# Networking Care Partnerships (South West) Limited

# Windsor Lodge

## Inspection report

43 Cranford Drive
Exmouth
Devon
EX8 2QD
Tel: 01395 263211
Website: none

Date of inspection visit: 1 and 9 December 2015
Date of publication: 25/01/2016

## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

An unannounced inspection took place at Windsor Lodge on 1 and 9 December 2015. We had previously inspected the service in October 2014 and found no breaches of regulations of the standards inspected.

Windsor Lodge is a residential home for people with a learning disability. This includes people with autism, and with sensory and physical disabilities. It is registered to provide accommodation with personal care for up to 11 people. When we visited, nine people lived there. Three people live in single flats, each supported by a dedicated team. For two people, the service was working towards implementing supported living arrangements. A supported living service is one where people live in their own home and may or may not receive personal care and support in order to promote their independence. People have tenancy agreements with a landlord and a separate agreement to receive their care and support from the care agency. As the housing and care arrangements are entirely separate, this means people can choose to change their care provider without losing their home.

# Summary of findings

However, the provider is not currently registered to provide personal care at this location. We reminded the registered manager that a change in registration is needed before personal care can be provided within a supported living arrangement.

The service had a registered manager who worked across two registered services and spent half their time at each. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's rights were not protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005. Where people appeared to lack capacity, staff had not undertaken any mental capacity assessments. This meant there was a lack of clarity about people's capacity to consent for their day to day care.

The quality of people's care records were inconsistent. Some people's risk assessments and care plans were not accurate or up to date and they did not always reflect the care the person received, although staff were very knowledgeable about people's individual care needs.

People were not protected because the quality monitoring systems in place were not fully effective. Some improvements needed still had not been made. A provider visit highlighted some areas for improvement and further actions were needed to fully address them. The registered manager was aware of this and was working on these.

The culture at the service was open and friendly. People knew who was in charge and said they were easy to talk to. Staff felt well supported by the registered manager and the deputy manager and described recent improvements. The provider had a range of quality monitoring arrangements in place. These included audits and regular health and safety checks.

Staff demonstrated awareness of the signs of abuse and knew how to report concerns. The service had reported some safeguarding concerns to the Care Quality Commission and actions taken to address these. We found improvements had been made in response, which showed lessons were learned. Accidents and incidents were reported and measures were taken to reduce risks for people.

The service had enough staff to support each person's individual needs and organised people's care around their wishes and preferences. Staff were experienced and undertook regular training relevant to the needs of the people they supported. Where people experienced behaviours that challenged the service, staff recognised 'triggers' for individuals. They used positive support techniques to de-escalate those behaviours.

People were supported to improve their health through good nutrition. Staff encouraged people to eat a well-balanced diet and make healthy eating choices. Staff encouraged each person to be active, and maintain their mobility.

Staff worked closely with local healthcare professionals such as the GP, community nurse and members of the local learning disability team. A health professional said staff sought advice appropriately about people's health needs and followed that advice.

People received person centred care. Staff knew people well, understood their needs and cared for them as individuals. People were relaxed and comfortable with staff that supported them. Staff knew what mattered to people, about people's lives their families and their interests and hobbies. Staff were discreet when supporting people with personal care, respected people's choices and acted in accordance with the person's wishes.

People were involved in developing and reviewing their care and support plan assisted by staff, relatives or others who knew them well.

Staff supported people to improve their independence and lead busy and fulfilling lives. People undertook lots of activities and were well known in their local community where they attended clubs, visited shops and were involved with their local church. Staff supported some people to undertake voluntary work.

# Summary of findings

Staff used a variety of methods to support people to communicate and provided each person the information they needed to make choices. For example, photographs, information in 'easy read' formats and one person had their own sign language book.

The provider had a complaints policy. People said they could to speak to staff about any problems. The service had not received any complaints since we last visited.

We found two breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## 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

Not all aspects of the service were safe.

Some people's risks were not managed well because information about them was out of date.

People were protected from abuse because staff knew how to recognise signs of abuse and reported suspected abuse, any concerns were dealt with robustly by the provider.

People were supported by enough staff.

People had their medicines on time and in a safe way.

People were protected because accidents and incidents were reported and actions were taken to reduce risks further.

**Is the service effective?**

Requires improvement

Not all aspects of the service were effective.

Staff offered people choices and supported them with their preferences.

However, people's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005.

People were supported to lead a healthy lifestyle. Staff recognised changes in people's health and sought health advice appropriately.

Staff received regular training relevant to the needs of people they supported and had ongoing support through supervision and appraisals.

**Is the service caring?**

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect.

People were supported by staff they knew well and had developed close relationships with.

Staff protected people's privacy and supported them sensitively with their personal care needs.

People were consulted and involved in decisions in ways appropriate to their individual communication skills.

**Is the service responsive?**

Requires improvement

Not all aspects of the service were responsive.

# Summary of findings

People's needs were assessed but some people's care records were not up to date about their current care needs, although staff knew how to care for people.

People received individualised care and support that met their needs.

People knew how to raise concerns and complaints. Any concerns raised were investigated, and the provider took action to address.

**Is the service well-led?**

Not all aspects of the service were well led.

People were not protected because the quality monitoring systems in place were not fully effective. Some improvements needed still had not been made.

The culture was open and focused on each person as an individual.

The provider had clear values and staff were positive about the support and leadership at the home.

**Requires improvement**

# Windsor 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 checked 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 unannounced inspection took place on 1 and 9 December 2015. An inspector and an expert by experience undertook the inspection. An expert-by-experience is a person who has personal experience of caring for someone who uses a learning disability service.

Prior to the inspection, we reviewed all the information we held about the service. This included the provider information return (PIR) and notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We met all nine people who lived at the service and observed staff interactions with them in communal areas of the home and spoke with one relative. We looked in detail at four people's care records.

We spoke with eight staff which included the registered manager, deputy manager and care staff. We looked at staff training, supervision and appraisal records of five staff. We looked at the provider's quality monitoring systems which included audits of medicines, health and safety checks and a provider visit report and action plan. We sought feedback from health and social care professionals such as members of the East Devon learning disability team and commissioners and we received a response from four of them.

Requires improvement

# Is the service safe?

## Our findings

People said they felt safe living at Windsor Lodge. A relative said, "He seems happy, and is safe there." However, risks were increased for people because the approach to risk was inconsistent. Some risks had not been assessed, others were overdue for review, and some were no longer relevant. For example, one person was at increased risk of pressure ulcers, as they had developed a pressure sore earlier this year during a hospital stay, which had now healed. There was no risk assessment in place about this risk, and no care plan to instruct staff about their skin care. However, we saw the person had the appropriate pressure relieving equipment and staff were following nursing advice. This meant they were taking the appropriate steps to reduce this risk. Another risk assessment about using the stairs because of their mobility needs was no longer relevant as the person had moved to a room downstairs more suited to their needs.

The service had different risk assessment tools in use, which was confusing and meant there was not a consistent approach to managing individual risk. The older risk assessments were more generic and were not person centred. Some did not include the person's name or a date, so it wasn't clear whether each risk assessment was relevant for that person.

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

The registered manager explained that following organisational changes, there had been a number of changes in paperwork. They were reviewing people's risk assessments to ensure they gave staff accurate and up to date information about current risks. Newer risk assessments were more comprehensive. For example, following a recent choking incident, staff had completed a detailed and individualised risk assessment for a person. This included measures to reduce their risk of choking such as dietary modifications and supervising the person's eating and drinking. This showed improvements in risk assessments were being made and more were planned.

Staff knew people well, and tried to minimise individual risks. For example, staff were aware of possible triggers for people with behaviours that may challenge the service. Although staff could describe any triggers and how they supported individuals, some people's care plans lacked detailed instructions for staff. This could increase the risks for others and staff, particularly for staff who were less familiar with the person and who may not be experienced in managing these behaviours.

One person became agitated during our visit. The staff member remained calm and asked the person if they would like to go outside to discuss the issue, which they agreed to and became much calmer. This was in accordance with the person's care plan. The member of staff explained that the person could become verbally aggressive, which upset other people, and found it harder to calm down when there were others around.

Staff balanced risks for individuals with the freedom to have new experiences. For example, staff were working with one person to prepare them to go to the local shop independently and had supported others to attend concerts and exhibitions in London.

Staff had completed safeguarding training and were aware of the signs of abuse and knew how to report concerns. Details about how to contact the local authority safeguarding team were on display at the service. The provider had a whistleblowing policy in place so staff could raise any concerns in confidence. Since the last inspection, the registered manager had notified the local authority and the Care Quality Commission (CQC) about three incidents of suspected abuse. Following each incident, the service worked with the local authority and the police to ensure these were investigated and kept CQC informed. Robust internal investigations were carried out and actions taken accordance with the providers' disciplinary procedures.

In the provider information return (PIR) the registered manager highlighted the improved security arrangements for managing people's monies and their medicines. Reviews of some people's financial arrangements were underway by the local authority. This was to check whether their current arrangements were still in their best interest. There were regular audits of medicines and increased scrutiny of people's finances, through daily checks of monies and receipts. The provider was also undertaking a financial audit to identify if any further improvements were needed. These measures helped reduce the risks of financial abuse.

Accidents and incidents were reported and were reviewed by the registered manager to identify if further actions were needed to reduce the risk of recurrence. For example,

Requires improvement

# Is the service safe?

referring a person with increased falls for a physiotherapy assessment. An electronic database was used to report all accidents/incidents to the provider, who monitored them to ensure actions were completed.

Staff were very aware of people's safety. Where people were at risk of falls and had mobility equipment, staff reminded them to use it when moving around the home and going outside. People were free to go in to the kitchen to make themselves drinks and snacks but were discouraged from doing so at busy times for their safety. Staff supported another person to keep safe whilst preparing food in their flat by helping them with tasks that involved using knives or other sharp objects.

Environmental risk assessments were in place and all hazardous chemicals such as cleaning products were kept locked away. The registered manager carried out monthly health and safety checks, although it wasn't always clear whether issues identified had been addressed. For example, a health and safety check in July 2015 identified three bedrooms where the window restrictors were faulty. We checked with the registered manager who confirmed these had been repaired. However, we noticed a window restrictor on the staircase wasn't working properly and asked the registered manager to address this.

Each person had a personal emergency evacuation plan (PEEP) in place. This took into account the individual's mobility and the support they would need from the emergency services to be evacuated from their flat in the event of a fire. Written contingency plans were in place for emergencies such as the loss of electricity, gas or the water supply.

People received their medicines safely and on time. We checked two people's medicines and found that all doses were given as prescribed. Staff completed a medication administration record (MAR) to document all medicines taken so all doses were accounted for. One person said they take paracetamol for pain when they need it, they said they just had to ask for it and staff gave it to them. Where people had medicines prescribed, as needed, (known as PRN), for managing behaviours that challenged the service, there were strict protocols in place about when these should be used.

Staff were trained and assessed to make sure they had the required skills and knowledge to support people with their medicines. Each person kept their medicines in a locked cupboard in their room. MAR charts were audited regularly so any discrepancies or gaps in documentation were immediately followed up. Any medicine errors were reported with and action taken to improve medicines management and people's safety.

People were supported by enough staff to meet their needs at a time and a pace that suited them. Three people said staff answered their call bell quickly whenever they used it. One said, "The staff come quickly if I press it." Where a person's care and support needs had changed, staffing levels were reviewed in consultation with their funding authority. For example, where a person needed more one to one support, or when a group of people went on a trip or a person went on holiday, extra staff were arranged to accompany them. Staff worked flexibly to cover sickness and staff leave, which provided continuity of care for people.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed at the service. All staff had police and disclosure and barring checks (DBS), and checks of qualifications and identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Requires improvement

# Is the service effective?

## Our findings

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Care Quality Commission (CQC) also monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

Staff had completed training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs). They understood relatives could not provide consent on the person's behalf, unless legally authorised to do so. However, where people lacked capacity, there was no documentary evidence that people's capacity to make particular decisions had been assessed or records of best interest decisions made.

For example, one person with a health condition had bedrails and a listening device at night which staff used to monitor their safety and wellbeing. However, there was no documentary evidence that a mental capacity assessment had been undertaken to assess whether the person had capacity to consent to this and there no record of a best interest decision about this. For another person, staff had concluded they did not have capacity to understand and consent to their nutrition and hydration care plan, although there was no recorded evidence the person's capacity to do so had been assessed.

We discussed this with the registered manager, who said some of these decisions were made before they came to work at the service. The provider's MCA policy was not available at the service to refer to, so we requested a copy following the inspection. The policy said, "Where the company has information that suggests the person might be unable to take some decisions at some times it will carry out or contribute to an assessment of that person's mental capacity … the assessment procedure should follow the two step assessment process recommended in the Mental Capacity Act's Code of Practice." This showed staff were not following this policy where they were making decisions about people's care and was not in accordance with the requirements of the MCA.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and social professionals were involved in more complex assessments. For example, a social care professional was undertaking a mental capacity assessment in relation to a person's finances and was involving family members in a 'best interest' decision about this.

Staff sought people's consent for all day to day support and decision making. For example about what time they wanted to get up, what they wanted to eat and how they wished to spend their day. Some of the newer support plans at the service included information about what support the person needed to participate in decisions about their care, in accordance with the MCA. For example, one person's nutrition and hydration support plan included information about how staff could support the person to participate in decisions about their eating and drinking. This included instructions for staff to communicate simply and clearly with the person and described how the person would push away food or drink if they did not want it.

Staff supported people to have as much freedom as possible and keep restrictions to a minimum. For example, one person went out independently each day and travelled around Devon by bus. The person had a mobile phone so they could contact staff and staff could contact them if they did not return at the expected time. The registered manager had recently made four DoLs applications for people living at the service because of the level of staff supervision they received. They were awaiting assessments of those people by the local authority DoLs team.

People's health care needs were met by staff who knew about their care and treatment needs. Staff worked closely with local healthcare professionals such as the GP, community nurse, psychiatrist and members of the local learning disability team. Each person had their own GP and dentist, and were supported to attend health appointments regularly. A health professional confirmed staff sought advice appropriately about people's health needs and followed that advice.

Requires improvement

# Is the service effective?

For example, following a choking episode where there were recent concerns about swallowing difficulties for one person, staff had sought advice from the person's GP. The person was referred for a speech and language therapy (SALT) and was awaiting assessment. Meanwhile, following telephone advice from the SALT, staff were giving the person a soft mashable diet and had a list of foods they needed to avoid. At lunchtime, a member of staff sat with the person, and reminded them to focus and eat slowly, which was in accordance with the advice given.

People gave us positive feedback about the food at the home. One person said, "Lovely food" another said "The food is good." At lunchtime, staff offered people a choice of meal and staff knew each person's food likes and dislikes. Some people were able to help themselves to various desserts from the kitchen, whereas others were offered a selection to choose from, according to their ability. There was a menu for evening meals that people had discussed and chosen. Some people chose to eat in the dining area and others ate in their rooms; two people living in flats made their own lunch, with staff support. People were offered regular snacks and drinks throughout the day. Where there were any concerns about nutrition and hydration, there was a care plan in place about this and staff monitored people's weight regularly and took action, when needed.

People were supported to improve their health through good nutrition and regular exercise. Staff encouraged people to eat a well-balanced diet and make healthy eating choices. For example, one person was overweight and a staff member was liaising with the person's GP to help them manage this. They encouraged the person to exercise regularly and make healthy eating choices. The person said they liked fruit salad, particularly grapes and watermelon and liked to help staff prepare it.

The provider had a training programme to ensure staff had the right knowledge and skills to provide people's care and treatment, and staff were supported to gain qualifications in care. They undertook regular update training such as safeguarding adults, health and safety, medicines management and moving and handling. Staff also undertook training specific to the needs of the people they supported. For example, in relation to autism, epilepsy and to manage people whose behaviours sometimes challenged the service. A health professional gave us positive feedback about how staff used positive support techniques to de-escalate challenging behaviours.

Staff were supported to maintain their good practice through regular one to one supervision. They said they appreciated the support they received from the registered manager or deputy manager and valued their availability to talk through any issues. Staff had an annual appraisal where they received feedback on their performance and discussed their future training and development needs.

We met a new member of staff undergoing their induction period who said staff were "Friendly and welcoming." They were undertaking the national skills for care, care certificate. The care certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. Their induction included working alongside more experienced staff to get to know people and how to support them and was flexible. This meant new staff did not work alone with people until they felt confident to do so. All new staff had a probationary period to assess they had the right skills attitudes and competency assessments were undertaken to check staff had the required skills.

The environment of the home met the needs of people who lived there. It was clean and well maintained, corridor areas were kept clutter free so people with mobility equipment could move around the home easily. One person's chair was height adjusted following their hip surgery. Where a person could no longer manage the stairs, they had moved downstairs, and the downstairs bathroom had disabled access. The home had three different communal areas where people could choose to spend time in or could spend time in an attractive garden. The lounge had been beautifully decorated for Christmas.

Good

# Is the service caring?

## Our findings

People said they were happy living at the service. One person said, "I like living here, the people here are my family now." Another said, "Yes I like it here." The atmosphere at the home was relaxed, welcoming and homely. Staff treated people with kindness and compassion, they spoke positively and fondly about people. There was lots chat, banter, and laughter. Staff listened attentively to what people had to say and responded to their requests. If staff could not attend to the person straight away, they explained this to the person and told them when it would happen. For example, when one person wanted to go out, staff explained they would go out with them as soon as another member of staff returned with another person.

People were supported by staff who knew what mattered to them. Staff knew about people's lives, their families, what they enjoyed doing and things that upset them. People's birthdays were celebrated and staff supported them to keep in touch with family and friends. A relative who lived in another part of the country said staff kept in regular contact with them. Another person was in daily contact with their mother via their mobile phone.

On the second day of our visit, people were looking forward to attending a carol service that evening in their local church. Staff supported people to be as independent as they wanted to be. One person said they usually got themselves washed and dressed but said, "Sometimes I have help when I am not feeling well." Staff encouraged people to clean their own rooms but respected people's choices. For example, if the person didn't want to do it on the planned day, then they didn't, and staff respected the person's choice.

Staff treated people with dignity and respected their privacy. Staff were discreet when supporting people with personal care, and acted in accordance with their wishes and preferences. One person said, "I have a bath when I want to, I tell the staff when I want one. Staff help me with a bath downstairs, it is easier to get in to." Staff never entered the person's flat or room without their agreement; they knocked and waited to be invited in.

One staff member spoke about how they motivated a person who was reluctant to have a bath. Previously the person had refused to wash, which had caused a personal hygiene concern. The staff member said they knew, the more staff insisted the person had a wash, the more likely the person was to refuse. Instead they discussed the situation calmly with the person and negotiated a compromise personal hygiene routine with them. They said the person now regularly washes although still needs occasional prompting. A health professional praised how staff supported a person with complex needs. They said staff knew the person well and supported them through more difficult times, trying lots of different things, and used positive reinforcement to motivate them.

Staff could interpret what people were saying or signing and recognise what any gestures meant, when it was not clear to others. For example, one person was unable to communicate verbally and had their own form of sign language, which staff knew and understood well. When we asked how new staff would be able to communicate with this person, we were shown a book of photos which showed staff what each sign meant. Previously, their relative said the person really struggled to communicate when they were admitted to hospital and did not eat and drink. However, since then, they said the provider arranged for staff to stay with the person during the day when they were admitted to hospital. This ensured the person was supported by staff they knew who could assist them to communicate with hospital staff.

Staff gave people information and explanations in a way that met their needs. For example, one person's care plan stated how to support them said, "Speak to me clearly in short sentences. I question consistently so need a full explanation of what has changed and why." Staff knew how to minimise their anxiety and redirect the person's attention. They used weekly pictorial/symbol calendars to help them plan their day. Other service information for people was provided in pictures, symbols and easy read formats.

Staff said care plans had been developed with the person, a relative or others who knew them well wherever possible. Some people had signed their care plans to confirm they agreed with them and knew they could attend their review meetings, although they did not always chose to do so. Some people's relatives attended review meetings regularly whilst staff kept in contact with others by phone. Where there was difference of views about future plans for one

Good

# Is the service caring?

person, staff involved outside agencies. This was so an independent assessment could be undertaken to ensure the person's wishes were taken into account in any decision making in their best interest.

Requires improvement

# Is the service responsive?

## Our findings

People were at increased risk because people's care records were not always accurate and did not always reflect the care they received. Care records were in two folders, which were difficult to navigate and included some duplicate, contradictory and conflicting information. There were different risk assessment and care plan formats in use. Although some aspects of people's care records were detailed and individualised, they also included older documentation which was out of date and had not been archived. Each person's current care and treatment plan took a long time to read and relevant information could not always be located promptly. This could increase risks for people, particularly where staff were less familiar with the person and their needs.

For example, staff told us about the complex care needs of a person and about how they were working with a number of professionals to support the person and try different approaches with them. However, when we looked at the person's care records, it did not have the level of detail or all the information staff described was needed to support this person's needs. A health professional commented that senior staff were happy to sit and talk through the person's care needs at review meetings, but were less good at writing up their care records. As the person was supported by a small team of care staff, this lack of detailed records meant it would be difficult for other staff who did not know the person well to work with them, such as in the event of staff absence.

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

The staff member who regularly supported this person was mindful of this and had just started to work with the person to collate key information a new staff member would need to support them. The registered manager was also aware of the need to further improve the quality of people's care records. They had made some improvements and to ensure they were more accurate and up to date. During the week of the inspection, new paperwork had been introduced in the form of a monthly booklet for staff to document what was happening to each person every day. This included information about the person's support needs with personal care, eating and drinking and how they had spent their day. Staff were positive about the introduction of new documentation and thought the new system would be easier to use.

The service used a key worker system, which meant named staff had named responsibility to liaise and support individuals. Staff described the role of a keyworker as being the contact for the person and supported people to clothes, toiletries and supported the person to send cards to family members at birthdays and Christmas and buy presents. Care staff completed people's daily care records, while the registered manager and deputy manager wrote the care plans and risk assessments. The registered manager had plans for staff to write a monthly report about each person and to hold monthly review meetings, which would be used to inform any changes to care records.

People received care that was personalised because staff knew people well, understood their needs and cared for them as individuals. For example, staff said one person was not themselves at the moment, which was often the sign they were about to have a seizure, so staff were making more regular checks on the person. People could choose what they wanted to do each day, what time they wanted to get up and the time they wanted to eat. Records of individual meetings were held, where staff discussed any problems and how to tackle them. For example, strategies to motivate a person to exercise more and discourage them from putting on more weight.

People were supported to have a wide variety of interests and hobbies and learn new skills. Some people attended a weekly cooking group and others an arts and crafts group. Others attended a local community club once a week which they said they really enjoyed. Several people had recently gone on a four day holiday to a hotel in Cornwall organised by the club, which they told us about. One person enjoyed their pamper session and their room overlooking the sea and other talked about the great food and entertainment. Previously some people had been to Spain with the same group.

There were lots of photos around the house of people at social events. Staff had supported people to go to London, have a holiday in America, at Centre Parcs in Longleat and to attend various concerts and exhibitions. One person attended a local football club and showed us their team mascot. Another person told us about their friend who

Requires improvement

# Is the service responsive?

lived locally and who they met regularly. A third person liked photography and staff took them out to have photos developed whilst we were there. This showed people were able to pursue their individual interests and hobbies.

Staff supported people to lead busy and fulfilling lives, access their local community and improve their independence. When we visited, one person was going to the supermarket with a member of staff to do some shopping. They liked to help the staff member to cook their dinner and said they were good at peeling potatoes. Another person was going into Exeter to choose some new clothes. The service had a mini bus which they used to transport people around in. One person had difficulty getting into this so a taxi was arranged for them when they went out.

Two people had pictorial calendars that staff used to help the person structure their day, to remind them about personal care routines, and household tasks such as doing their washing and cleaning their room. People were well known in their local area and visited shops, the hairdresser, local banks and their local church. Some people did voluntary work at a local charity shop, which staff supported them with. Staff said one person did not always want to go so they tried to talk to the person and encourage them to change their mind because it benefitted them but did not insist they go.

People's bedrooms were personalised with family photos, pictures, ornaments, favourite music and films. One person was a fan of Elvis and had decorated their flat with lots of their pictures. Another person liked to watch sport and that they had a sports channel on their TV. People could keep their personal items around the home if they wished. For example, one person had their dolls in the lounge.

People told us how their views on the running of the home were sought; one person recalled they had been to a residents' meeting but could not remember when. However, records of review meetings showed people were involved and consulted. For example, one person remembered they were asked "What they would like to do and where they would like to go on holiday". The provider last completed a feedback survey for people in 2013, the registered manager said work was underway to design an improved survey tool suitable for people's individual communication needs. This will enable people to give feedback about the service.

The provider had a written complaints policy and procedure. Written information about how to raise concerns or complaints was available in the home in an easy read format. When we asked a person what they would do if they were unhappy about something, they said they would "Talk to some of the staff". Since the last inspection, the complaints log showed no complaints had been received by the service.

Requires improvement

# Is the service well-led?

## Our findings

People and staff felt well supported at the service. However, further improvements in quality monitoring arrangements were needed because concerns identified by the provider about consent and record keeping had not been fully addressed.

A provider visit was carried out in July 2015, using a structured assessment tool based on the CQC standards. The report identified several areas where improvements were needed, and prioritised some areas which needed urgent action to address. For example, in relation to the need to make DoLs applications for some people, and to update risk assessments and make them more individualised. The report also identified the need to improve documentation about how people's consent to care and support was recorded within the service. The action plan showed the registered manager was working on addressing them, but some actions were overdue, which had not been followed up by the provider.

The provider had a range of policies and procedures in place for staff. However, the Mental Capacity Act (MCA) policy 2005 did not include detailed guidance or a framework to guide staff about how to assess and document mental capacity assessments and 'best interest' decisions.

The provider had a range of quality monitoring arrangements in place. The registered manager and deputy manager had undertaken environmental, finance and medicine audits and made improvements in response to their findings. There was a training matrix to check staff kept up to date with training. Accidents and incidents were monitored to identify any at trends and patterns and actions were taken to reduce risks.

The registered manager worked across two locations and spent half their time at each, supported by the deputy manager. Staff were positive about the support they received from management. They said they felt things had improved under the management team, who worked well together and were making some good changes, such as the introduction of new daily records. One staff member said, "The new management is much better. There is a lot of communication, we have regular staff meetings and when I mention something, it gets sorted straightaway," a sentiment other staff echoed. Two professionals commented that whilst management staff were very pleasant, they sometimes had to chase to get things done, for example to set up requested meetings.

The registered manager said the local provider had been taken over by a national company called Eden Futures. They said this was a positive development because they were introducing more structured systems for quality monitoring. Staff said these changes did not really affect them on a day to day basis.

The culture at the service was open and friendly. People knew who was in charge, one person told us the name of the deputy manager who was in charge of the shift that day. They said, "She checks to make sure everything is OK." Another person said, "I like (person), I can talk to her." All the staff we met said they enjoyed working at Windsor Lodge. Two staff had been there for 12 and 15 years respectively. Staff said they liked working with people of different ages and varying needs.

Each day staff had a verbal handover meeting and used a handover booked to communicate messages between staff. New information about people's care such as copies of guidance about food preparation and an updated risk assessment for the person with a choking risk was in the handover folder. A daily diary was used to remind staff about people's appointments, report repairs and supplies needed. This showed essential information about each person and the day to day running of the home was effectively communicated between the staff team.

Staff meeting minutes for September 2015 showed staff had discussed the plans to introduce new documentation and to improve the quality of care records. Improvements had been made in monitoring people's finance and medicines following audits. Where staff raised issues, positive action was taken in response. For example, following a discussion about staff doing their fair share of household tasks on each shift, a system was agreed for staff to document this in the staff handover book. This was to ensure a record was kept, which was being monitored by the registered manager. Discussions about what was not working so well showed staff were reminded about the need to report all medicine errors on an incident form and to label all new medicines with the date of opening to ensure they met storage guidelines. Other issues discussed were staff conduct in relation to use of mobile phones.

Requires improvement

# Is the service well-led?

The November 2015 meeting minutes showed the measures agreed in September 2015 were implemented. Staff reported the new cleaning rota was working well and resulted in improved cleanliness and tidiness. Changes in practice had reduced medicine errors. This showed lessons were learned and the service was committed to making further improvements. Staff reported that morale had improved lately and that staff were a lot more positive.

The provider had an employee forum, so a staff member from each home could represent staff views to the provider.

Information in the home showed staff received quarterly updates from the provider. In the provider information return, the registered manager outlined how evidence based practice and good practice initiatives were used to promote best practice. For example, NICE guidelines for managing medicines and the Dignity in Care 10 steps. This meant the service was following some national good practice guidelines.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>How the regulation was not being met:<br><br>People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005. The service did not complete any mental capacity assessments. Where people lacked capacity, it was not clear whether people had consented to some decisions about their care.<br><br>This is a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met:<br><br>Some people's care records were not detailed enough and were not accurate and not up to date about their care and treatment needs.<br><br>This is a breach of regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |