Warrington Homes Limited(The)

Warrington Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 10 and 11 of August 2017 and the first day of the inspection was unannounced. The registered manager, staff and people at the service were aware of our visit on the 11 August 2017.

The Warrington Lodge provides accommodation and personal care for up to 21 people with a diagnosis of dementia and at the time of the inspection there were 20 people living at the service.

A registered manager was in post. 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.

Where wedges were used to prevent people from falling our of bed capacity assessments were not carried out before making best interest decisions. Some documentation included references to making best interest decision to deliver personal care to people who resisted and were at risk of skin breakdown. However, the framework needed to make these decisions were not in place. The registered manager agreed to complete capacity assessments where appropriate.

The staff we spoke with were knowledgeable about enabling people to make day to day decisions. We saw staff gain consent before any task or activity took place. The people at the service were subject to continuous supervision and applications to deprive people of their liberty were made. to the appropriate supervisory authority. Records were clear where Lasting Power of Attorney were in place and copies of activated orders were kept in care records.

People told us they liked living at the care home. They said the staff were kind and that their privacy and dignity was respected. Relatives said their family members were safe living at the service and had no "concerns".

Members of staff said they had attended safeguarding of vulnerable adults training. Their comments indicated their understanding of the safeguarding of adults from abuse procedures. Staff knew the types of abuse and how to identify abuse. Staff were knowledgeable about the actions they needed to take where their concerns were not taken seriously by the registered manager.

People received care that was individual to their needs. Care plans were detailed and included people's preferences. People and where appropriate their relatives were involved in the reviewing process of their care needs. There was a programme of group activities and some one to one activities were taking place for people who preferred not to join group activities.

Risks were assessed and appropriate action was taken to meet the identified risk. Staff were knowledgeable

about the people at risk and the actions needed to minimise the risks.

The rotas in place showed there was sufficient staff on duty to meet people needs. Catering and housekeeping staff as well as an activities coordinator was employed. Staff said the staffing levels were adequate to meet people's needs. People told us their care was not rushed and staff took time to listen to them.

Safe systems of medicine management systems were in place. People were supported with their ongoing healthcare needs. The health and social healthcare professionals told us their advice was followed and requests for visits were made at the appropriate times.

Staff were supported with the roles and responsibility. New staff had an induction to prepare them for the role they were employed to undertake. Staff attended training to meet the needs of people which included dementia awareness. There was an expectation that staff completed recognised vocational training for working with vulnerable adults which included Care Certificate and Quality Credit Framework (QCF). There were opportunities for staff's professional development which included one to one supervision with the in house trainer and annual appraisals with the registered manager.

Quality assurance systems were in place. The views of people and their relatives were gathered and action was taken from the feedback received. Social and healthcare professionals were positive about the care and treatment people receive.

The staff said they had good support they felt they had a voice. The staff were commended by relatives for the care they delivered to their family members living at the home. Staff meetings were the forums used to share information about changes in policy and to discuss issues relating to joint working. Staff said the team worked well together and felt valued by the organisation.

The home was designed for people living with dementia. There were signs to help people find their way around. We saw there were seating areas and points of interest for people that liked to walk around the home. Memory boxes on bedroom which contained objects of interest specific to the person helped people find their way to their bedrooms.

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

Personal emergency evacuation procedures were in place to safely evacuate the property in the event of an emergency.

There were sufficient staff to support people and we observed that staff were visible and available to people.

Medicines were well managed safely.

People said they were safe living at the home. The staff knew the types of abuse and the responsibilities placed on them to report abuse.

Risk were assessed. Members of staff knew the risk to each individual and the actions needed to minimise the risk.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to make day to day decisions. Care plans contained mental capacity assessments. We found two examples when best interest decisions was taken before capacity assessments were undertaken.

Staff had the knowledge and skills to carry out their roles and systems were in place to support staff with the responsibilities of their role.

People had access to ongoing healthcare.

The dietary requirements of people were catered for. There was a choice of meals.

Is the service caring?

Good

The service was caring

People were treated with kindness and compassion. We saw some positive interactions between staff and people using the

service. Staff knew people's needs well and there was a calm and friendly atmosphere.

Staff showed concern for people's well-being. They understood the importance of developing relationships with people.

Personal details and profiles gave guidance to staff on people's relationships with family and friends, their likes and dislikes and preferences on how personal care was to be met.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Good

The service was responsive

Care plans were person centred, monitored monthly and reviewed with people and where appropriate their relatives.

People told us staff knew how to meet their needs. There were opportunities for people to participate in group activities and some one to one activities.

There were no complaints received at the home.

Is the service well-led?

Good

The service was well led.

The views of people were gathered using surveys. The feedback from people and visitors was good and the registered manager responded in writing on the actions taken from feedback received.

Quality assurance systems were in place and audits were used to assess the provision of care delivered.

Staff said the team worked well together and the registered manager was approachable and felt valued.

Warrington Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 10 and 11 August 2017 and the first day of the inspection was unannounced.

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. We reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by two inspectors one of which was the lead inspector and an Expert by Experience. Experts by experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services.

We spoke with six people and two relatives about their views on the quality of the care. We spoke with the registered manager, head of care, assistant head of care, senior carers and four care staff. We also spoke with the chef, housekeeper and activities coordinator as well as social and healthcare professionals.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included seven care plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Good

Is the service safe?

Our findings

People said they felt safe living at the home. The two relatives we spoke with said their family members were safe at the home. A relative said there was a caring environment and "felt absolutely happy" with their family member living at the home. They said the staff "would always check on her to make sure she was safe". Another relative said their family member was "very safe and secure at the home and was very well cared for". Staff said they had attended training on how to protect people from avoidable abuse and harm. All staff said they felt confident to raise concerns and felt that they would be taken seriously.

Care files included risk assessments relating to people's needs such as falls, pressure damage, and nutrition and hydration. Risk assessments were also undertaken with regard individual needs such as use of a wheelchair, burns and scalds, choking, bathing and showering, moving and handling equipment and bedroom safety checks. All risk assessments and care plans seen were up to date and had been signed as reviewed each month. A member of staff said risk assessments were developed where risks were identified. They said where appropriate training was delivered to ensure safe techniques were used for example moving and handling, healthcare professional were consulted and monitoring charts were used to ensure action plans were followed.

People were being protected from risk. Two people were assessed as being at high risk of developing pressure ulcers and they needed to use a pressure cushion in their wheelchairs. We visited them and found that they were sat on appropriate pressure relief cushions. Appropriate pressure relief mattresses were also provided. Neither person had developed any pressure damage.

One person had some swallowing difficulties and had been assessed as being at risk. They had been referred to a speech and language therapist and a swallowing assessment had been carried out. The outcome was recorded in the persons care plan and it was recommended that they ate only a "soft" diet. We saw that this was provided for them at lunchtime. Also they had some yoghurt on their table in their room should they wish to eat something between meals.

Some people had been assessed as requiring the use of moving and handling aids. The equipment to be used, along with the number of staff required, had been recorded in their care plan. We asked two staff members about the peoples moving and handling needs. They were able to tell us the equipment they used and the number of staff required. The registered manager told us " we have brightly decorated peoples walking frames as this has be proven to reduce the incidence of falls amongst older people."

Where people were assessed as being at risk from falls, staff made frequent checks and records kept of these checks. People's rooms were fitted with sensors to alert staff when people who were assessed as at risk from falling got out of their bed or went out of their room through the door. These were being used mainly at night.

We saw records that showed that incidents and accidents were being recorded and reviewed by the management team. The home had a health and safety committee which met every two months. Meetings

were recorded. Other information seen included an analysis of falls in the home.

Accidents and incidents involving people and staff were clearly recorded and reviewed by the registered manager to ensure they had been responded to appropriately.

Personal emergency evacuation procedures were in place to identify the people most at risk in the event of a fire and detailed the assistance required from the staff for a safe evacuation from the home.

Annual fire risk assessments were undertaken by an external contractor to identify potential fire hazards within the home and where appropriate take action to reduce or remove the risks. The actions identified to reduce the risk of fire included weekly fire alarm testing, equipment testing, fire training for staff and fire drills to ensure staff knew the procedure in the event of a fire. We saw testing of equipment included emergency lighting check, portable electrical appliance testing and gas boiler checks.

There were sufficient staff to support people and we observed that staff were visible and available to people. The rota in place showed during the week the registered manager and head of care as well as four care staff were on duty throughout the day and four staff in the afternoon. At weekends there were four staff throughout the day. At night there were two staff awake in the premises. We saw the staff on duty reflected rota as well as an activities coordinator, catering and housekeeping staff.

Medicine systems were safe. People told us the staff administered their medicines. A pharmacy provided the majority of medicines in a monitored dosage system. This reduced the risk of dispensing errors.

Senior Carers were responsible for the administration of medicines. They had undertaken medicine management training along with competency checks. We observed a medication administration round and saw that the senior carer was organised and safe practice was observed. They were wearing a tabard with 'Do Not Disturb' written on them in order to ensure minimum distraction during the medicine round. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to.

Medicine administration records (MAR) included any known medicine allergies and a photo of the person for easy identification of the person. MAR sheets were signed following administration and there were no gaps on the sheets reviewed. Appropriate codes had been entered when medicines had not been administered. The receipt of medicines was being recorded on MAR sheets and witnessed by two people.

Records relating to the application of prescribed topical medicines were seen in separate files. These were complete. Body maps, to specifically indicate which area of the body the topical medicine should be applied to, were in use.

Individual care plans relating to medicine management were in place and included the use of 'when required' (PRN) medicines. This is seen as good practice as it directs staff as to when, how often and for how long the medicine can be used and improves monitoring of effects and reduces the risk of misuse.

One person told us "the whole home was very clean and tidy and the bedroom was very large with private facilities". A relative said "the home is very clean and tidy with a good ambiance and fresh fragrance." A housekeeper said they had attended courses to ensure they had the skills needed to undertake their role which included "team leading". They told us there was enough equipment to ensure good standards of hygiene and to reduce cross infection. It was also stated there were schedules for cleaning the home which were followed by housekeeping staff.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Deprivation of liberty authorisations had been sought.

We found staff were using a mattress wedge at night for two people who had been assessed as at risk of falling out of bed. We were shown how their beds were positioned with one side against a wall and the wedge was inserted under the mattress on the open side. The registered manager and head of care said that the wedges were used instead of bed rails as they were a lesser risk to people. However, the use of wedges was not seen as restricting the person's liberty. One person said they had the freedom to come and go.

Although these measures were put in place in order to keep people safe, they could also be seen as a method of restraint. The head of care acknowledged the need to reassess the people using a mental capacity assessment, which would lead to a best interest decision involving all relevant parties. The registered manager and head of care were to undertake mental capacity assessments for the use of wedges.

Care plans showed staff were not always clear on the principles of "best interest" decisions. For example, the personal care plan for one person gave staff guidance on the steps to be taken for one person who resisted personal care. Further guidance was for staff to take the least restrictive "best interest" decisions where the person did not accept their assistance and there was a risk of skin breakdown. However, a mental capacity assessment was not undertaken to ensure decisions taken were appropriate. The registered manager and head of care told us following the inspection that where there were references for staff to take best interest decision were to be removed and was to be used "only where a mental capacity assessment has taken place".

The records of a person who was receiving their medicines covertly showed that a mental capacity assessment had been undertaken prior to a best interest decision, which had been made by the person's advocate, a GP and staff members.

We checked whether the staff were working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. When we asked a member of staff what they would do if a person refused their support they replied "I would just leave them and try again later; or another carer [staff]. You have to respect what they say." They confirmed that they had received training in relation to mental capacity and DoLS. When asked about best interest's decisions they said "You have to

involve a senior manager, the family, the person and the GP." Another member of staff explained how people were enabled to make day to day decisions and the people that helped with making decisions where people lacked capacity.

New staff were supported to perform the roles they were employed to perform. The in-house trainer told us their role included supporting new staff through their induction. They said four staff including housekeeping staff were currently undertaking the Care Certificate [set of standards for social care and health workers that should be covered as part of induction training of new care workers]. The in-house trainer also told us staff had to complete the Care Certificate within the first 12 weeks of starting work at the home.

The staff we spoke with confirmed they had received induction training before starting work at the service. . They said they had shadowed more experienced staff until they felt confident to work alone if necessary. They also confirmed that they had received one to one supervision, although one staff said they thought that this was every six months. A member of staff who had progressed to another role within the home told us an induction into their new role had taken place. They said their induction included specific training for their role and shadowing more senior staff.

Staff had the knowledge and skills needed to carry out the roles and responsibilities. The in-house trainer told us that staff not on the Care Certificate were expected to complete the Qualifications Credit Framework (QCF) training [framework for creating and accrediting qualifications in England, Wales and Northern Ireland]. They said staff on apprenticeship programme were also expected to complete QCF for working at the service. Staff attended mandatory training set by the provider which included dementia awareness, fire safety, first aid, food hygiene, diet and nutrition and Health and Safety. The in-house trainer said staff attended mandatory training alongside their QCF training.

The staff we spoke with confirmed that other training had been provided, such as dementia awareness, mental capacity act and safeguarding. One member of staff had commenced the Care Certificate and another had obtained a level two diploma in health and social care. The registered manager said staff had lead roles such as dementia awareness and nutrition and was a point of knowledge for other staff to gain advice.

Staff had effective support to undertake the responsibilities of their role and with their professional development. The registered manager said staff had four one to one meetings per year with the in-house trainer and annual appraisals were with the registered manager. The in-house trainer told us during one to one supervisions staff development plans were discussed which included their training needs and future goals.

People told us the food was good. One person said the food was "very good and ample size proportions. Tea and coffee was readily available". They said there was a jug of diluted orange squash in her room. The comments from other people included "the meals were very good and enjoyable". "Meals were very good and excellent portions given". A relative told us they had experience of eating at the home and found the food to be "very good" and "enjoyed the meal". Fruit, savoury snacks and a selection of drinks were available in various communal areas around the house for people to help themselves to.

The dietary requirements of people were catered for at the home. The chef told us there were people on high calorie, gluten free and soft diets. They said the staff kept them informed about people's Malnutrition Universal Screening Tool (MUST) scores and where people had medium and high MUST scores high calorie diets were served. It was also explained that gluten free ingredients were used for cakes, puddings and soups. This meant people on gluten free diets were able to eat the same meals as people on restrictions free

diets. We were shown prepared meals where moulds were used for people on soft diets which meant their meals appeared more appetizing.

People were asked about their meal preferences including their likes and dislikes. We were shown the forms completed by people during their admission to the home which included their likes, dislikes and preferred meals. We saw photos of meals were used for people to indicate their preferred meals. The chef said the forms were updated three monthly to ensure people were having their preferred meals. We saw two choices of meals were served at each meal.

The chef told us "we work together. Someone [staff] has an idea we come together and do it." The chef told us that recently themed meals were being served. The chef said there was a "mad hatters tea party" and we saw photographs of this event. There was to be a "sea side" themed meal and on the day of the inspection we saw the "ice cream man" visiting the home and people were able to go and buy their ice cream from this vendor.

People had access to ongoing healthcare. We spoke to a GP on a visit to the home who stated the staff were "fantastic and excellent and in a lot of ways they are onto everything". They said the staff managed complex behaviours. This GP said there were links between them and elderly care specialists. This ensured staff were supported to deliver appropriate care to people living with dementia. The GP also told us the staff requested visits in a timely manner, advise was followed and there were discussions about the appropriateness of the care to be delivered. Another professional told us they were supporting the staff deliver care to one person with complex needs. They said the staff assessed the needs of the person, introduced measures and carried out checks before contacting them. This professional said this helped them make decisions on the order of treatment to follow as the staff had already taken the appropriate initial steps.

Records in care files indicated that people had been seen by health care professionals such as GP's podiatrists, speech and language therapists and members of the community mental health and nursing teams.

The home was purpose built and designed for people living with dementia. We saw there were clear visible signs and the décor of the property helped people find facilities such as toilets as well as their way around the home. A healthcare professional told us the layout of the building gave people cues on their whereabouts within the building by the pictures on display. They said the colours of the doors ensured that people were not distracted by rooms that were non-essential to people. For example, sluice rooms doors were the same colour of the walls. While doors to the toilet were blue to remind people of water.

Bedrooms were single and lockable and with en-suite facilities. People has access to a large, accessible, enclosed external courtyard area that contained seating areas and raised flowerbeds.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. We saw some positive interactions between staff and people using the service.

People told us the staff were good. One person said "the place was wonderful and staff very caring and courteous". A relative said the home "gave the best care and support" to their family member. They said the staff were caring, supportive and professional in their approach to all the people.

Staff had a good understanding that people needed to feel they mattered and it was important to build trusting relationships with people. A member of staff "everybody is different and some people like reassurance knowing the individuals helped build caring relationships. Family and friends will give [staff] feedback about their [people] liked and dislikes. It's a small home and people have continuity from staff." One person said they felt the home was of a very high standard with staff who were prepared to listen and take their time to help. They didn't feel rushed and it was a pleasure to have such a relaxing atmosphere in the home. Another person told us the staff were very friendly and approachable and they would go out of their way to make sure things got done straight away. One person said the staff were fully supportive of their needs and very caring. They said staff took time and listened to them when they needed someone to talk to. A relative said the staff "were all very caring in their approach to people and their family member."

There were "Memory Boxes" on the walls outside people's rooms which contained objects that related specifically to the person. For example, personal photographs and mementos. People's names and photographs were displayed on the door to their rooms. Memory boxes helped people locate their bedrooms. Care plans gave staff guidance on "what was important to the person, what was working and what was not working."

People were involved in the planning of their care. "This is Me" booklets detailed people's needs. Along with this, specific care plans and risk assessments with regard to communication. People's life stories were part of their care plans which included their education, employments, family and interests. Care recorded included people preferences which included "What was important to the person" "How to support me" and "What was working well and What was not working". The information held was brief and needed expanding for areas not working well and where support was needed for example, people who became anxious. The registered manager told us these sections of the care plans were to be developed further.

The homes Equality, diversity and inclusion procedures clarified that "every service user has their individual needs comprehensively addressed. He or she will be treated equally and without discrimination." Within the procedure the aims of the service were defined and stated that people's differences were celebrated and avoids "treating people unequally." People told us their rights were respected. They told us the staff respected their rights to privacy and dignity. One person said they were "well respected by all the staff her care and dignity was very good." Another person said they had the level of privacy they needed. A member of staff said understanding people's needs, knocking on doors, maintaining confidentiality of records were examples of respecting people's rights.

The GP told us the staff with the support of the district nurse team delivered compassionate care to people on their end of life journey. They said "planning was good. Care plans were updated, medicines were reviewed" and were based on people's wishes.

People's preferences and choices for their end of life care was clearly recorded and kept under review. Staff told us they had attended end of life training to ensure people had appropriate care and treatment at the end stages of their life. They said there were flexible arrangements to ensure people's loved ones where appropriate were with them during this pathway. Care plans included their wishes in the event of their death, the people to be contacted in the event their health deteriorated. Copies of their do not attempt resuscitation (DNAR) were included to ensure staff were aware of their wishes for natural death.

Good

Is the service responsive?

Our findings

People's care was responsive to their needs. Their needs were assessed and preferences on how to meet their needs were gathered before moving to the home. Initial assessment documentation and other records confirmed there were opportunities for introductory visits before making the decision to live permanently at the home.

Care files contained an information sheet at the front giving general information such as their next of kin or guardianship details, GP, language spoken, previous occupation and any medical conditions they had.

People's care was personalised. For example; One care plan stated that a person liked to have a pillow put under their arm whilst they were in their wheelchair to stop them leaning to one side. We visited them and found that they had the pillow in place. For another person their care plan included their preferred first name. Daily routines included people's preferences such as times to rise and retire, personal care regimes and activities. The person's medical diagnosis was also included within people's daily routine plans.

The eating and drinking care plans for one person dated 13 July 2017 included their likes and dislikes, favourite meals and how staff were to assist them. We noted the person had consistently lost weight and some steps to monitor deterioration of health were documented. For example, the GP was consulted and the potential of developing malnutrition was assessed. A high score was given from malnutrition universal assessment tool (MUST) used to assess the potential of the person developing malnutrition. While the care plan included that snacks were be served between meals the care plan was not clear on the actions to be taken to monitor the person's weight loss and potential health deterioration. The action plan did not draw together the action plan for people at high risk of developing malnutrition. For example, high calories meals to be served, weekly weights and monitoring of food intake. The food intake records were not always completed and information was not included on the actions taken when meals were declined. The head of care told us that in future food and fluid intake charts were to be analysed to ensure records were correctly completed and people's food intake was monitored and action taken. This meant the reasons for the person losing weight was not clearly known and investigated. All staff have been asked to include on the food chart the amount and type of food/drink a resident has consumed. The registered manager told us following the inspection that the advice given by health professional were to be added to the appropriate care plan "so that all the information is one place."

Daily record of the care and support people received was kept. Also, staff completed records of the interventions they carried out, such as safety checks and personal hygiene. We were present during part of the handover of information when there was a shift change. People's current needs, administration of when required medicines, changes of the care plans, results of tests and visitors were part of the handover for staff.

Staff told us where people's needs changed the information was passed to the head of care to update care plans. A member of staff said families were involved where appropriate in the care plan review process. A relative told us they were invited to either attend or view their family members six monthly review minutes.

They said their suggestions and consultations about any adjustment to the care plans gained before they were implemented. All care files seen contained a record sheet signed by staff that indicated that care plans had been reviewed monthly. Plans seen also contained records of six monthly care reviews involving people's families.

Overall people said activities were organised but one person said they "would have liked to get out a bit more". When asked what they would change in the home one staff member said "More outings for those that don't go out much.' Another said "I think there should be a room to do activities in." Records of social activity were available in people's care files, however one seen indicated that the person had spent a lot of time just watching TV or listening to music.

The activities co-ordinator told us about their ideas for activities and these included getting people out and other outdoor events all dependent on weather. Themed activities included weekly dressing up as movie characters or Caribbean theme and getting all people involved in these events. A better TV with a large screen for the main lounge was purchased especially for movie afternoons and other events

Monthly residents meetings to discuss various topics and also included the welfare of the people in the home and the care they were given. We were shown the monthly newsletter with lots of information, the programme of planned activities. There were some one to one time with people who preferred not to join group activities and there were twice weekly outside entertainers visit. For example, Sudoku, crossword and mindfulness colouring books."

The registered manager following the inspection told us "we have introduced more named one to one sessions [with people] into our activities and wellbeing programme, specifically targeted at those residents who may be more at risk of social isolation. We are also introducing more active activities".

The complaints procedure was in simple English and in large print to ensure people were able to read and understand the procedure. People were to approach the registered manager with complaints and the director where their complaints were not resolved. The timescales for responding to concerns and the contact details of the registered manager and senior managers were included in the procedure. There were no complaints received at the home since the last inspection.

Good

Is the service well-led?

Our findings

The vision and values of the organisation included the principles of care. For example, independence, choice, privacy and dignity. Staff valued the people they cared for and were motivated to provide people with high quality care. A member of staff described the values as being to maintain "good quality of life, treat people with dignity."

Feedback about the service was gathered from people, relatives, staff and social and healthcare professionals. The overall 92% good rating from the 2016 survey was from the 15 people and relatives that gave feedback about the home. This feedback included having more fresh fruit accessible within the home and making key-codes to exit and entry door accessible to relatives. The registered manager reported in writing the results of the surveys and the actions to be taken.

Staff said they felt well supported. The staff's feedback was gathered using surveys and the registered manager responded to the comments received in writing to all staff. Staff meetings were organised according to the roles of the staff. For example, senior staff meetings were held monthly, care staff meetings and night staff meetings were three monthly. The minutes of the meetings were recorded and staff signed the minutes to show they had read the minutes and agreed with the actions. We saw that at the meeting in June 2017 codes of conduct was discussed, changes in policy and procedures were discussed.

Members of staff said their feedback was valued by the registered manager. "I love it here, the management are very helpful." They confirmed that they had regular staff meetings that they found useful saying "They [registered manager and head of care] ask what we can improve on; we do have our say." Another staff member told us how an issue they had brought up had been dealt with positively by the managers and described the home as "Very well run." The third member of staff described the home as "Lovely. Everyone is really nice. We have a good team and we work well together." They said that they felt they were able to bring things up in meetings and were listened to. They described the managers as proactive.

The staff received 17 thank you cards and monetary donations for the care delivered to their family members at the home. A professional with regular contact with people who use the service provided us with written feedback about the staff. The comments from this professional included "I have never ceased to be amazed by the care and attention that the residents receive from the staff. They are always treated with the utmost respect and dignity. There seems to be an ethos of care and understanding ' woven' into the fabric of Warrington Lodge and the greatest compliment I can pay is that I would be happy for my mum to move in should the need ever arise."

A registered manager was in post and had an understanding of the key challenges. The registered manager told us their management style was working as part of the team and leadership was by example and fairness to staff. They said "each other [staff] were on an even level. [I] encourage staff to speak up. It's important to listen to staff." This registered manager told us the challenges included "trying to keep everybody happy but as long as I can go home and think I have done my best even if some people may not be happy. Recruitment can be a challenge and changes of legislation. The staff are passionate and we share the end goal." A

member of staff said the team worked well together, the registered manager was approachable and there were opportunities for progression within the home.

The members of board visit monthly to speak with people, staff and review sample documents which ensures they understand and were aware of the effectiveness of the service delivery. We saw from the report dated 4 August 2017 there were conversations with people, staff and visitors and the environment was assessed.

The director was based at the home and weekly meetings with registered manager took place. At the weekly the business plans, occupancy levels and management of the home was discussed. We saw that at the most recent meeting annual policy objectives and succession plan were discussed. Other areas discussed included improvements of the environment and risk register

Auditing systems were in place to measure and review the delivery of care, treatment and support people receive. Audits for infection control, care planning, medicines and staff practices were undertaken. Spot checks of individual staff undertaking tasks were three monthly. Copies of the observations were provided to the specific staff and where gaps in their knowledge and skills were identified these areas were made part of the professional development plans.

Infection control audits were undertaken by the registered every three months. We saw where shortfalls were found during the audit; an action plan had been developed. For example, missing bins were replaced, equipment was replaced and paper hand towels replaced fabric towels.

Medicine audits were undertaken by the head of care three times weekly. The member of staff with lead roles in medicines told us part of the role included learning from medicine errors. For example, safeguards were introduced to prevent repeated errors which included better identification of medicines and additional training for the staff involved. They said audits included checks of medicines brought forward to the next cycle and for medicines not within the monitored dosage system.

Care plan audits were monthly by the head of care and where there were changes to the people's needs the care plans were amended.

The registered manager had developed links with organisations that included being part of an organisation whose role was to support independent providers. The registered manager told us that at these meetings other registered managers were able to "network, share good practice ideas and conferences of relevant topics were organised". The registered manager had also developed links within the community for people to access facilities. For example, there were arrangements for one person to attend a local primary school to assist the children with their reading and swimming for another.