Bewick Waverley Limited

Waverley Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

We carried out an inspection of Waverley Lodge Care Home on17 August, 22 and 28 September 2016. The first and second days of the inspection were unannounced. We last inspected Waverley Lodge Care Home in January 2016 to follow up previously identified breaches of regulation. We found the service was not meeting the regulation regarding safe care and treatment. Other regulations in force at that time were being met.

Waverley Lodge is a care home providing accommodation with nursing and personal care for up to 45 people. The service is primarily for older people, including people with dementia.

The service had a registered manager in post. A registered manager is a person who has registered with the CQC 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 and assisted us during this inspection.

People told us they felt safe and were well cared for. Staff took steps to safeguard vulnerable adults from harm and promoted their human rights. Incidents were dealt with appropriately and referred on to the appropriate authorities, which helped to keep people safe.

The building was generally safe and mostly well maintained. A small number of maintenance items were identified and some bathing and shower facilities required refurbishment. The property was purpose built as a care home and further steps had been taken to make the building suitable for the people living there, including for people living with dementia. Additional signage and control measures were used to highlight and minimise potential hazards and orientate people to the building. Risks associated with the building and working practices were assessed and steps taken to reduce the likelihood of harm occurring. The home was clean throughout, although some inappropriate storage was evident in a sluice room. There was limited availability of moving and handling equipment.

We observed staff acted in a courteous, professional manner when supporting people. Further guidance was required to promote safe manual handling for some individuals. We observed most staff adhered to safe manual handling practices, but queried the use of under arm support when staff transferred people from lounge armchairs to wheel chairs.

We received mixed views regarding the adequacy of staffing levels. The provider had a robust system to ensure new staff were subject to thorough recruitment checks. Improvements had been made to the way medicines were managed although record keeping and audit arrangements required further work to ensure medicines could be well accounted for.

As Waverley Lodge Care Home is registered as a care home, CQC is required by law to monitor the operation

of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the registered manager was familiar with the processes involved in the application for DoLS. Arrangements were in place to assess people's mental capacity and to identify if decisions needed to be taken on behalf of a person in their best interests. Where necessary, DoLS had been applied for, although further guidance was needed where people received their medicines covertly. We observed staff obtained people's consent before providing care.

Staff had completed safety and care related training relevant to their role and the needs of people using the service. Further training was planned on a regular cycle to ensure their skills and knowledge were up to date. The majority of staff told us they were well supported by the registered manager. Formal supervision meetings were conducted and staff told us they could seek guidance and advice from the registered manager and nurses on duty. Staff performance was assessed and targets set for their on-going training and development.

People's nutritional status was assessed and plans of care put in place. People's health needs were identified and external professionals involved if necessary. This ensured people's general medical needs were met promptly. People were provided with assistance to access healthcare services.

Staff displayed an attentive, caring and supportive attitude. We observed staff interacted positively with people. We saw that staff treated people with respect and explained clearly to us how people's privacy, dignity and confidentiality were maintained.

Activities were offered within the home on a group and one to one basis. Visitors were able to come and go freely. The home had a variety of communal rooms and quiet spaces which enabled people to sit in company or enjoy a quieter atmosphere. Staff understood the needs of people and we saw care plans and associated documentation were clear, up to date and person centred.

People using the service and most staff spoke well of the registered manager and they felt the service had good leadership. Some staff felt arrangements to rotate staff into different units in the home could have been more effectively managed. We fed back these comments to the registered manager. People using the service, visitors and staff said they would recommend the home to family or friends. We found there were a range of systems to assess and monitor the quality of the service, which included feedback from people receiving care and others. Some areas requiring improvements had not been fully addressed or improvements had not been sustained when the registered manager was absent.

We made recommendations regarding assessing and determining safe staffing levels and activities.

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

Inadequate

The service was not consistently safe.

People said they were safe and were well cared for. New staff were subject to robust recruitment checks. Staff appeared unhurried, but we received mixed feedback about whether they were sufficient to meet people's needs safely.

Routine checks were undertaken to ensure the service was safe, although the completion of electrical and gas safety works could not be evidenced. There were systems in place to manage risks and respond to safeguarding matters.

Medicines were not always managed safely, with records not always fully or accurately completed and audits failing to identify and address the issues we found.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were supported by the registered manager and who received safety and care related training. Further training reflective of people's needs was planned.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had developed good links with healthcare professionals and where necessary actively worked with them to promote and improve people's health and well-being.

Is the service caring?

Good

The service was caring.

Staff displayed a caring and supportive attitude.

People's dignity and privacy were respected.

Staff were aware of people's individual needs, backgrounds and

personalities. This helped staff provide personalised care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

A limited range of activities were offered.

People were satisfied with the care and support provided.

Care plans were person centred and people's abilities and preferences were recorded.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had a registered manager in post. People using the service and staff made mostly positive comments about them.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people using the service and their relatives. These did not always result in timely improvements.

Waverley 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 checked whether the provider was 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 17 August, 22 and 28 September 2016 and the first two days were unannounced. The inspection team consisted of an adult social care inspector and a pharmacist inspector who assisted at the inspection on 17 August 2016.

Before the inspection we reviewed the information we held about the service, including notifications. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. Before the inspection, the provider completed 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. We contacted the local authority commissioners of the service.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home, including observations, speaking with people, interviewing staff and reviewing records. 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. We spoke with four people who used the service and three visitors. We spoke with the registered manager and eight members of staff, including six care workers the chef and an ancillary worker.

We looked at a sample of records including four people's care plans and other associated documentation, medicine records, four staff files, which included staff training and supervision records, two staff member's recruitment records, complaint, accident and incident records, policies and procedures, risk assessments and audit documents.

Inadequate

Is the service safe?

Our findings

We checked the action taken in response to the breach in legal requirements about medicines management that we had found at our last inspection. Some items of concern had been addressed such as signed as administered medicines being stored in pots in the medicines trolley. At this inspection we found staff ensured hand written entries were signed and countersigned by a second member of staff to verify the accuracy of the instructions, which was not the case at our last inspection.

Audits had not led to improvements to some issues we found at our previous inspection. Records relating to medicines were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly recorded when they were received into the home or when medicines were carried forward from the previous month. This meant accurate records of medicine stocks were not available and care workers could not monitor when further medicines would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose. As found at the last inspection, one staff signature was difficult to distinguish from another code used to record non-administration.

We saw that the application of some creams had been delegated to carers. Although the home had a policy stating there should be a topical medicines application record in place with information on where to apply, and the frequency of application, the guidance we saw was incomplete and the recording of the application of these products was poor. For all of the people on the ground floor a topical application chart was written out for the start of the medicine administration cycle but had not been completed for any person.

When we checked a sample of medicines alongside the records for 16 people, we found that eight medicines for four people did not match up so we could not be sure if people were having their medication administered correctly.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent and refuse treatment. We saw that the GP had authorised covert administration (adding medicines to food) for two people who did not have capacity and were refusing essential medicines. However, the information on which medicines staff could give covertly or how they would do this was not up to date. This information would help to ensure that staff gave people their medicines safely when they were unable to give consent.

We looked at the guidance information kept about medicines to be administered 'when required'. Whilst this was available for most people, we found this was not kept up to date when changes happened or when new medicines were started. This information would help to ensure staff gave people their medicines in a safe, consistent and appropriate way. For example, one person had a regular medicine changed to when required but no guidance had been put in place to assist care staff in their decision making about when it would be used. For another person the prescribed dose had changed but the guidance had not been updated to reflect this.

We looked at the current medicines administration record for one person prescribed a medicine with a variable dose, depending on regular blood tests. Written confirmation of the current dose was kept with the person's medicines administration record (MAR) sheet. Care staff were able to check the correct dose to give. Staff had recorded that this medicine had been given correctly. Arrangements were in place for the safe administration of this medicine. For a medicine that is administered as a patch, a system was in place for recording the site of application; however, this was not fully completed for one person whose records we looked at.

Medicines kept at the home were stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators that stored items of medication. Staff knew the required procedures for managing controlled drugs. Controlled drugs were appropriately stored and signed for when they were administered. Eye drops, which have a short shelf life once opened were marked with the date of opening. This meant that the home could confirm that they were safe to use.

The registered manager monitored and checked medicines to make sure they were being handled properly and that systems were safe. We found that whilst a daily and weekly system of medicine checks was in place, issues were not always identified or the registered manager was not always notified of discrepancies so that appropriate action could be taken.

Although staff had worked to ensure improvements to administration arrangements, recording and audit arrangements required further work to ensure they were robust and accurate. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service said they felt safe and comfortable at Waverley Lodge Care Home. When asked if they felt safe one person said, "I'm checked through the day." Another person said, "If I press the buzzer the nurses come straight away. I've no concerns." A relative said to us, "I think it's safe." Another said, "My mum's well looked after."

Staff were clear about the procedures they would follow should they suspect abuse. They explained the steps they would take to report such concerns if they arose. One said, "I'd go to the nurse." They expressed confidence that allegations and concerns would be handled appropriately by the registered manager and other senior staff. A comment was, "They get well dealt with." Staff confirmed they had attended relevant training on identifying and reporting abuse. The registered manager and other senior staff were aware of when they needed to report concerns to the local safeguarding adult's team and where appropriate to other agencies. We saw that concerns had been reported appropriately so steps could be taken to protect people from the risk of further harm.

Arrangements for identifying and managing risks were not always completed in sufficient detail. Where concerns were apparent about a person's mobility, behaviour, or general welfare and there was the risk of them being harmed, staff had assessed the risks and developed plans of care to address these. Risk assessments were in place to inform staff of the area of concern and to ensure a consistent approach was taken to minimise risks. Needs assessments, support plans and risk assessments were periodically reviewed and kept up to date to ensure they accurately reflected people's level of need, and the associated level of risk. Examples included risks associated with manual handling, falls and pressure area care. Some of those relating to people's mobility and manual handling needs required updating as they did not reflect the person's current needs.

Staff use handling belts and safe manual handling techniques during the mealtime on the first floor. In

contrast staff used inappropriate manual handling techniques when supporting two people to move from lounge to wheelchairs. Manual handling plans for one of these people contained only limited information about the type of support to be provided and for the second did not detail the level of support and equipment to be used when supporting chair to chair transfers. A staff member told us, "Most service users need two staff to attend to their needs." When asked about the equipment available another said, "We've a hoist, moving belt but the turn table's gone. There's no stand aid. The bath hoist is manual." We asked staff to show us where equipment, such as handling belts were located. They were not always able to locate such equipment in a timely manner. We also found that only one mobile hoist was available, as the second hoist required repair or replacement. We highlighted these concerns to the registered manager so immediate action could be taken to review manual handling guidance, practice and the availability of equipment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents were logged and analysed. Each month accidents were summarised and reviewed, the majority of which were un-witnessed falls. Records included provision for the registered manager to detail the findings from any investigation and lessons learnt. Where people were at particular risk of falls, or other accidents, referrals were made to other professionals such as the General Practitioner (GP).

The registered manager's view was that staffing levels were adequate to meet people's needs safely. A needs dependency tool was used to formulate staffing levels. This enabled the registered manager to determine a baseline figure from which to determine suitable staffing levels. We heard mixed views about the adequacy of staffing levels. A person who used the service whom we spoke with said staff were able to respond to their needs promptly and would regularly check on their wellbeing. A relative said, "(Staff) could do with more. At the weekend there's two staff for the whole floor." Another commented to us, "Most of the time there's enough staff." Two staff said, "We need more staff." Others felt staff levels were suitable. Staffing rotas indicated that care and nursing staff levels were the same during the week and at the weekend. We observed many people on both floors required two staff to assist them with manual handling and also required observation due to the risk of falling and incidents of aggression. This meant there were occasions when people would be left unattended.

We recommend the registered person seeks advice from a reputable source on the suitability and applicability of the staffing assessment tool used at this location in relation to the needs of people living there.

Overall, the home was safe and clean, although we highlighted several hazards which required attention. Individual rooms were clean and fresh-smelling. Wardrobes were secured to the walls, windows were restricted and other practical measures were in place to keep people safe. For example, bath hot water temperatures were maintained within a safe and comfortable range. Magnetically secured doors were fitted in areas where there was a risk of people accessing stairwells to prevent inadvertent access to these areas hazardous to people with reduced mobility, and to reduce the risk of unobserved falls. We were able to gain access to the unlocked sluice room on the first floor. We ensured this was locked and highlighted this to the registered manager to ensure nobody accidently accessed this area. Some fire exits had trip hazards, including loose paving and a bramble that had grown across an exit at ground level. These were highlighted for immediate attention.

Electricity, gas and water system checks were carried out by external contractors. A legionella survey had been undertaken and risk factors had been dealt with. At the last electrical installation inspection there were 26 items classified as 'Potentially dangerous. Urgent remedial action required' and 136 observations

classified as 'Improvement recommended'. Confirmation we requested that the potentially dangerous items had been addressed was not supplied to us during or after the inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were vetted for their suitability to work with vulnerable adults before they were confirmed in post. The application form included provision for staff to provide a detailed employment history. Other checks were carried out by the registered manager and included ensuring the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions. We found one worker had only one reference and an employment history was not available for inspection. We highlighted these gaps to the registered manager who confirmed receipt of this information shortly after our inspection

Good

Is the service effective?

Our findings

People who used the service made positive remarks about the staff team and their ability to do their jobs effectively. One person said of the staff, "The staff are very, very good. I have everything I require." A relative remarked to us, "It's fine the staff are excellent, it's clean and tidy." A thank you card included the statement, "I think you are all amazing and do a fantastic job."

Staff said they received individual and group supervision and attended training relevant to their job role and people's needs. One staff member said of their training, "I've had quite a lot of training." Staff we spoke with said they received occasional supervision with the registered manager. A staff member told us, "I had a supervision not that long ago and had first aid training. Our moving and handling training is up to date." Records confirmed staff attended individual supervisions and group meetings in line with the provider's expectations. The records of supervision meetings contained a summary of the discussion and the topics covered were relevant to staff roles and their general welfare. Where specific problem areas were identified, these were discussed and recorded so that expected standards of work were clarified.

Records showed staff had received safety related training on topics such as first aid, moving and handling, and food hygiene. Topics and learning opportunities relevant to the health and care needs of people using the service were also offered. Further training was planned, including refresher training once training was deemed to be out of date. Staff also had access to additional information and learning material relevant to the needs of people living at Waverley Lodge Care Home.

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.

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 of authorisations to deprive a person of their liberty were being met. There had been 12 DoLS authorisations applied for and granted during the past year. Those we examined were being adhered to appropriately, with any restrictions being the least restrictive possible.

People living at the home told us they were not subject to unnecessary restrictions. We observed people being offered day to day choices and people were able to move freely within the home and gardens. We discussed the requirements of the MCA and the associated DoLS with the registered manager. They told us people's capacity to make decisions for themselves was considered as part of a formal assessment. We also saw people's decision making capacity and consideration of 'best interests' was included within the care planning and risk assessment processes. Those people living with dementia had their capacity to make decisions assessed. Where they lacked capacity and decisions were taken in their best interests, a DoLS had

been applied for. A copy of the authorisation was retained on file so staff were aware of any relevant conditions attached to the authorisation, including those relating to medicines. We highlighted the need for the registered manager to review the safeguards and care plan guidance for two people where it was deemed in their best interests to receive essential medicines by covert administration, in line with National Institute for Health and Clinical Excellence (NICE) guidelines.

We recommend that the registered manager considers the NICE guidelines on managing medicines in care homes.

People expressed positive opinions on the food and drink provided and the support they received. Comments we heard included, "I've got everything I require. The food's quite nice actually", "I couldn't eat before I came here, but I'm eating now. I couldn't be happier", "I'm a very fussy eater. The chef will do something special for me if I don't want what's on the menu", "It's very good food. I get plenty to drink", "I have a drink, everything's at hand" and "I'm building up. They weigh me regular."

Staff undertook nutritional risk assessments and if necessary drew up a plan of care for meeting dietary needs. People's weights were regularly monitored to ensure care was effective and to identify the need for additional advice and support from the GP or dietitian. We saw this support and advice had been arranged where people were at risk of malnutrition. The chef told us they would fortify meals with full fat milk and butter to help people build and maintain their weight. The chef informed us that there was good communication between catering and care staff and that smaller meal portions and finger foods would be provided where this was an identified need. We observed staff were kind and caring when offering support at meal times, being seated with those people who needed help to eat and drink.

We observed people living at the home being offered drinks and asked their preference at regular intervals. Drinks were available for people in their bedrooms. Where people were at risk of poor hydration, this was recorded and their fluid intake monitored.

People using the service confirmed that health care from health professionals, such as the GP or dentist could be accessed as and when required. One person said in relation to medical professionals, "Everybody's here to sort things out." Another person remarked, "I've got the Doctor coming today." A relative told us, "The nurses will contact the doctor if they think it's necessary." Records showed people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. Links with other health care professionals and specialists to help make sure people received appropriate healthcare had been made. We saw care plans relating to healthcare needs were in place and provided information relevant to the healthcare need. Medical history information was gathered and was available in a way that could easily be communicated with other services, for example when someone needed to be admitted to hospital at short notice.

Good

Is the service caring?

Our findings

People using the service told us they were happy living at the home and their privacy and dignity were promoted. One person said, "The girls are out of this world. They bend over backwards for you." A visitor told us, "(My relative) is always clean and tidy." The thank you cards we looked at expressed the caring and compassionate approach of staff. A person using the service had written, "Every time I've asked for help you've been there for me." A selection of cards from relatives included the comments, "You have all shown professionalism but even more than that you have been an extended family showing huge amounts of love, kindness and humour", "I'd like to thank you for the way you looked after my dad with such care, compassion and friendliness. It is of great comfort to know he had people around him who cared" and "She really loved it there and was very happy … the lovely staff gave 100% care."

We saw people being spoken with considerately and staff were seen to be polite. We observed the people using the service to be relaxed when in the presence of staff. We observed staff members interacted in a caring and respectful manner with people using the service. For example, support offered at meal times was carried out discreetly and at a pace that suited each person. Where staff provided one to one support they sat with, chatted to and interacted politely with the person. We observed appropriate humour and warmth from staff towards people using the service.

Staff handled potentially challenging situations in a sensitive and patient way. Where people were unable to tell us about their care, we observed they were relaxed in the company of staff and responded positively when they engaged with them. People cared for in bed looked comfortable, well cared for and had the necessary aids for their safety and comfort. The atmosphere in the home appeared calm, friendly, warm and welcoming. The care records written by staff were clear, factual and used appropriate, respectful language.

Staff s induction training included the need to take a person-centred approach. On-going training included equality and diversity awareness. Staff were positive about the way they worked with people and their role. One said, "Our priority is the residents. You've got to enjoy your work to come in and we enjoy it." Those we spoke with knew people well and were able to describe people's preferences and how care would be tailored to meet their individual needs.

Staff acted appropriately to maintain people's privacy when discussing confidential issues or helping people with their medicines. Staff we spoke with were clear about the need to ensure people's privacy, making sure personal matters were not discussed openly and records were stored securely. People confirmed staff would knock on bedroom doors before entering and we saw this during the inspection. During the inspection we observed people were able to spend time in the privacy of their own rooms and in different areas of the home. We also saw practical steps had been taken to preserve people's privacy, such as door locks fitted to toilets and bathrooms.

People and those important to them told us they were involved in decisions about their care and stated if they had any worries they could approach the staff and they would help. Relatives informed us that they were kept up to date and involved in important decisions about the person's care. One relative said, "The

communication's excellent." A staff member told us, "We know our residents really well." Evidence that people using the service were involved in aspects of planning their care and treatment was also documented in care files. The registered manager was aware of local advocacy services available to support decision making for people should this be needed. Staff told us they were updated about people's needs at 'hand over' meetings to ensure such decisions were implemented in practice, although, when asked they remarked that handovers were facilitated by staff either arriving at work early or staying on once their shift had ended.

Requires Improvement

Is the service responsive?

Our findings

People told us the service was responsive to their needs and they were listened to. One person told us, "If I'm unhappy I can speak to the manager." Another person said, "It's absolutely fantastic. I've no complaints."

Staff identified and planned for people's specific needs through the care planning and review process. We saw people had individual care plans in place to ensure staff had the correct information to help them maintain their health, well-being and individual identity. When people had moved to Waverley Lodge Care Home an initial assessment of their needs had been undertaken. Their needs had been reviewed and re-assessed since that time. From these reviews and assessments a number of areas of support had been identified by staff for which care plans were developed. These outlined the care needed from staff. Areas included care in relation to people's nutritional needs, mobility and medicines.

Staff developed care plans with a focus on maintaining people's well-being and independence. Care plans were evaluated periodically to ensure there were meaningful and based on the progress made in achieving identified goals, such as helping people to gain weight or maintain good personal hygiene. We provided advice to the registered manager on areas where these needed updating or where further detail would be beneficial to improve guidance for staff. This included where a person needed help with their mobility and with medicines.

Care plans were sufficiently detailed to guide staffs' care practice and gave a clear summary about each person and their needs. Staff detailed the advice and input of other care professionals, such as the General Practitioner (GP), within individual care plans so that their guidance could be incorporated into care practice.

Progress records were available for each person. These were individual to the person and written with sufficient details to record their daily routine and note significant events. The records also helped monitor people's health and well-being. Additional monitoring records helped evidence the care and support provided, for example with weights, diet and fluid intake. Areas of concern were recorded and these were escalated appropriately, for example to the GP and other community healthcare professionals, such as the dietitian, speech and language therapist and psychiatric staff from the local 'challenging behaviour team'.

Staff had a good knowledge of the people living at the home and could clearly explain how they provided support that was important to each person. Staff were readily able to describe people's preferences, such as those relating to their health and social care needs, personal preferences and leisure pastimes.

The people living at Waverley Lodge Care Home accessed activities in the service. A person at the home informed us, "We get entertainers." Another person told us, "There's something coming up; a singer." A relative expressed the view, "There's not a lot (of activities) in the afternoon. There's been a minibus to Blyth for fish and chips, tea dancing, crafts and baking. There was a singer and Irish dancing." During our inspection we saw people were able to accept visitors throughout the day and could receive their guests in private or shared lounges. Some staff expressed the view that the amount of activities could be improved

and that this could be improved if there was a reduction in associated paperwork.

We recommend the provider reviews the scope and frequency of activities offered in the home.

People using the service expressed a good understanding of to whom and how to complain. Most said they would speak to a member of staff and the registered manager if they had any concerns. Relatives told us, "We've no serious complaints", "If I'm not sure about things I'd contact the staff straight away. I would speak to (manager) if they can't help" and "Small things will get resolved. They're not ignored." The registered manager informed us there were no complaints received over the past year. A record of compliments was kept, as well as numerous thank you cards, where people expressed thanks and gratitude for the care given and approach of staff.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2016 breaches of legal requirements were found. These included a failure to ensure suitable arrangements for the safe care and treatment of people using the service. This was specifically in relation to the safe management of medicines. The provider also failed to send an action plan to the Care Quality Commission (CQC) as requested at that time. The provider and registered manager assured us they would develop and send to CQC an action plan outlining how they would comply with legal requirements. The action plan received was brief and made no mention of the safe management of medicines.

We saw the registered manager, senior staff and a handyman carried out a range of checks and audits at the home. These included audits of medicines, equipment and the safety and condition of the building. Internal safety checks were recorded in documentation commonly applied across all of the provider's services and covered aspects of fire and environmental safety expected of regulatory bodies.

Although some aspects of medicines management had improved since we last inspected, we found continued shortfalls in recording and audit arrangements. We also found that improvements required as a result of routine safety checks, for example to the electrical and gas services, could not be clearly tracked and evidence necessary improvements in the safety of the service. We also found recruitment records for a newly employed worker were not available until after our inspection, and audit systems had not identified the absence of this information; required for the registered manager to verify staff had been safely recruited.

We concluded that the systems in place to assess, monitor and improve the quality and safety of the service, and to mitigate risks to people living at the home, had not been consistently effective.

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

At the time of our inspection there was a registered manager in place. They had been registered in respect of this service in May 2005. One person told us, "[Manager] she's like one of us. I can't fault her. She's interested in how I'm getting on." Another said, "The manager's very interested." A visitor said of the home, "It's fairly well run." The majority of people, visitors and staff we spoke with said they would recommend the service. Comments included, "I would recommend. I had a look round a few places. This was the nicest one and I haven't regretted it", "I'd recommend it to everybody" and "I'd probably recommend. I feel the décor needs an upgrade."

Staff expressed mixed views about the leadership of the service. One staff member said, "I can tell her [manager] anything. I would go to her or above." Others expressed concerns about the approach taken to revise working arrangements in the home. We saw these concerns had also been raised at staff meetings. These comments were shared with the registered manager so they could review the approach taken and on-going consultation with staff.

The registered manager was present and assisted us with the inspection. They appeared to know the people using the service and the staff well and had a visible presence within the home. Paper records we requested were produced for us promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and was open to working with us in a co-operative and transparent way. They were aware of the requirements to send the Care Quality Commission notifications for certain events and had done so, with one exception relating to an incident reported to the police. We reminded the registered manager of the need to notify CQC of such events and this was sent to us on our request shortly after the inspection.

The home had a clear staffing structure, with a Registered Manager, supported by senior carers. The registered manager was an experienced social care practitioner, however at the time of the inspection the deputy manager's post was vacant and there was no identified clinical lead. The registered manager and senior carers attended on-going training to maintain their awareness of current good practice. They also sought the advice and input of relevant professionals, including nurses employed at the home and external health and social care professionals.

Annual questionnaire surveys were carried out and those received from people using the service, their relatives and care professionals contained positive feedback. Comments included; "Staff always happy", "Staff are happy and helpful", "Yes the cleaner works very hard to keep the place clean", "Yes everyone is lovely here" and "Most of the staff are lovely."

People using the service and staff had the opportunity to be involved in the running of the home and to be consulted on subjects important to them. Staff said they were kept informed about matters affecting the home, either directly by attending meetings, supervisions at handovers or by less formal methods. The registered manager told us there were staff meetings and meetings for people living in the home. Records confirmed this was the case, and evidenced that there were discussions on what had gone well and what could be improved in the future. The team meetings included discussions about practical matters affecting the operation of the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to reduce risks to the safety of people using the service. Regulation 12(1)(2)(b)

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 provider had not ensured that effective systems were operated to assess, monitor and improve the quality and safety of the services provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. Regulation 17 (1)(2)(a)(b)