Werneth Lodge Limited

Werneth Lodge Care Home

Inspection report

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Date of inspection visit:
03 October 2016

Date of publication:
07 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 3 October 2016.

We last inspected Werneth Lodge in May 2014. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Werneth Lodge is a care home that provides accommodation and personal care for up to 42 older people, including some people who live with dementia.

A manager was in place and they had applied to become registered with Care Quality Commission. 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 who used the service told us they felt safe. There were sufficient staff employed to provide consistent and safe care to people. People received their medicines in a safe way. Risk assessments were in place and they accurately identified current risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected. Records were not always up-to-date or regularly reviewed to reflect peoples' care and support requirements.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions themselves. They also received other training to meet people's care needs.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

Staff and people who used the service said the manager was supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

Staff knew the care needs of the people they supported.

People had the opportunity to give their views about the service. There was regular consultation with people or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided, however the auditing of care records was not effective. The environment was maintained for the benefit of people who used the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to governance. You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Staffing levels were sufficient to meet people's current needs safely. People received their medicines in a safe way. Risk assessments were up to date and identified current risks to people's health and safety.

People were protected from abuse and avoidable harm. Appropriate checks were carried out before new staff began working with people. Staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals. People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received a varied diet and support was provided for people with specialist nutritional needs. The environment was becoming better maintained for the benefit of people who used the service.

Is the service caring?

Good

The service was caring.

Staff were very caring and respectful. People said the staff team were kind and patient as they provided care and support. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff.

There was a programme of activities and entertainment. Staff engaged and interacted with people at all times and not just when they supported them. People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A manager was in place. Staff told us they were supportive and could be approached at any time for advice and information. We were told they were introducing changes to improve the running of the service. People who lived at the home and their relatives told us the atmosphere was good.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. They were not always effective as they had not ensured that records reflected the care that people received.

Werneth 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 3 October 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made judgements in the report. We also reviewed the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We contacted the local authority commissioners and the local authority safeguarding team.

During this inspection we carried out observations using 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 communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with eight people who lived at Werneth Lodge, the manager, one domestic member of staff, one cook and five support workers. We observed care and support in communal areas and looked in the kitchen, dining rooms, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for four people, the recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the manager had completed.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak with staff. People's comments included, "I feel safe here", "There are plenty of staff" and "We have enough staff."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found eight concerns had been logged appropriately. Safeguarding alerts had been raised by the home and investigated and resolved. The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities or independent investigations were carried out. Where incidents had been investigated and resolved internally information had been shared with other agencies for example, the local authority and the CQC.

Staff had a good understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and were able to tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the manager. Staff members commented, "If I had concerns I'd go straight to the manager", and, "I'd tell the senior."

We were told staffing levels were determined by the number of people using the service and their needs. We considered there were sufficient staff to meet people's needs at the time of inspection on most units. There were 31 people who were living at the home who were supported by six support workers and one senior support worker between the hours of 8:00am and 8:00pm. These numbers did not include the manager.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, behaviours described as distressed, moving and assisting and falls. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the management team so that appropriate action could be taken. We were told all incidents were audited in the home to check action was taken as required to help protect people. The manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring.

A personal emergency evacuation plan (PEEP) giving guidance if the home needed to be evacuated in an emergency was available for each person. They took into account people's mobility and moving and assisting needs. PEEPs were reviewed monthly to ensure they were up to date.

People received their medicines in a safe way. Systems were in place to ensure that all medicines had been

ordered, stored securely, administered safely and audited. Medicines were stored securely within the medicines trollies and treatment room. Records showed current temperatures relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Information was available with regard to the use of 'when required' medicines which may be required when people were in pain or agitated or distressed. Detailed information and guidance was available for each person to help staff support them if they were agitated or distressed. Guidance was in place to advise staff where 'when required' medicines should be used for agitation and distress to ensure a consistent approach.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of other checks were available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, I've done some specialist training", I've done Korsakoff training", "We have practical training sessions" and, "Some of the training is carried out by the area manager."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff told us new staff completed an induction and studied for the Care Certificate in health and social care as part of their induction training. We were told existing staff also studied for the Care Certificate. Staff members' comments included, "I did three days induction when I started", "All staff study for the Care Certificate" and "We shadow staff as part of induction."

The staff training record showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included, mental health, dignity in care, dementia care, distressed behaviour, catheter care, pressure area care, Parkinson's disease, diabetes, care planning and drugs and alcohol.

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "I do supervisions with some support workers", "[Name] does my supervision" and "The manager does my supervision." Staff told us they were well supported to carry out their caring role. Staff said they could also approach the manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. For example, one record stated, 'I have soft foods due to problems with my oesophagus and normal fluids.' There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised nutritional screening tool. This included monitoring people's weight and recording any incidence of weight loss.

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We saw food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received nice food. People's comments included, "I have to watch what I eat", "There is plenty to eat" and "There is always a choice." We saw people's comments from the provider's survey included, 'The food is good', 'Breakfast is always on time', 'We've got a good cook', 'Smashing food' and 'I love the prawn cocktail.' Hot and cold drinks were available throughout the day.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, the dietician, optician, speech and language teams, behavioural team and General Practitioner(GP). Records were kept of visits and any changes and advice was reflected in people's care plans. For example, we saw a care plan was available from the behavioural team to provide guidance to staff for a person who displayed distressed reactions. Comments from a GP in response to a provider survey of 2015 stated, 'Staff are very organised and make time to accompany me on my visit to patients in the home which makes my visit more effective for patient care.'

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and had received training in the MCA and the related DoLS. The manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The manager told us two applications had been authorised and 13 applications were being processed by the local authority.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. For example, one care plan stated, '[Name] has full capacity and will make all their choices and decisions independently'. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

People's needs were discussed and communicated at staff handover sessions when all staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. Staff members' comments included, "We have handovers every day as communication is so important amongst staff", "Communication is okay" and "We're told how people are when we come on duty."

There was a programme of decoration around the home. The manager showed us the programme of redecoration that had taken place in communal areas and bedrooms. We were shown the list of areas that were to be decorated and improved. However, we considered improvements were required to the hall flooring and the stair case carpet leading to the lower ground floor as they were worn and marked. The registered manager told us that this would be addressed. After the inspection we were informed carpet and floor covering had been replaced in the identified areas.

Good

Is the service caring?

Our findings

People we spoke with were positive about the care and support provided. People's comments included "Staff are kind", "The staff are very caring", "Its brilliant here" and "The staff are fantastic."

People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people were very relaxed. Staff were patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, "Give me your hand to help you feel the pudding dish." Staff offered assistance to people as they moved from their seat or when a staff member offered a person a choice of drink.

We observed the lunch time meal. The meal time was relaxed and unhurried. Staff interacted with people as they served them. Tables were set for three or four and staff remained in the dining area to provide encouragement and support to people. Staff provided prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way. For example, "Have you had enough to eat" and "Shall I top your tea up." We observed people were given a choice of meal and staff verbally described and showed people what was available. We observed a staff member showed a person two plates of food and explained their choices to them.

Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say, for example, if they were in pain. For example, one care plan recorded, 'Will tell staff if they are in pain.' Staff gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Other people told us they were offered choices and involved in daily decision making about other aspects of their care. For example, activities, bathing and rising and retiring routine. Peoples' care plans contained detail of how staff were to support them with their choices. Examples in care plans included 'At mealtimes show [Name] what is on the menu, they can choose what they want to eat', and "[Name] is very aware of what they can and can't do and staff are to check with them to ensure."

Information was available for people to keep them informed and to help them make choices. Notice boards were available that advertised the daily menus and activities available. The results of provider surveys that were completed by people and their relatives were also displayed. Information included the action that had been taken where improvements were required, for example, with regard to food and menus.

People's privacy and dignity were respected. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt cardio pulmonary resuscitation" (DNACPR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told an advocate was involved with one person to provide an independent 'voice' due to the person's circumstances.

Requires Improvement

Is the service responsive?

Our findings

We had concerns with some aspects of record keeping.

Staff knew the individual care and support needs of people, as they provided the day to day support, however care records did not all reflect the care provided by staff.

Records confirmed that pre-admission assessments were carried out. Record keeping for some people however was not consistent. Up-to-date written information was not always available for staff to respond to people's changing needs. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Records did not show that monthly assessments of all peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition and pressure area care. Care plans were usually developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, activities of daily living, communication and moving and assisting needs. However, a care plan was not in place for a person who had been assessed as being at risk of pressure area damage. A record stated, 'I have a Waterlow score of 30 and I am at very high risk of developing pressure weakness,' but no care plan was in place to inform staff of the action to take to address the risk.

A person's care plan for nutrition stated they required a soft diet because of problems with swallowing however we observed the person was not served with a soft diet at the teatime meal. We checked with the manager who told us the person had chosen their meal and no longer required a soft diet but the care plan had not been updated to reflect this change in need. We also checked with the cook who told us they were not aware the person required a soft diet. They told us they received verbal information from staff when people required a specialised diet. However, a formal record was not available in the kitchen to show changes that had been communicated about people's dietary requirements. The manager told us that this would be addressed.

Care plans provided details for staff about how the person's care needs were to be met. Examples in care plans included, '[Name] requires their hair washing by the staff and weekly they will go to the hairdresser. Staff are to let [Name] know when the hairdresser is in the home ', 'Staff must let [Name] know when the library visits to see if they want to change their books', '[Name] enjoys a cup of tea with two sugars'. However, there was no evidence of regular evaluation of people's care plans to ensure they reflected the current needs of people.

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans. However, not all relevant information was recorded in an accessible place. For example, a GP had visited a person but this was not documented in the daily record that all staff read but rather the information was included in a separate record of people visiting that was not easily accessible.

Charts were completed to record any staff intervention with a person, for example, recording food and fluid intake, when staff turned a person in bed where it was an identified risk regarding pressure areas, when personal hygiene was attended to and other interventions. However, we noted the food charts did not accurately record the person's daily nutritional intake. The fluid charts did not total the amount of fluid the person had drunk each day in order to monitor the daily amount of fluid taken where the person was at risk of dehydration and pressure area issues. The manager told us that this this would be addressed. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

An activities organiser was available and when they were not on duty staff carried out activities with people. A programme of activities was advertised and this included, memory bingo, baking, conversation, ball games, quizzes and card games, sing-a-long, musical bingo, pamper sessions, hairdressing. People were supported individually to follow their previous interests and hobbies. For example, a person was supported to play chess. Entertainers visited the home and people had the opportunity to visit the local community for individual and group outings.

Regular meetings were held with people who used the service and their relatives as part of consultation with people about the running of the home. For example, people were informed about the programme of refurbishment that was taking place. Other topics included for menus and activities. The registered manager told us meetings provided feedback from people about the running of the home. We saw meetings were held every two months in order to assist communication between people who used the service, relatives and staff at the home.

People said they knew how to complain. Peoples' comments included, "I'm fine here, the care is very good", "I'd speak to the manager if I had any concerns" and "I've no complaints." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw six had been received and had been investigated and resolved.

Requires Improvement

Is the service well-led?

Our findings

A manager was in place who was in the process of registering with the Care Quality Commission. The manager had been pro-active in submitting statutory notifications to the Care Quality Commission, such as safeguarding notifications, applications for Deprivation of Liberty Safeguards and serious injuries.

The manager had been recently appointed and they had worked at the service for several years in other caring roles. They were enthusiastic and had many ideas to introduce to promote the well-being of people who used the service. Staff we spoke with were very positive about their management and had respect for them. The manager told us they had introduced changes to the service to help it run smoothly and to ensure it was well-led for the benefit of people. They responded quickly to address any concerns that may be raised. The atmosphere in the home was friendly and relaxed. Staff said they felt well-supported. They said they could approach the manager at any time to discuss any issues. Staff members' comments included, "The new manager is 100% approachable", "I have great respect for the manager" and "There's good teamwork and we all get on."

The manager was introducing changes to promote more person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may have wanted, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were being encouraged to retain control in their life and be involved in daily decision making.

We had concerns with some aspects of the auditing of records.

Records showed audits were carried out regularly. They showed results of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included fire checks and health and safety. Monthly audits included checks on accidents and incidents, health and safety, staff training and supervision, records, medicines management, infection control, nutrition, home presentation and falls and mobility. Checks were also carried out on personnel files and finances. The manager told us monthly visits were carried out by the area manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents and staff files. We also saw a care director's report from August 2016 that had included a check on pressure area care, weights and safeguarding alerts. Audits and visits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. We saw the action that the manager had introduced as the result of their audits in August 2016 for example, record keeping. This included more effective communication, care planning and pressure area care

During the inspection we highlighted some deficits in record keeping and some work was required to ensure the audits that were being carried out were more effective in the future. This was to ensure people's care needs were more accurately reflected in their care records. The issues we found as part of our inspection had not been picked up by the audits that had been carried out.

However, as identified we considered more work was required to ensure the audits were effective to ensure people's care needs were more accurately reflected in care records.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Staff told us and we saw staff meeting minutes to show staff meetings took place regularly and these included senior staff meetings, night staff meetings, support worker meetings and domestic and kitchen staff meetings. Areas discussed included, laundry, care related issues topics, resident dining experience and staff performance.
Meetings assisted communication and helped to keep staff informed and involved in the running of the home.

Regular analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence, for example, when a person had fallen.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were completed annually by staff and people who used the service. We saw some surveys had been completed by people who used the service and professionals for 2015. Results were analysed and action taken to respond to people's feedback. We saw the results of the last survey were advertised in the hallway. The display was broken down to show all actions taken. For example, 'What you said, what we did and what we will do next, e.g. complaints about laundry, laundry assistant employed, retain them and get your feedback.' This showed people were listened to and the manager was pro-active in involving people and improving outcomes for them as they used the service. Comments from the last survey included, '[Name] is well-looked after at Werneth Lodge and I am satisfied with the care they receive' and 'Everything works so don't mend it.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured systems and processes were established and operated to ensure compliance with the registered persons need to: assess, monitor and improve the quality and safety of the service; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, maintain an accurate, complete and contemporaneous record for each person; evaluate and improve their practice. Regulation 17 (2)(a)(c)(f)