Four Seasons Health Care (England) Limited

Westroyd Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 7 February 2017 and was unannounced. We returned announced on 8 February 2017.

Westroyd Care Home is registered to provide care for up to 55 people who require residential care without nursing. The home is split in to two units, the House and the Lodge. The House provides care to people who have needs associated with older age, whilst the Lodge provides care to people who live with dementia. Each unit provides care on two floors, has its own lounge and dining rooms. At the time of our inspection there were 42 people using the service.

A manager had been in post since October 2016 and was in the process of applying for registration. It is a requirement that the home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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.

At a comprehensive inspection in August 2016 the overall rating for this service was Requires Improvement with one breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 was identified. We asked the provider to make improvements to ensure the safe management of medicines.

The provider sent us an action plan stating they would have addressed the breach of Regulation 12 by September 2016.

During this inspection we found the provider was continuing to breach this regulation. Medicines were still not managed in a safe way. People could not be assured they would get their medicines when they were prescribed.

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

People said they felt safe at the home. Staff understood how to report any concerns and were confident these would be dealt with by the manager. People did not always think there were enough staff on duty to support them. Staff had been recruited in a safe way to make sure they were suitable for their role.

People received support from staff who had the appropriate skills and knowledge to support people living at the service. Staff had received regular training in areas relevant for the people they supported.

People and relatives told us staff were kind and caring. Staff were respectful and helpful when supporting people. Staff were able to develop good relationships with the people who lived at Westroyd Care Home.

Relatives felt the activities in the Lodge were good but people living in the House still felt they needed to

improve.

Staff understood the requirements of the Mental Capacity Act (2005) and understood how to obtain people's consent before they offered care and support. Staff knew how to support people to make decisions for themselves. Where people may have lacked the capacity to make their own decisions, the provider had followed the requirements of the Act.

People enjoyed the food that was offered to them and received the right support with their nutrition and hydration needs. People could choose what they ate and their preferences and requirements were known by staff.

People had access to healthcare professionals to maintain good health.

The provider has systems in place to enable people to make a complaint or comment on the service and where comments were received these were acted upon. Relatives and staff felt they could talk with the manager at any time and said they were approachable.

Staff were clear about their roles and responsibilities. They knew how to raise concerns if they had needed to about the practice of a colleague. Staff were able to make suggestions for how the service could improve.

The manager understood the requirements of their roll, including informing CQC of any incidents or accidents.

The provider's quality assurance systems were not always effective in making sure people received a safe and good quality service. For example, the provider's checks had not identified shortfalls in the safe management of medicines.

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 management of medicines was inconsistent across the House and the Lodge and meant that people did not always get their medicines as prescribed.

Staffing levels did not always ensure people felt confident that their needs would be met at all times.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities to protect people.

Individual risks had been assessed and identified as part of the care planning process.

Recruitment practices were safe and relevant checks had been completed before staff commenced work

Is the service effective?

Good

The service was effective.

Where people lacked the capacity to make decisions, their plans of care showed that decisions had been made for them in their best interest and in consultation with others. Staff members understood the principles of the Mental Capacity Act 2005.

People now received a balanced and varied diet and their nutritional needs were met. Records showed where people needed to have their nutrition and hydration monitored this was carried out.

Staff were aware of people's health care needs and referred them to health professionals when needed.

Is the service caring?

Good

The service was caring.

People told us the staff team were kind and caring and we observed staff members treating people in a caring and considerate manner.

People's privacy and dignity were respected.

People were supported and encouraged to make choices about their care and support on a daily basis.

Is the service responsive?

Good

The service was responsive.

People's assessment and review of their needs occurred regularly.

People's support and their plans focused on them as individuals in line with their preferences.

People and their relatives knew how to make a complaint if they had wanted to and could give feedback to the provider.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

Quality assurance checks were not always robust or effective enough to ensure that shortfalls in medicine's management.

There is currently no registered manager for this service.

Staff were encouraged to contribute to the improvement of the home and could report any concerns to their manager.

Staff understood their roles and responsibilities and were supported by the manager and could give suggestions for improvements to the service.

Westroyd 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.

The inspection visit took place on 7 February 2017 and was unannounced. We returned announced on 8 February 2017.

The inspection team consisted of two inspectors, an inspector manager, an expert-by-experience. A specialist advisor, whose area of knowledge was people living with dementia and a member of the CQC medicines team. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information that we held about the service to inform and plan our inspection. We contacted the local authority that funded some of the care of people used the service and Healthwatch Leicestershire, the local consumer champion for people using adult social care services, to see if they had feedback about the service.

We spoke with 12 people who used the service and with five relatives. We also spoke with the area manager, the manager, two unit managers, two cooks, the activity organiser and five care staff.

We looked at seven people's care plans and associated records in detail. We also looked at the medicine records of 28 people and the associated medicine care records of eight people. We looked at information about the support staff received through training and appraisal. We viewed three staff recruitment files to see how the provider operated their recruitment procedures to ensure they only recruited staff that were suited to work for the service. We reviewed records associated with the provider's monitoring of the quality of the service. These included surveys and audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 9 August 2016, we identified a breach in relation to unsafe medicines as the registered person had not ensured that people were protected against unsafe management of medicines.

During this inspection we asked people if they received medicine such as pain relief when they needed them. One person told us, "I don't do my own medication. They bring my medication to me at the breakfast table, so that's at about 9.30am. Sometimes they bring my medication to the lounge at about 4.30 to 6pm." Another person said, "When I first hurt my arm it hurt but it doesn't hurt any more. I don't need painkillers now." The person told us they had been given pain relief when they had needed it.

One of the unit manager's told us that they had attended medicines management and administration training arranged by the provider when they started work at Westroyd Care Home. They had their competency assessed and attended annual updates. They understood what action to take in the event of a medication administration error to ensure the safety of the person in the first instance and then how this is reported as an incident.

Medicines were not being given to patients as prescribed. In the House we were told that the 7am medicine round was not being done. All medicines that were written on the MAR sheets to be given at this time were given between 8.30 and 10.45 each morning. This included weekly treatments to prevent osteoporosis that are ineffective if given with other medicines or food. We also saw that Parkinson's treatments that need to be spaced evenly throughout the day to be fully effective, this may result in the person experiencing more discomfort or adverse effects of the Parkinson's disease. We observed medicines with instructions on the label stating 'to be taken half an hour before food being given with a person's breakfast. This would risk the person being in discomfort or not protected from stomach irritation. Staff told us this was because there was insufficient staff to administer medicines early in the morning. We brought this to the manager's attention who was unaware that staff were not administering people's medicines when they were needed. When we returned on the second day of our inspection we were informed that people's medicines had been administered at the appropriate time.

Some people were prescribed medicines on a when required basis. The provider's medicine policy requires that protocols to describe the use of these medicines should be included in people's records. However, these were not consistently in use. We also found that people's records did not always include sufficient information to show staff how and when to administer these medicines or how to respond if they should observe adverse effects to treatment. This meant that people may not have received their medicine in a consistent way and when it was needed

Where variable doses were prescribed we saw that the administration record did not always detail how much medicine had been given to a person on each occasion. This would mean that, in the event of further treatment being needed, a clinician would be unaware of the total dose already given to the person.

Some people within the home took controlled drugs (medicines that require additional record keeping and

storage due to their potential for misuse), we saw that records of administration of these medicines were not kept in accordance with the homes policy. We were told that an individual had received two of these medicines at the beginning of the observed medicine round. However, the medicine administration record (MAR) chart had not been signed to indicate administration. Care staff told us this was due to waiting for another member of staff to double sign the chart. We checked the MAR chart throughout the day and found it still had not been signed by 4 pm. We brought this to the regional manager and manager's attention. They told us they would ensure that in future all medicines that required two signatures were signed for at the point of administration.

MAR charts were not consistently completed when a person refused or did not require medicines. From the information recorded it was not possible to determine whether a person had refused medicines prior to them being prepared for administration or after preparation. This meant that the provider could not reliably track stock levels.

The manager told us that they completed three levels of audit of medicines in the service, daily, weekly and monthly. We saw a completed monthly audit however; they had not identified the issues of concern we had identified. This meant that we could not be assured of the robustness of the audit process. We brought this to the regional manager and manager's attention.

We saw that medicines were stored securely on both units although we could not be assured that medicines requiring refrigerated storage were stored at the correct temperatures. The fridge temperature was not being recorded in line with the home's policy; the maximum and minimum temperature was not being recorded and the thermometer was not being reset daily. This meant that the care staff could not be assured that medicines remained safe and effective to use.

This is a continued breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had medicines given via a skin patch; charts were now in place to ensure staff were able to correctly rotate the sites of application.

Where people were receiving medicines via a topically applied cream or ointment we saw that the provider had put in place topical administration charts. This ensured staff were aware of where and how often to apply the cream and records of application were being kept.

Following the first day of our inspection the regional manager requested the provider's own pharmacy technician to provide support to the service. We spoke with this person during the second day. They told us they had started work on the concerns we had raised during our first day of inspection. They had been in contact with the GP regarding medicines that stated 'as required' to have them reviewed to ensure staff had sufficient information to administer the medicines when the person needed them. Changes were being made to the timings of medicine administration rounds to ensure people received their medicines when they needed them and staff were being reminded about consistent recording where people refused their medicines.

People who used the service told us they felt safe at Westroyd Care Home. One person told us, "I'm safe here. I'm not unhappy here, I was unhappy at my last place." Another person commented, "I'm safe here. I've not heard of anything going on." A relative told us, "I've never ever seen anything that concerns me".

Staff knew how to identify and respond to signs of abuse. They knew about the provider's procedures for

reporting suspected or actual abuse. All staff had received training in safeguarding people from abuse or avoidable harm. Staff we spoke with demonstrated knowledge about the types of abuse. One staff member told us, "I look for physical signs, for example bruising, body language. I'd report using our reporting system. I've not had to so far, but I'm confident the manager would take any report seriously."

At the last inspection we found that the provider's recruitment procedures had not been followed. We saw that a member of staff had received a check with the Disclosure and Barring Scheme (DBS) check that showed they had previous spent convictions. A DBS check provides information as to whether someone is suitable to work at a service. There were no associated risk assessments in place to ensure this person was suitable to work in the service. When we looked at records during this inspection we found that all required risk assessments were now in place ensuring that the person was suitable to work at the service. Required checks had been carried out prior to new members of staff commencing work. This included obtaining suitable references and a DBS check.

At the last inspection we had found risk assessment had not been personalised. At this inspection we found that risks associated with people's care and support had been assessed and reviewed on a monthly basis. Risks to people had been assessed and documented which meant that staff had information on how to protect people from possible harm. For example, where a person was at risk of developing pressure ulcers, the risk assessment detailed what action staff should take to reduce the risk. We saw that other assessments focused on what people could do or needed support with and were regularly reviewed.

We saw that people had personalised emergency evacuation plans in place to ensure that staff had the information they needed to keep people safe in the event of an emergency such as a fire.

Where people had experienced a fall, we saw that records indicated what action had been taken to prevent a similar incident occurring again. This included, where appropriate, referrals to the falls clinic for further advice.

We checked to see if the premises and equipment were being maintained to keep people safe. Regular monitoring and safety checks of equipment were carried out to help keep people safe. People had access to specialist equipment such as wheelchairs, stair lift, walking frames, hoists, specialist beds or bathing aids to use whilst having a bath or shower. Fire, electrical, and safety equipment was inspected on a regular basis. There were systems in place to monitor when maintenance work had been completed.

We received mixed views from people and their relatives about the number of staff on duty to meet their needs. One person told us, "There are enough staff during the day but I don't think that there are enough staff at night." Another person said, "There could be more staff." Two relatives we spoke with also commented on staffing levels, they told us they were concerned about the support their [person] would receive if an incident happened and staff were taken away to manage it. A third relative said, "I think that there are enough staff."

Most of the care staff we spoke with in the House told us they did not think there were enough staff to meet people's needs. One staff member told us, "It would be better if we had more staff. There are people here who need two carers to support them at times and that can leave just one carer looking out for 13 people. That'd be difficult if something happened, say if another person needed support from two people." Another staff member commented, "We have more staff now, three cares and a senior. However, we need more at times. For example, we can have a medications round to do, a person requiring two staff for hoisting. That leaves one staff but they could have visitors to deal with. The manager does listen to our views about staffing but I think their hands are tied." A third staff member said, "We've raised views about staffing. The

manager listens but the powers that be don't support her. I think we need five care staff (including senior) in The House." During our inspection we noted that there were long periods of time where there were no staff in the lounge in the House.

In the Lodge the unit manager reported that the staffing levels had recently been increased and they felt this helped co-ordinate the shift better and had more time to ensure that care plans were up to date. The staff also reported that they felt the residents had benefited from this as the staff had more time to spend talking with them and personal care tasks were less rushed.

We saw that staffing levels were an issue after lunch when people were being brought into the lounge (The House). People in wheel chairs were being told they would have to wait until another staff member was able to assist with helping person to transfer to a chair. We saw staff effectively 'stacking' people at the entrance to the lounge as they waited for staff to become available to assist with transfers. On several occasions we saw that people waited for approximately five minutes before staff were available to provide support.

We discussed staffing deployment with the area manager and the manager. We were told that the provider had a staffing tool that looked at the dependency needs of people and it was used to decide on the number of care hours needed. This was used in conjunction with a discussion between the manager and the area manager to ensure that people's needs were reflected in the hours needed. The area manager told us they had very recently increased the staffing levels in the Lodge but would look at how staff were deployed across both units.

Good

Is the service effective?

Our findings

During this inspection people we spoke with confirmed they received a choice of meals and drinks throughout the day. One person told us, "We have a choice of food for breakfast. I just have cereal but you could have a cooked breakfast. We could have tea or fruit juice. About 10 o'clock we get something to drink. If I want a drink or something I only need to ask." Another person said, "I have cereals and toast for my breakfast but you could have porridge if you want to. We have two choices for dinner. It's always good. I'm not hard to please. If I didn't get something that I liked I would ask. The girls [staff] will soon get it for you." Relatives also thought the food was good. One relative said, "The staff make sure [person] has enough to drink." Another relative told us, "When my [person] arrived the cook came to introduce themselves and ask my [person] what sort of food they liked."

We spoke with the cook both at the Lodge and the House. They both were able to tell us about people's nutritional needs, including who was on a special diet, such as diet controlled diabetes or softened diets. During the morning we saw the kitchen assistant going to each person and asking them what they would like to eat for lunch. We saw that the menu was on display in both the Lodge and the House's dining room. We did discuss with the manager that although they were displayed they were small print and maybe difficult for people with limited sight to read. They told us that they were planning to change the menus to a more suitable format.

We saw staff in both units assisting people where necessary to eat their meal. We did note that staff in the Lodge sat with people encouraging them to talk as well as enquiring as to whether they were enjoying the meal. The atmosphere was calm and pleasant, with music playing quietly in the background. Food was presented in an appetising manner. Plates were a distinctive blue colour on white tablecloths. The dinner plates and pudding bowls were of a deep design which assisted people to get food onto spoons or forks. This follows current good practice recommendations from Alzheimer's Society on how to support people living with dementia to eat a healthy diet.

A variety of drinks were served throughout the day by the kitchen assistants. We observed them ask people by their name and offer a choice of drinks. One person had recently been prescribed thickeners by the speech and language therapy team (SALT), the assistant reminded the person about this and sought consent to add this to the drink.

Where people needed their fluid and food intake monitored this was taking place. In some cases the monitoring forms were stored in people's bedrooms to ensure that staff kept them up to date.

People we spoke with did not comment on whether they felt the staff team had the skills and knowledge to properly meet their individual care and support needs. However, one person did comment, "They seem to know what they are doing."

Staff told us that they had all received an induction when they started and had an annual appraisal and formal supervision every six months and informal supervision as and when required. One member staff felt

that supervision and appraisal were more beneficial now that it was provided by the unit manger rather than the home manager, "It just felt like a paper exercise before." Another staff member told us, "I've had a lot of training. Most is eLearning which I like. I've completed the dementia training (Dementia Care Framework) over a four month period. That was good and informative. I use the training and put it into practice." They were able to give examples of how they used their knowledge in their day to day work. "I know how important reminiscence is to people. Some like to talk about their experience during the war. I know which people like to listen to music because doing that makes a difference for them. We have activities. There is a plan, but it's not rigid, we react to people's choices and preferences on the day."

We checked the training records and these confirmed that a number of training sessions had been provided throughout 2016 and 2017. These included safeguarding training, moving and handling training and pressure ulcer prevention.

Staff members had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and those we spoke with during our visit understood the principles of the MCA and DoLS. One staff member told us, "We assess capacity all the time. As many off our residents have fluctuating capacity some days they are able to make choices about what they would like to eat and wear."

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

People can only be deprived of their liberty 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. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. At the time of the inspection the registered manager had submitted applications for DoLS authorisations. This demonstrated they understood the MCA.

Mental capacity assessments were included in the records we looked at. Where people had not been able to make certain decisions, it was evident that these decisions had been made in their best interests and by people who knew them well. We heard and observed staff seek consent to interventions where people required support with personal care. For example, "Can I help you with that?" and "Would you like to go into the lounge?" We saw that whenever possible, people had been involved in making day to day decisions about their care and support and staff gave us examples of how they obtained people's consent to their care on a daily basis. A relative also confirmed that they were involved in supporting a person with their best interest decisions. They told us, "I've been involved in decisions. I've seen the care plan; I was involved in the DoLS assessment."

People told us they were supported to see healthcare professionals when they needed to see them, this was also confirmed by relatives and records. One person told us, "I'm not ill but if I was ill they would get a doctor for me." A relative commented, "If my [person] needs a doctor staff call one out. They always tell me as well." Records showed that staff were responsive to fluctuations in people's health needs. Visits made by healthcare professionals such as, dietician, dentist and physiotherapy were recorded including any action

for staff to follow up.

Good

Is the service caring?

Our findings

People we spoke with were very positive about the care they received. They told us that the staff team were kind and caring and they looked after them very well. A person commented, "There staff are very good. I've got no complaints there. The night staff are lovely they knock my door and come in to check we're OK." Another person said, "I always feel that it's my own fault if I don't get what I want because all you need to do is ask. You take it and make it what you can. All you need to do is ask. I like it very much (here) we can't complain." Another relative commented several times throughout our conversation with them that they felt the care their [person] was receiving was significantly better than the previous home they had been in. They told us, "[Person] is new here. [Person] has only been here a few weeks. We really like it here. [Person] is better looked after than they were at their last care home. [Person] is always dressed appropriately. Their room is nice."

We observed the staff team interacting with the people using the service. Staff were kind and respectful. At different points during the day we saw staff assisting people to transfer using a hoist. Each time we saw staff do this they ensured the person was appropriately supported and explained throughout what they were doing. This ensured the person did not become anxious whilst they were being manoeuvred into their chair from their wheelchair.

People told us that staff treated them with respect and supported their dignity. One person commented, "The staff always knock before they come in my room." Another person added, "The staff are kind and caring."

We saw staff use different ways of enhancing communication by touch, ensuring they were at eye level with those residents who were seated, and altering the tone of their voice appropriately. This made interactions we saw between staff people warm and compassionate.

Staff were discreet when people needed assistance ensuring their dignity was maintained. We observed staff throughout the day knocking on people's door to ask permission to enter. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively. We saw staff with a person who became anxious after lunch and staff member sat with them until they became less anxious.

People told us they felt involved in decisions about their care and support. Comments from people included, "I go to my room at about 9.30. I look after myself. The staff offer to help me but I don't need any help." and "I'm definitely supported here."

People using the service told us that their relatives could visit at any time and visitors we spoke with during our inspection confirmed this. Visitor logs also showed that people were able to visit throughout the day and evening. A person said, "I do have visitors, they are free to come and go as they please." One relative told us, "We feel at ease here. We're made to feel welcome and we can visit whenever we want to."

We looked at people's plans of care to see if they included details about how they wanted their end of life

plans to be managed. Where people were identified as 'Do not resuscitate' (DNAR) forms did not always comply fully with the joint guidance from the British medical association resuscitation committee and the royal college of nursing 2014. This states: 'full and clear documentation of decisions about CPR, the reasons for them and the discussions that informed the decisions is an essential part of high quality care.' However in discussion with staff, we were told a person who was identified as being at end of life, had recently become more unwell. The paramedics were called as staff were clear that the person's physical presentation did not fall within the scope of their DNAR. This meant people can be assured that staff will act upon people's end of life choices.

We noted that there was no dementia friendly signage to guide people around the building or into bathrooms or toilets. The corridors were very similar in colour. Clear sign posting is important to promote orientation and independence. There were no names on bedroom doors or visual cues to prompt people to their personal space. Staff said these had been taken down recently. All of the staff were aware of the planned refurbishment programme. The area manager confirmed that as part of the provider's on-going maintenance of the service there was a refurbishment plan in place.

Good

Is the service responsive?

Our findings

People's needs had been assessed prior to moving into the home. This process included looking at, for example, people's care and communication needs. This helped the manager to understand the needs of people as well as ensuring the service was able to meet their needs. The manager told us that each person had a review after moving into the home to ensure that the service was able to meet their needs. The review was completed with the person and people who were important to them, for example family members.

People had support plans that were focused on them as individuals. They were written in such a way that staff would know how to support people in line with their preferences. For example, each record had a completed profile "this is me" that contained historical information about them and their life's journey to the present time. There was information on choices and preferences, for personal care this include preferred routine, gender of care staff, shower or bath and clothing style and colours and described personal items that were important to the person. The manager and staff told us that this information was gained from people where they could contribute or from their relatives. We also saw information available for healthcare professionals if people had required a hospital admission.

One person's support plan described how they had an "empathy doll" called baby boy. The use of the doll was recorded empathetically and described behaviours that would suggest the person wished to have the doll. For example, "If [person] is sitting forward and holding themselves tightly." Or "If [person] starts to wander around." This meant staff had the information they needed to ensure people received their care as they wanted it.

We saw that care plans were reviewed in response to people's fluctuations in care needs. The views of family were sort and families were contacted regularly with updates on professional visits and appointments attended. Relatives we spoke with confirmed that they were contacted regularly. One relative told us, "Communication is really good. Staff inform us any healthcare professional visits. We are given feedback if we can't attend."

Relatives we spoke with confirmed that they had been involved in people's care plans and reviews. One relative told us, "I've been involved in decisions. I've seen the care plan. The staff keep me informed."

Staff spoke warmly and compassionately about people who used the service and were able to provide detailed descriptions of people's care needs in a very person centred way.

People had mixed views about what activities were available to them. This depended upon whether the person lived in the House or the Lodge. One person who lived in the House told us, I do nothing all day. I like to chat to people but people don't chat. We have a TV in the lounge, I watch it occasionally. Sometimes they put on games but not very often." Another person commented, "After breakfast I come to the lounge. I could go to my room if I want to but I like to come here to socialise. I like to talk to [person] they are my friend. We get on really well. I like drawing in my room. I draw the view from my window. I have the radio on in my room. I don't watch TV, I prefer company. There are no activities. They do organise things sometimes." We

spoke with the manager about the lack of activities in the House and were told that they had employed a new activities organiser following the last inspection in August 2016 but shortly after they had started work in September 2016 they were called for jury service. As a result they had been away from work for 13 weeks.

We saw that the activities organiser was now back at work and had started to introduce activities to the House. They told us, "In the summer I would like to do some gardening with the residents. Money is a problem though. Some activities are more popular than others and so I'll have to see which ones people like."

In the Lodge we saw five people playing dominos, supported by a different activities organiser, people were quite competitive and appeared to have enjoyed the session. People were given subtle support where they were slow to make decisions about moves using appropriate humour and banter. For example "look he's trying to cheat again." People laughed and were enjoying the camaraderie. Relatives told us, "The activities person is fantastic, they do something every day. They involve people not just the same few. [Person] used to do jigsaws or painting but as their dementia has progressed they don't get involved. Staff tailor their day to how they react to things. They are happy to sit with a magazine."

We also saw an activities timetable on display. Activities that people had taken part in were documented by staff in their daily notes and they had noted how people had responded to them.

People and their relatives knew how to make a complaint should they have needed to. One person told us, "I've never had a complaint. If I did have a complaint I would feel happy talking to someone. I would tell one of the staff." However, one person did comment, "I've never made a complaint. I wouldn't feel comfortable making a complaint." They did not elaborate. A relative told us, "I know about the complaints policy and find all the staff approachable." Another relative said, "[Person] has not been here long and so we've had no complaints but if we did we would happily complain." There was also a complaints procedure available for relatives and visitors which detailed the procedure that the provider would take in the event of receiving a complaint.

There were arrangements for people and relatives to provide feedback to the service. We saw that there were electronic tablets in the reception area that were for people using the service, relatives, visiting professionals and staff to give feedback. The manager also told us that part of their quality monitoring they encourage people to feedback and staff must try to get at least one comment about the service a day. The manager told us that they encourage comments and complaints by having an open door policy. They told us that as a result of complaints by relatives they had increased the staffing in the House. We also saw that they provided feedback in the form of "what you said" "what we did" which was displayed in the reception area. Comments we saw included, "Such a brilliant atmosphere today all staff and residents appear happy." And "The atmosphere has completely changed for the better, all staff appear much happier in their roles which has reflected onto the residents."

Requires Improvement

Is the service well-led?

Our findings

Quality assurance system in place had not always identified the shortfalls for the safe management of medicines. A variety of audits were carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. However the audit for the management of medicines were not robust or effective enough to identify where the service was not meeting people's needs safely. For example, we identified that people were not getting their medicines as prescribed but this had not been identified in the audit. This meant that the provider could not be assured of the robustness of the audit process.

We also noted that when the activities organiser for the House was away for 13 weeks on jury service the provider had not made any alternative arrangements for people to have meaningful activities during this time. This meant that people who lived in the House were not provided with activities that were stimulating or promoted their well being.

There is a requirement for a registered manager to be in post. The new manager started at the service in October 2017 and has yet to become registered. They did however tell us they had started the process and the area manger confirmed that the manager would be supported to become the registered manager for the service.

People we spoke with who use the service could not recall who the manager was or if they had met them. However, relatives and staff members spoke positively about the manager and how they were approachable. One relative told us, "Things are so much better since they [manager] have arrived." They added, "[Manager] has made themselves known to people, they are visible." Another relative also commented, "[Manager] is very good, very friendly." Staff also commented how things had improved since the new manager had arrived. One staff member said, "Things are loads better with the new manager." Another staff member told us, "We know what's going on, communication is much better and so are the staffing levels and the atmosphere is much better. The manager listens and acts on what we say or explains why things can't happen."

People could not recall any meetings with the manager or of being asked their opinion of the service. One person told us, "There are no resident's meetings. I've not made any suggestions." Whilst another person commented, I've not done a questionnaire, I have no suggestions." However a relative did tell us, "Relative's meetings were patchy in the past but we think [manager] will start them again." The manager told us they intended to restart meetings with families and people who use the service shortly to ensure people had the opportunity to voice their opinion about the service.

The provider did have systems in place to obtain feedback from people and we saw the results of questionnaires. The outcomes of these were on display in the reception area of the service.

Services are required to display the rating of their service to people and visitors. We saw this had been displayed in the reception area of the service.

Staff had the opportunity to help the service improve and to ensure they were meeting people's needs. Staff were able to contribute through a variety of methods such as staff meetings and one to one meetings. Staff told us that they were able to discuss the service and quality of care provided, best practices and people's care needs. One staff member told us, "We have good staff meetings. All sorts gets discussed."

Staff knew how to report poor practice of their colleagues should they have need to. One staff member told us, "If I saw poor practice I would speak with the manager or take it forward if nothing was done. I would speak to social services or Care Quality Commission (CQC)." We saw that the provider had made available a whistleblowing policy and procedure for staff to follow with details of other organisations staff could report concerns to if they had needed to. This meant staff knew what to do to where they had concerns about poor practice.

The manager was aware of their responsibilities. They could describe the need to alert the relevant organisations of significant incidents that had occurred including the need to keep family members informed of an event that may impact on their relative's wellbeing. We saw that the manager was being supported by the wider organisation to deliver the care and support as detailed in the provider's mission statement and statement of purpose. The area manager visited the service to provide support and advice to the manager. The manager also had access to the provider's other support networks such as their in-house pharmacy technician, who was called in during the second day of our inspection to advice on how to improve the medicine's management.