Your Health Limited

Langwith Lodge Care Home

Inspection report

The Park
Nether Langwith
Mansfield
Nottinghamshire
NG20 9ES

Tel: 01623742204
Website: www.yourhealthgroup.co.uk

Date of inspection visit:
19 November 2015

Date of publication:
07 January 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 19 November 2015. Langwith Lodge Care Home provides accommodation for persons who require personal care, for up to a maximum of 54 people. On the day of our inspection 28 people were using the service and 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.

People told us they felt safe at the home and that there were enough staff to support them. However relatives and staff felt more staff were needed at busy times. People were supported by staff who could identify the different types of abuse and knew who to report any concerns to.

The risks to people's safety were not always appropriately assessed and well managed and were not always regularly reviewed. Evacuation plans for one person had not been reviewed and did not reflect their current needs. Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the registered manager and had been investigated. People's medicines were not always safely managed or stored securely and there were some errors with recording of what medicines people had been administered.

The registered manager did not always ensure the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguard had been appropriately applied.

People had access to external healthcare professionals however the guidance and recommendations made by them were not always implemented. People spoke positively about the staff and were supported by staff who received supervision which assessed the quality of their work. However some staff had only received one supervision in the last eleven months. The majority of the staff training was up to date; however there were a small number of areas where refresher training was needed. People we spoke with told us they liked the food and drink provided at the home. Some relatives felt more staff were needed to support people during meal times.

People felt the staff were kind and caring and treated them with respect. Information for people on how to access independent advice about decisions they made was not available. Other information about external health and social care services was also not available. People told us they felt included in decisions made about their care and support although people's records did not always reflect this. There were positive examples of staff treating people with dignity and respect although we also saw some poor interactions. People were encouraged to do as much for themselves as possible and staff understood people's likes and dislikes.

People's care records contained an initial assessment of their needs however once care plans were in place they were not regularly reviewed. Staff were provided with some people's life histories to enable them to use this information to support people. However this was not in place for all. People spoke positively about the activities at the home although there was a lack of information available to inform people what activities were available to them. People felt able to make a complaint if they needed to but information about the process was not fully available and was provided in a format that some people may find difficult to understand.

The registered manager did not have auditing processes in place to monitor the risks to people's care and support needs and the service as a whole. The registered manager ensured that the CQC were provided with the appropriate statutory notifications, however one of these did not contain an accurate account of an incident that had occurred. People were encouraged to become involved with development of the service and were given the opportunity to give their opinions on how things could improve. Relatives told us they thought the quality of the service had improved since the registered manager started working at the home. However some staff members felt the registered manager was not always approachable.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The risks to people's safety were not always appropriately assessed or reviewed.

People's medicines were not always safely managed.

People were supported by staff who had received safeguarding adults training and knew who to report concerns to.

Some relatives and staff felt more staff were required to support people at busy times of the day.

Accidents and incidents at the home had been recorded, reported to the registered manager and investigated.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA and DoLS were not always appropriately applied.

People had access to external healthcare professionals however records showed that people's day to day health needs may not have always been met.

Staff received supervisions of their work but these were not carried out regularly enough.

People received support from staff who had the right skills; however some staff required refresher training for some subjects.

The majority of the people liked the food and drink they received.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Information for people on how to access independent advice about decisions they may make and how to access information from other social and health care organisations was not available.

People felt included in decisions made about their care and support although people's records did not always reflect this.

People were cared for by staff who were kind and caring, however there were a small number occasions where people's dignity was not appropriately respected.

People were encouraged to do as much for themselves as possible and staff understood people's likes and dislikes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records contained guidance for staff to support people's personalised needs however these were not always regularly reviewed.

People spoke positively about the activities at the home, however there was a lack of information available for them to explain what was available.

People felt able to make a complaint if they needed to, however the complaints procedure was inaccessible and in a format some may find hard to understand.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager did not have the auditing processes in place to ensure the risks to people and the service as a whole were appropriately managed.

People and relatives were able to contribute to the development of the service although some of the staff found the registered manager unapproachable.

Statutory notifications were sent to the CQC but one of these contained information that did not accurately reflect an incident that had occurred.

Langwith Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 November 2015 and was unannounced.

The inspection team consisted of three inspectors.

Before the inspection, we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law.

We spoke with nine people who used the service, seven relatives, four members of the care staff and one domestic assistant, the deputy manager and the registered manager.

We looked at all or parts of the care records and other relevant records of seven people who used the service, as well as a range of records relating to the running of the service.

We 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.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy with the way their medicines were managed by the staff. One person said, "They look after the tablets, you always get them at the right time." They're [staff] never short of any."

People's medicines were not always stored, handled, managed or recorded in a way that would ensure people were always protected from the risks associated with medicines. People's medicines were not always stored securely. The room where the medicines were stored was not always locked. On one occasion we observed the keys were left in one of the medicine trolleys which was stored in the unlocked room with no staff present. Because medicines were not always stored safely there was a risk that some medicines might go missing or that a person might access them which would pose a risk to their health and safety.

We found two examples where the date in which topical medicines were opened had not always been recorded. A topical medicine is applied to a particular place on or in the body. For example we saw a person's eye drops which had been prescribed on 12 September 2015 was still in use on the day of inspection. This should have been discarded four weeks after opening, but had been administered to the person thirteen times after this date. This could reduce the effectiveness of the eye drops and placed the person's health at risk.

Where people were prescribed 'as needed' medicines there were no protocols in place advising staff when they should be administered or where the dosage varied how much to give. 'As needed' medicines are only used when needed for a specific situation, such as intermittent chest pain, constipation, or pain. We saw one person had mistakenly received their medicine four times a day for a week because the staff had not ensured that the medicine should only be given 'as needed'. A staff member did eventually identify this error and sought advice from the person's GP. However the lack of detailed information for staff when administering these types of medicines could increase the risk of them receiving them in an inconsistent way, placing their health at risk.

Processes were in place to manage controlled drugs. Controlled drugs have the potential to be misused and have stricter legal controls on their supply to prevent them being obtained illegally. However the processes were not always appropriately applied. There was a controlled drugs register, used to record the number of controlled drugs on the premises. However records were not always in place to record when a person had been administered them. The lack of accurate recording could indicate that people's health and safety at risk.

The concerns we found in relation to medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks to people's safety were not always appropriately assessed and managed. Risk assessments were not always completed and where they were, they were not always reflective of people's current level of need. For example one person's care records stated that they were fully mobile but would require assistance to their wheelchair. However a member of staff we spoke with told us that this was not correct and the

person's was unable to mobilise independently. Additionally this person's evacuation risk assessment, dated 12 June 2011, stated the person should be transferred to a wheelchair if a quick evacuation of the premises was required. After our discussions with this staff member it was clear that this would not be possible. The lack of up to date risk assessments and evacuation procedures for this person placed their safety at risk.

Other people's care records had also not been reviewed and updated. One person's falls risk assessment had not been reviewed since July 2014 and for another person their moving and handling risk assessments had not been reviewed since August 2014. Due to the complex nature of their support needs the lack of regular review of the risks associated with their care could place their safety at risk.

We raised these issues with the registered manager. They acknowledged that more needed to be done to ensure that all people had the appropriate risk assessments in place and that when they were that they were reviewed regularly. The registered manager told us they would address these issues immediately.

Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the registered manager. The registered manager told us they reviewed the incident reports and made recommendations to staff to reduce the risk of these incidents happening again. The records we viewed reflected this. However the records did not contain reference to the registered manager carrying out a review to ensure their recommendations had been implemented. The registered manager assured us they were confident that staff had carried out their requests, but was unable to evidence this in people's records.

The premises were managed in a way that reduced the risk to people's safety. Regular testing and servicing of fire detection equipment, gas installations and equipment used to support people were carried out. A business continuity plan was in place which contained information on how people's safety would be maintained if there was a loss of power, water or a gas leak.

People told us they felt safe living at the home. One person said, "I feel safe when they [staff] help me, they know what to do."

The risk to people's safety was reduced because the staff who supported them had attended safeguarding adults training, could identify the signs of abuse and knew who to report concerns to both internally and to external agencies. A safeguarding adults policy was in place. However people were not provided with information about how to keep themselves safe, or who to report concerns to if they felt they or others had been the victim of abuse.

People who used the service did not raise any concerns with us about the number of staff provided to support them. However some relatives and staff did. Some relatives felt more staff were needed during busy periods such as lunch and dinner times. One relative said, "There are not enough staff to take [family member] outside. I do it because I'm here a lot, but some people don't have anyone to visit them."

A staff member said, "The staffing levels are tight and it feels very busy at times." Another staff member described what it was like to work in a certain part of the home. They said, "It can be worrying if you are on your own there. You have to be careful how you manage things and ask for help from others if you need it." We raised this with the registered manager. They told us they regularly assessed people's needs and were confident that there was an appropriate number of staff to keep them safe, but they would review the concerns raised.

Throughout the inspection we saw people were responded to in a timely manner. When a nursing call bell

had been pressed, which indicated that a person required the assistance of a member of staff in their bedroom or other part the home, staff responded quickly to them. This reduced the risk to people's safety by ensuring they were not left for long periods of time without support.

We looked at the recruitment files for three members of staff. All files had the appropriate records in place including; references, details of previous employment and proof of identity documents. We also saw criminal record checks had been conducted before staff commenced working at the service. These checks enabled the registered manager to make safer recruitment decisions reducing the risk of people receiving support from inappropriate staff.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

We reviewed people's care records and found a number of examples where a MCA assessment should have been carried out but had not been. There were not always assessments in place for people who required support with their medicines, personal care or their finances. Some of these people were living with dementia and would be unable to give their consent to the decisions made on the behalf, which meant decisions could be made that were not in their best interest.

We raised this with the registered manager. They told us they were aware that many people did not have mental capacity assessments in place that should have. They told us they would immediately review the care records of people most at risk, to ensure that where decisions were made for them that the appropriate legal guidance was followed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The manager was aware of their responsibilities and told us if they had concerns they would raise these with the local authority.

Records showed that applications had been completed for some people, but not all who required it. We reviewed the care records for one person and it was stated that this person did not have the capacity to understand decisions about their safety when they were outside of the home. However no application had been made for this person. This meant they may be having their liberty illegally deprived. We also saw an example where a person came to the service in July 2015 and records showed they attempted to leave the home on a regular basis. The person's records showed staff regularly stopped them doing so as they had been assessed as being unable to maintain their own safety when in the community. An application for DoLS had not been made until October 2015 for this person, which meant the person may have had their liberty illegally deprived for three months.

We raised this with the registered manager. They told us they prioritised the people they deemed to be most at risk, but acknowledged that the two people referred to in this report would also be assessed as high risk. They told us the person without a DoLS application in place would have one made immediately.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who offered them choices and respected their wishes. We saw some good

examples of staff communicating effectively with people to ensure they understood what was being asked of them and then waiting for a response before adhering to their wishes.

The registered manager told us prior to commencing their role staff were provided with an in-depth induction which equipped them with the skills they needed to carry out their role. We saw plans were in place for new staff to commence a new nationally recognised qualification called the 'Care Certificate'. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives people who use services and their friends and relatives the confidence that the staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff told us they felt well trained and had the skills they needed to carry out their role effectively. One staff member said, "The training you get is pretty good. Some of the training is face to face. We recently did hoist training again." A relative spoke highly of the staff and how they supported them with moving around the home. They said, "Staff help [name] to get up from their chair; there are always two of them to help [name] get them to their zimmer frame. They are very careful with him. As far as I know they haven't had any falls or anything like that."

People were supported by staff who had a regular and varied training programme to enable them to have the skills to carry out their role effectively. Records showed staff had received training in the safe moving and handling of people, safeguarding of adults and mental capacity. Where staff required refresher training records showed that this had been booked for them. On the day of the inspection an external training provider was providing MCA and DoLS training to the staff who required it.

Staff told us they felt supported by the registered manager. However records showed that staff did not receive regular formal supervision or appraisal of their work. 10 of the 32 staff working at the home had only received one supervision in the last eleven months. This lack of monitoring increased the risk of staff providing ineffective and inconsistent care and support for people. We raised this with the registered manager. They told us they were aware that the supervisions had not been conducted as often as they would like them to be, but assured us that they had plans in place to delegate the responsibility of some of the supervisions to other members of the management team to ensure they were completed.

The majority of the people we spoke with told us they liked the food and drink provided at the home. One person said, "You get good food here." Another person said, "The food here is good, you always get a choice. It couldn't be better." A relative said, "I can't fault the main meals at all. There are good choices; they can have what they want." Most relatives felt there were enough staff to support their family members at mealtimes, although others said they felt more were needed.

We observed the lunchtime experience on both days of the inspection. We saw some positive interactions with staff discreetly offering people an apron to protect their clothes. We also saw people were offered specially adapted equipment to support them with eating their meal independently of staff. However we also saw some negative interactions. For example we observed staff talking over people and some of the language used was not always appropriate. People were given verbal choices of what to eat and no menus were available. People were not always offered the choice of where to sit and it took staff too long to notice that a person was struggling with their food as they were sat too far from the table.

People who had specific dietary requirements, as a result of their cultural or religious background, or specific health condition such as diabetes, were supported to have the appropriate food and drink to meet their needs.

People who had been assessed as being at risk of dehydration, malnutrition or excessive weight gain or loss had plans in place to support them. We saw food and fluid monitoring charts were in place to record the amount of food and drink that people consumed. We looked at a sample of these records. Whilst some records were completed appropriately others did not always record the amounts people had consumed or whether they had consumed the required amount to support healthy diet and weight monitoring.

Care records showed that other health and social care professionals were involved in people's care as appropriate to support staff in managing their day to day health needs. However, some people's records showed that people's needs may not have always been met. For example a person records stated that a type of cream was to be applied to them, but their records did not indicate that this had happened.

Records for another person advised that the person required a crash mat and sensor mat. These are used to reduce the risk of injury if a person falls out of bed and also to alert staff if they have done so. However we found that bed rails and bumpers were in place. This meant the person's day to day health needs may not have been met appropriately.

Records showed that referrals to external health care professionals were made when people's needs changed. We saw referrals were made to occupational therapists, falls specialist and dementia outreach teams.

Requires Improvement

Is the service caring?

Our findings

People told us they felt able to make decisions about their care. During the inspection we observed staff provide people with information about their day to day care needs. However, we saw little recorded evidence of people, and where appropriate their relatives, being involved with discussions about planning of their care. The registered manager told us they would remind staff when carrying out reviews or when a discussion had been held with a person about their care that it is was recorded within their care records.

Information to support people if they wished to speak with an independent advocate was not available. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. This meant people who may wish to speak with someone other than staff or relatives about their care would be unable to do so.

The registered manager told us they had volunteers come to the home and talk with people about their care needs and then their views were reported back to them to act on. However people were not always provided with information within the home about external services they could access if they wished to discuss aspects of their care and support that may not be provided by the staff.

There was no information about other health or social care services such as the contact details for the local authority or social workers. Other examples included no information for people about how to manage their finances, or who to contact if they had a concern about a medical condition they or someone else was living with. This lack of information limited people's ability to make independent choices and decisions about their own care. The registered manager acknowledged more needed to be done to ensure people had the information they needed to take control of their own care and support needs.

People spoke positively about the staff who supported them. One person said, "It's all pretty good. The staff are always nice; they have time to talk to you." Another person said, "I am very comfortable here. I feel like I am with family." A relative said, "The staff here are really good, they're very nice indeed." Another relative said, "I feel like they look after [family member] well and they know them."

People's care records contained information about their personal likes and dislikes. The staff we spoke with had a good understanding of people's needs and preferences. A member of staff said, "The best bit of the job is the people we look after. When I get a spare 5 minutes I like to sit and have a chat with people."

Staff responded quickly to offer reassurance to people who had become distressed or showed signs of discomfort. We observed one person become tearful and upset shortly after their visitors left. A member of staff approached the person; spoke softly and gently to them and distracted them until their mood improved. It was clear the staff member knew the person well and how to respond to them in a caring way. Additionally, nursing call bells, used by people within their rooms or other parts of the home to call staff if they needed support, were answered in a timely manner.

People's religious and cultural needs were discussed with them or where appropriate their relative before

they commenced living at the home. Plans were in place to support people in the way they wanted. The registered manager could explain how they and the staff supported a person we had identified who had very specific religious needs.

We saw some good examples of staff treating people with dignity throughout the inspection. A relative we spoke with said, "The staff are a good bunch, they work hard. I feel like they look after [family member] well and they know them well. [Name] responds well to the male staff, they are happy to have them help her." Another relative said, "In the past [family member's] personal hygiene wasn't always looked after properly, but things like that have improved."

However, we also saw examples where people's may not have been treated with the level of dignity they should expect. For example, when we observed the lunchtime meal being served we saw a member of staff supporting three people with eating their lunch at the same time. This meant they were unable to engage in meaningful conversation with the people and to treat them in a dignified way. Additionally, staff had not noticed that a person had started to eat their meal with their fingers which compromised this person's dignity.

There was also a lack information available in the home to advise people how they should expect to be treated with dignity and what they should do if they felt they or others were not being treated appropriately.

The staff were kind and caring and we saw some good examples of staff treating people with respect. Where people required assistance with moving around the home the staff were patient and respectful of people's wishes to remain as independent as they could be. We observed staff assist people to walk through to dining area, giving reassurance and encouragement while people walked carefully with their frames. People responded positively to them.

We also observed some examples where staff were not as respectful as they could have been. For example, when a person was having difficulty with their food a staff member said to them, "Shall I get you a bib? Do you want a bib?" The reference to a 'bib', made in front of others, could be deemed as disrespectful.

People's relatives were able to visit their family members whenever they wanted to. There were no unnecessary restrictions in place.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained an initial assessment of people's needs. These assessments contained information about how people wanted their care to be provided and how the staff would meet their personalised needs. Care plans were then put in place to enable staff to have the guidance they needed to support people effectively.

However the records we looked at were not always regularly reviewed. Some care plans had not been reviewed since March 2015. When reviews had taken place there was little recorded evidence of people or relatives being involved. This meant the care plans provided for staff to support people may not reflect people's current needs or how they wished their care to be provided. This could place people's health and welfare at risk.

The registered manager had started to introduce people's life history and the things that were important to them by placing a one page display outside each person's bedroom. Details such as people's interests and hobbies and other information such as the name of pets they had had were included. They told us this enabled staff to have information to refer to when supporting people within their bedrooms. This process had not yet been completed for all people.

People's care records contained references to how people would like their personal care to be provided. This included people's preference for male or female staff to support them.

People told us they felt there were suitable activities at the home and were able to do what they wanted to do. One person told us they, "We go out in the garden when the weather is good, and down to the lake. The grounds are lovely. I grow tomatoes in my greenhouse, they all get eaten. I really enjoy it." A relative said, "Sometimes they have entertainers to come in and play music, sometimes there are ball games and other things happening." However one relative we spoke with said they felt their family member was restricted from going out due to their complex needs as they required more than one staff member to support them.

People's records showed the 'lifestyle coordinators' spent time with people for one to one activities such as having their nails done and other group activities. However there was no information provided within the home which explained to people what activities were planned. We were told a plan was being put together for December for the run up to Christmas. This meant people were reliant on staff to inform them what was happening at the home. This also could restrict their ability to make plans for the day or weeks ahead and to decide what they wanted to do and when.

People were encouraged to take part in social activities and to sit with others to help them avoid becoming socially isolated. We observed staff speak with people to see if they were happy with where they were sat within the home or whether they wanted company from them or from others. A relative we spoke with said, "Everyone is out of their rooms and spending time together."

People were not provided with the information they needed to raise a complaint. The complaints procedure

was stored behind a glass noticeboard. The procedure was more than one page long which meant people would be unable to access all of it. The part of the procedure that was accessible was provided in small typed font which may prove difficult for people to read. The registered manager acknowledged that the way the process was provided for people would not enable them to be aware of the process to follow if they had any concerns.

We reviewed the registered manager's register of complaints and saw they responded to these in a timely manner in line with their complaints policy.

Requires Improvement

Is the service well-led?

Our findings

The registered manager did not have the auditing processes in place to assess, identify and manage the risks to people who used the service. There were no audits available for us to review. Key areas that could affect people's health and safety were not regularly monitored. These included the quality of people's care records, the environment people lived in or whether staff were managing people's medicines appropriately.

The registered manager had not ensured that there were robust records in place. The manager had not identified that people's care records lacked detail, were not fully completed and did always accurately reflect the level of care and support that people received.

The lack of quality monitoring and assurance processes, along with the other concerns raised within this report increased the risk to people's health and safety.

These were examples of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us the registered manager was interested in their views in how the service could improve and develop. A relative said, "The monthly meetings have been good, they talk about changes in the home and fund raising, all sorts of things really. Things have been a lot better since the manager came to the home." Another relative said, "We come to the monthly meetings, it's the same people who come every time but it's useful. There have been a lot of improvements recently. The new flooring in the main hall and new carpet in the lounge have made a big difference, it is much better than it was before."

Some staff told us they felt able to give their opinions on how the service could improve and the registered manager respected their views. "The manager encourages you to speak out and stand up for yourself and for the residents." However other staff felt the manager was less approachable. One said, "I don't feel able to talk to him very easily or find him very approachable. He's too busy, you feel like you are being brushed off."

The registered manager told us they had regular meetings with a group of visitors who volunteered to speak with people who used the service to gain their views on how things could be improved. They told us recently there had been complaints that there was no hot meal option available in the evenings. They told us they listened to the feedback and people now have that choice available to them.

The registered manager told us they planned to support people to have better access to their local community. They told us a local school has been invited to sing Christmas carols with the people who use the service. They were also in the process of organising an 'Alzheimer's Walk' to encourage people within the community to go on walks with people from Langwith Lodge.

The registered manager told us they were aware of their responsibilities to meet the conditions of their CQC registration. The CQC must be informed via a statutory notification if a person received a serious injury or if they were being deprived of their liberty. Our records showed that appropriate notifications had been sent

when required. However we did find one example where the information provided to the CQC regarding an incident was not correct and did not match the information that was recorded within the person's records. This meant we were not provided with accurate information at the time of the incident to enable us to assess whether further actions were required by us or the provider.

The registered manager told us they held regular staff meetings to discuss the risks to people and the service as a whole and how they could contribute to reducing those risks. A member of staff said, "There is a monthly meeting for all the staff. We get feedback on any issues. Sometimes it is difficult but it does help to get things sorted out." Some staff raised concerns with us about a recent change to the numbers of hours they worked due to new staff starting at the service. They told us this had affected their morale. This could have an impact on the quality of the service people received.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always ensure; (1) Care of service users must only be provided with the consent of the relevant person. (3) where a service user is 16 or over and unable to give such consent because they lack the capacity to do so, the registered person acts in accordance with the 2005 Act

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always; (g) ensure the proper and safe management of medicines;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always; (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk

which arise from the carrying on of the regulated activity.
(c) maintain securely an accurate, complete record