in breach of Regulation 22 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, because people who used the service were at risk due to insufficient numbers of suitably qualified staff on duty. During this inspection, we looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe.

We looked at staffing rotas and a staffing levels calculator that the service used to determine staffing levels throughout the home. The registered manager told us that in determining staffing levels, they looked at the dependency level of each person who used the service and applied the staffing level calculator. Additionally, if they felt they needed more staff to meet people's needs they would increase staff numbers and also reallocate staff between units to meet increased demands.

When speaking with relatives and people who used the service we were consistently told that there was a problem of understaffing throughout the home. Comments from people who used the service included; "There isn't enough staff here. They can't come to help because there's only two staff on and they have the other side to look after. I do have to wait for help. I rang my bell in my room yesterday at 9 o'clock and they didn't come till 10 o'clock to help me." "I feel safe in here because I've got a buzzer, but there isn't enough staff and I have to wait for things to be done. I'm having to wait so long to be got up in the mornings. I'm the last they get round to get me out of bed. It upsets me and I have to shout and make a fuss. It even makes me cry having to wait so long to be got up."

One person who used the service told us; "They woke me up at half past six. Then they didn't come back till 7 o'clock. I didn't get a drink or breakfast till 9 o'clock. There's a lot of residents and not enough staff to look after us. The student comes in two days a week. She goes to our floor. When it's busy downstairs she has to go there. We have to watch out when we need a carer coming in and snatch them. Trouble is you forget what you need by the time they are passing you. They're very short staffed." Another person who used the service said "There isn't enough staff. They are always in a rush. Every now and again I'm left too long before they see to me." Other comments from people who used the service included; "I have medicine in the mornings. Sometimes they are late giving them to me. I don't know what medicines I have at the moment. The staff sort that out for me. Sometimes they could do with a bit more staff. They're always busy. I sometimes wonder if they have enough staff to cover the needs of people."

One visiting relative told us; "Staff come in to see to her or I ask them to see to her. Sometimes they are busy and I have to wait to get their attention. She's been in two or three other places and I think this is the best, but there isn't enough staff. There isn't enough staff to attend to her. She

needs quick attention which she doesn't get. She ended up in A & E because staff didn't come when she buzzed them. The staff left her too long and she blacked out. They had to send for an ambulance and she was kept in for four days. The management had a meeting about this."

Both nurses and care staff told us they believed there were insufficient numbers of staff on duty. Care staff felt that the care staffing levels were very poor and felt that management planned staffing on the numbers of people who used the service as opposed to individual dependency needs. One carer told us: "This is one of the heaviest units. We have a lot of clients who prefer to stay in bed and this automatically increases their dependency on the carers." Another carer said "On some mornings we literally do not have the time to serve mid-morning drinks to patients as we are still dealing with care needs." "My only concern is staffing, we manage but some people are getting their breakfast at 10.30am and lunch is at 12.30pm." "We have a dependency scale which I think is outdated and there should be another means of assessing numbers of care staff. It can get very busy here, but we need more carers."

Other comments from staff included; "Staffing levels are not good enough. We should have five staff but it's usually four and even then it's a struggle because of people's needs. More people need a lot more attention now. We are always rushing to get things done. Now we struggle to do the basics. It's an emotional strain as well. I leave work sometimes feeling I haven't done a good job, because I haven't had the time to have a chat or anything. Even having a chat with someone is part of their needs." "We can't give them the care needed, because we are so busy. I think staffing is a problem throughout the home. We have told management we are short staffed, but nothing seems to change here. I definitely think both staff and residents are at risk as a result." "I feel quite emotional as you can't give the care people need."

We observed the main lounge of the first floor nursing unit from 10.00am until 12.30pm. We noted that a student on work experience had been left alone with between nine and eleven people during this period. Care staff came in to the lounge on two occasions to transfer people for short periods of time and then left leaving the student alone in the lounge. Our observations indicated that the student was being used by staff as a 'minder' for people in the lounge which was unsafe practice. We subsequently spoke to management, who confirmed the student was present to observe and engage with people and was not to be utilised as an extra member of staff.

We saw the student help two people on different occasions who were trying to stand and almost fell over. On both these occasions the student was in the kitchen preparing drinks and people had been left alone. We saw the student calming and reassuring people in the lounge, in addition to escorting them back into their chairs alone.

At 10.25am a person who used the service asked to go to the toilet just as two care staff were transferring another person who wanted to use the bathroom. The student who was present in the room spoke to the person and said that as soon as the care staff had finished they would attend to their needs.

At 10.40am the two members of staff returned to the lounge, however the person who had asked to use the toilet at 10.25am told us; "You have to go when you have to go. I've been wetting myself." We found the person had to tolerate the indignity of wetting themselves as there were no qualified staff to support them using the toilet when they required it. One member of staff told us; "We usually have two carers on each corridor which is not enough. People have to wait to be toileted, turned or sat up in bed, it's not good enough." We saw staff then transfer the person into a wheelchair and took them to the toilet. They returned a short while later with the person wearing clean clothing.

In relation to providing planned care, we looked at the Service Communication Book for week commencing 09 March 2015, which showed that seven people who were living in nursing unit located in The House, did not have an assisted bath/shower that week. We spoke with staff about this concern. Staff told us this was not due to the person's preference, but due to the lack of time available to them. They found it frustrating that they were not able to meet the hygiene needs of these people. One person who used the service told us; "Staff come and tell me when I'm to have a bath or a shower. I would like it if they would ask me which I wanted." Another person who used the service said "I like having a bath. They tell me when I'm having one." One member of care staff told us; "If there is four of us on it is difficult then to give people a bath, though if they ask we will give them a bath."

Inadequate

Is the service safe?

We found that staffing arrangements did not protect people from the risks associated with inappropriate or unsafe care, because care was not delivered in such a way to meet people's individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care.

We raised the issue of staffing levels with the registered manager and regional manager of the service following the concerns raised. The registered manager told us that together with the Bed Manager, they would conduct a full review of staffing in line with the dependency of people who used the service.

We checked to see how people who lived at the home were protected against abuse. We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. Staff that we spoke with were all able to confidently tell us about the principles of Safeguarding and more importantly, they all correctly sited the process to follow if the felt that abuse or potential abuse had occurred. We found that all staff had received training in safeguarding vulnerable adults, which we verified by looking at training records. One member of care staff told us "Management would respond to any safeguarding concern and I would have no hesitation in reporting any concerns."

We reviewed a sample of recruitment records, which demonstrated that staff had been safely and effectively recruited. Appropriate criminal records bureau (CRB) disclosures or Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained.

Requires Improvement

Is the service effective?

Our findings

Westwood Lodge provided care for people coming to the end of their lives due to deteriorating palliative illnesses. The home was part of the National Gold Standards Framework for end of life care, which enabled people to have a comfortable, dignified and pain free death.

We were informed by the deputy manager that end of life patients were managed by trained staff including the management of Syringe Drivers. We asked for evidence to demonstrate that staff were adequately trained to ensure safe end of life (EoL) practice. We were shown evidence that referred to the mechanisms and functions of how a syringe driver operated. However, we could not find any evidence that confirmed training or a competency measurement framework around safely caring for a person who was attached to a syringe driver during EoL care.

We spoke to management team and nurses about end of life care and were unable to obtain assurances that safe and consistent syringe driver care was being delivered by the service. We found the service could not provide us with a policy or procedure that would support staff to deliver a safe and consistent level of care. When we spoke to staff we received conflicting responses. This included areas such as the change of the subcutaneous line, the regularity of the checking of the syringe driver delivery dose whilst driver in use and support doses drug calculations in terms of maintenance, over a 24 hour period. Both management and staff confirmed individual nurse competencies around managing EoL care was not measured by the service.

We found the registered person had not protected people against the risk of associated with the safe delivery of EoL care. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

We looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. On the whole, staff told us they felt fully supported in their roles and were valued by management. One registered nurse told us; “I feel we get plenty of support and training. I do feel valued. The management are like friends to us so we can speak easily about any concerns we have.” Another member of staff said “We get plenty of training which is updated. I get supervision with the nurse in charge.”

Other comments from staff included: “One of the good things here is there is always opportunities for training and going on courses.” “We are encouraged with training and development.” “I have completed a diploma in college and my induction including shadowing a senior carer for a week.” “As part of my induction, I had three days training and I then shadowed for a week. I felt it was enough as I had previous training in other employment.” “I don’t always feel valued and appreciated. I think management take you for granted.”

We looked at training records to confirm what training staff had received. This included; National Vocational Qualifications (NVQ), manual handling, health and safety, infection control and safeguarding adults. We asked to see evidence of Tissue Viability Training/ Wound Assessment for trained staff, which the management were unable to provide. We were assured that suitable training for staff would be sourced.

We looked at supervision and annual appraisal records and spoke to staff about the supervision they received. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner.

The home was contracted to provide 20 beds on the ground floor nursing unit for NHS patients. This was known as the Community Nursing Beds Unit and was intended to relieve winter pressures on hospitals and accommodated short stay patients of an average of 10 to 14 days. We spoke to a senior visiting health care professional from the local hospital, who spoke very favourably of the services provided by the home. They told us the model of care at the home had been excellent and they were very pleased with the services they received. They had a large team that visited the home to support patients and they had never received negative feed-back about the service.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the

Requires Improvement

Is the service effective?

Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw there were procedures in place to guide staff on when a DoLS application should be made. We spoke to the registered manager, who was able to demonstrate that the service had submitted a number of applications in line with guidance from the local authority. We spoke with staff to ascertain their understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. We found that they all demonstrated an underpinning knowledge regarding this legislation.

Throughout our inspection, we observed staff seeking consent from people before undertaking any tasks. For example we observed a member of staff asking a person what time they would like help with a shower. We saw another member of staff asking whether the person wanted to wear their slippers or shoes today.

We found the home did not have signage features that would help to orientate people living with varying degrees of dementia. People who used the service were able to wander about the corridors and communal areas. Improvements were required to ensure the signage was better suited to deal with the needs of people living with dementia such as themed corridors or bathroom doors coloured in the same colour to help recognition.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

During our inspection we checked to see how people's nutritional needs were met. As part of the inspection we used the Short Observational Framework for Inspection (SOFI) during lunch. People chose to have their lunch in one of the three dining areas within the home or in their bedrooms. We observed staff offering a choice of hot and cold drinks to people and asking them whether they wanted to wear an apron to protect their clothing. We saw that a three week menu was displayed on the dining room wall though it did not represent what was being served on the day of our inspection.

We saw a choice of hot meals were available and saw staff asking people what they wanted. They were offered further portions if requested. We saw one person being supported with a special diet which was reflected in their care plan.

We received a mixed response from people regarding the quality of food available. One relative told us; "Because of his condition he can't eat a lot, but the food looks nice and they are meeting his needs." Another visiting relative said "Food is definitely good." One person who used the service said "I don't like the food here. It seems to be the same food every day. They did have a good cook at one time but he left. We get the same things every time. You can have a drink anytime. They do weigh us." Another person who used the service told us; "I don't like the food here. It's all the same, every day. They don't give me a choice. There's too much the same."

Other comments included; "The food is awful. It is repetitive. For example. It's always stews, shepherd's pie or chicken and ham pie. It's mostly stew type food. My family bring me most of my food. Staff don't always ask me what food I want and forget to put me down for a meal when I have asked for one. I can go from lunchtime until tea time before I am offered a drink." "The food here is terrible. It's the same food day after day. My relative is on a low cholesterol diet which is totally ignored." "The food seems to be good here but she is on pureed food and drink."

We looked at care files and found that individual nutritional needs were assessed and planned for by the home. We saw evidence that nutritional and hydration risk assessments had been undertaken by the service. These were reviewed on a monthly basis including people's weights. Care plans included direction on individual eating and drinking needs of people who used the service.

Requires Improvement

Is the service caring?

Our findings

On the whole, people who used the service told us that staff were kind and considerate. One person who used the service said "The staff will do anything for you but there's not enough of them." Another person who used the service said "Bless them, nothing is too much trouble for them." A visiting relative of a person coming to the end of their life said "We have never had any concerns regarding the care. The staff are great and also update you on any changes." A member of the Clergy who was visiting the home at the time of our inspection told us they could only highly praise the staff as they were constantly on the go and never seemed to complain.

People told us that though staff were caring they were often too busy develop positive caring relationships. One person who used the service said "Most staff will have a chat but some are always too busy to talk. You can't expect them to talk to you when there's only two people on for so many of us." Another person who used the service said "Some of the staff are lovely and explain they are doing their best, but I still am the one waiting for attention. There are some very good staff who know what they are doing and there are others who don't seem to care. Staff don't have the time to sit and chat and find out what I like."

Other comments included; "Staff don't sit and chat with me. They've too much work to do. I would like them to have a chat with me. They are very kind and never nasty to me. My family get me ready for bed every night and wash me every morning." "Every other morning there are different carers so I don't get continuity of care. Some of them don't know me and I can't always understand their English." "I can ask for things and they say they will come back but they don't."

We observed an agency nurse administering medication during the morning in the lounge area on the first floor. We saw the nurse approach one person who used the service and stood over them and said "Your tablets. Open your mouth." The person clearly did not know who the nurse was and became agitated saying "Who are you? Why don't they have the same nurses? I don't know you. What are you giving me? I like to know where I am. There are a lot of mistakes with medicines. I've not had this one before." The nurse then muttered "Jesus" with her hands on her hip and sought the assistance of a member of care staff. The member of care staff came over and tried to give the person the same tablets who continued to refuse. The care staff member then said "We can't force her to take them" and walked away.

The agency nurse repeated twice that if they didn't swallow the tablets they would have to go to hospital. The person became more agitated, which resulted in our expert by experience, who was part of the inspection team intervening. They spoke to the nurse and were then able to reassure the person who calmed down. The person continued to decline some of the tablets they did not recognise.

Although we had no concerns that the medicines were offered and administered safely, the approach and manner of communication by the nurse with a person they did not know, had resulted in the person becoming upset and agitated. A more sensitive and friendly approach with a suitable explanation of the medicines may have avoided the resulting altercation. We subsequently spoke to the nurse who said "I think it's very heavy for one nurse, medication, controlled drugs and insulin, it's too much for one nurse."

Requires Improvement

Is the service responsive?

Our findings

We looked at a sample of nine care files. All care plans provided instructions to staff on the level of care and support required for each person. This included instructions on people's capacity needs, medication, communication, breathing, eating and drinking and personal cleansing. This demonstrated evidence of providing person centred care and included relatives of people who used the service signing and agreeing to their loved ones planned care. However, we found two care files contained admission sheets that had not been fully completed.

We looked at one care plan which documented that one person who used the service had five Grade 4 pressure sores on various areas of their body. The documentation advised that these were present on the transfer of the person from another care provider. We found that these were safely documented within the care plan and suitable wound management plan for each area had been completed. The Deputy Manager was able to advise that the pressure sores had improved.

We witnessed a staff handover meeting involving the night and day staff. Together with the two nurses who conducted the handover, it was also attended by care staff. People who used the service were referred to by their first name and an overview was provided of how they were and whether there were any concerns and included medication and GP appointments. This enabled the new shift to be kept up to date with any changing needs or concerns.

We were told by the registered manager that the service employed an activities coordinator who was currently on leave. On the day of our inspection we saw limited physical and mental stimulation for people who used the service. We asked to see the Activity Diary but this was not provided. In the main reception area we saw advertised a coffee shop took place every Friday and a social night every second Thursday where drinks, dominos and bingo were available from 6.00pm.

During over last inspection in September 2014, we questioned the effectiveness of the role of activities co-ordinator managing and organising activities and interests for more than 76 residents across three units. During this inspection, people we spoke with told us very little activities took place and that there was nothing to do at the home. One person who used the service said "We don't do any activities at all. We have to just sit here all day. My bottom gets sore sitting here." Another person told us; "I've never been taken out by staff. I get fed up in here. There's nothing to do. We very rarely get a game of bingo or do anything."

Other comments included; "Staff don't have the time to sit and chat and find out what I like. There is bingo and dominoes. They play DVD films but I've already seen them. The staff don't take me out but my daughters do. I don't get out very often. I'd like to go out in the garden more often. My daughter comes and makes us a little barbecue outside. My window has an opening into the garden so she can take me just outside for the barbecue." "There isn't activities. Staff don't have time because they are working. I do like to play bingo and things. Somebody comes in and plays it with us. You get prizes if you win. They do cooking. I've not done it. They have a proper kitchen and go in there." "Not a lot to do. I'm happy with the TV."

A visiting relative told us; "She doesn't go out with staff but we take her out. She is sat around a lot, but at least she's now got a friend in here. I'd like to see staff doing activities with her." "No activities take place. There used to be bingo and dominoes etc., but this has all stopped and doesn't take place anymore." "No mental or physical stimulation that I' aware of."

We found the service did listen to people's concerns and experiences about the service. The provider had effective systems in place to record, respond to and investigate any complaints made about the service.

We looked at minutes from a resident's meeting on the 01 December 2014, which had been attended by six people who used the service. Issues such as the menu and Christmas fair had been discussed. We also viewed minutes from a families meeting held on the 16 December 2014. People had also completed a customer satisfaction survey in 2014. The result of which had been analysed by the provider and included areas such as overall satisfaction with service and likelihood to recommend. One relative told us "They are very responsive to our needs. The senior nurse is very compassionate and caring. They tell me they are here for me and not just my dad and they have reassured me. No concerns or any worries, we can come anytime."

Requires Improvement

Is the service well-led?

Our findings

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. These included care plans and nursing care plans. We looked at medication audits that had been undertaken. Kitchen checks for cleanliness and food storage were undertaken. Environmental and equipment checks were undertaken including window restrictors, hoist, slings and baths. Checks were also undertaken of the call bell system and fire safety equipment and systems. We looked at infection control audits that had been undertaken by the service.

However, as a result of the concerns we identified around medication, infection control, meeting people's individual needs and EoL care, it was apparent the service was not effectively assessing and monitoring the quality of service provision.

We found the registered person did not effectively monitor the quality of service provision. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

There was a registered manager in place. 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 registered manager was present throughout our inspection having only recently returned from a period of absence from the home.

On the whole, we received mixed feed-back regarding the leadership and management of the establishment from people who used the service. One person who used the service told us; "I have no idea who was in charge." A visiting relative told us "Overall, first impressions weren't good, but things have improved. They have run the extra mile for us." Another relative said "Mostly my son and daughter make complaints for our X. They have meetings with management but management don't take much notice."

Staff told us they believed there was an open and transparent culture within the home and would have no hesitation in approaching managers about any concerns. However, some staff stated that while the managers were very approachable, they were not proactive in dealing with issues or personal problems. In respect of staffing concerns one member of staff said "The management's position is the current numbers are sufficient." Another member of staff told us "Management do encourage an open culture, I wouldn't hesitate to report any concerns."

Other comments from staff included; "The management are very approachable, any issues I feel I could go and speak to them." "Management are very approachable." "Feel management team is the best it has been." "There is an open and honest culture here. You can raise issues and something will be done." "For me it's an open management and culture."

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. During our inspection we identified several matters that had not been reported to us by means of formal notifications. We are currently considering our options in relation to this failure, on the part of the provider. We are dealing with this matter outside of the inspection process.

Since our last inspection and in response to our concerns about staffing levels at that time, the service has introduced a call bell system that allowed the service to monitor how long it takes staff to respond to requests for assistance. We were shown data relating to response times, however no analysis of this data had been undertaken. We were informed that the data was often used in respect of any complaints made. Following discussion, the management indicated using the data more pro-actively as a means of identifying any re-occurring themes.

We looked at minutes from staff meetings. These included external professionals meetings, nurses and housekeeping. We found minutes to be detailed and included topics such as medication, internal audits and handovers.

We found the provider had been accredited with a Gold Award for Investors in People recognition. Investors in People is a management framework for high performance through people. Formed in 1991, Investors in People was established by the UK Government to help organisations

Requires Improvement

Is the service well-led?

get the best from their people. Organisations that demonstrate the Investors in People Standard achieve accreditation through a rigorous and objective assessment to determine their performance.

The service ran a staff awards scheme to reward high quality and outstanding service. Relatives and staff could nominate staff they felt deserved an award.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have appropriate arrangements in place to manage the administration of medicines safely .** **The service did not have effective systems to prevent the spread of health care associated infections.** **The service failed to ensure staff providing EoL care had the necessary qualifications, competence, skills and experience to do so safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The service did not have suitable arrangements in place to effectively meet the care and welfare needs of people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service did not effectively monitor the quality of service provision.**