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

Summary of findings

Overall summary

The inspection took place on 9 August 2016 and was unannounced we returned on 10 August 2016 announced.

Westroyd Care Home is registered to provide care for up to 66 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 residential needs 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 38 people using the service.

The service had a registered manager. 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.

Systems for the safe management and storage were not being followed. The medicines room was not secure and procedures to monitor the use of pain relief patches was not always being followed.

Recruitment practices were not always followed. Risk assessments had not been completed before staff with spent convictions commenced work.

Complaints procedures were not being followed. People may not have their complaints investigated and receive information about any action taken.

Quality assurance systems were not robust or effective enough to identify all the shortfalls in the service. These included lack of some risk assessments and not all records being up to date and accurate.

People on respite were not always supported to retain their skills for returning home.

People told us they felt safe living at Westroyd Care Home

There were sufficient staff to provide people's care needs but the deployment of staff had an impact on the personalised support provided. Although staff were provided in the numbers that had been assessed as needed by the registered manager, staff were very busy, responding and providing care tasks such as personal care to people.

We found that staff were knowledgeable about people's needs and risks and what action to take to protect them from these risks. However new care staff or agency staff did not have this knowledge or access to up to date information to provide appropriate and safe care to people.

People were supported to have sufficient to eat and drink to maintain good health. People had mixed views about the quality of the food. Information in care plans did not always reflect the dietary support people received.

Suitable arrangements were in place for people to receive on-going support from healthcare professionals.

Some staff and people who used the service did not have confidence in the registered manager as they did not feel they managed the service in the best interest of people living there.

Mental Capacity Act (MCA) 2005 and best interest decisions were general and did not reflect the person's needs. The registered manager had not made to apply for a Deprivation of Liberty Safeguard authorisation when they were required. This meant people were being deprived for their liberty without due authorisation.

People were cared for by caring staff. People's privacy was respected and promoted. We saw examples of caring practice from staff. People's preferences, likes and dislikes were not always recorded in their care plans. Which meant that new or agency staff would not be aware of how people preferred to receive their care.

The environment in the Lodge was not dementia friendly and there was a lack of directional signage to communal areas and the stairs, lift or bedrooms.

The business contingency plan that was in place to minimise the risk to the home in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding was significantly out of date.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

The management of medicines was not consistent across the two units. People who lived at the Lodge did not always receive their medicines safely.

Risks associated with people's care and support had not always been assessed appropriately.

Recruitment procedures were not always followed ensuring staff were suitable to work with people using the service. Staff were not always deployed in the most effective way to meet people's needs.

People were protected from the risks of abuse as staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Information for people who were at risk of not having their nutritional needs met was not always up to date. People had enough to eat and drink and were offered choice.

Information regarding people's capacity to make decisions did not relate to their individual needs.

Deprivation of Liberty Safeguards applications had not been completed and submitted for all those at risk.

Staff received training and had the skills and knowledge to fulfil their role.

The staff team 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.

Care staff were respectful and consulted people before they offered support. People said their care and treatment was delivered in a dignified manner.

Staff were caring towards people.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not personalised and summary profiles in place to identify important information about the person and their preferences were not always completed.

People's needs were not reviewed consistently and information was not always updated or changes made in response to these needs.

People living in the House did not have access to activities that were important and relevant to them. People were not protected from social isolation.

The provider had arrangements in place for people to share their views of the service. Their views were acted upon.

Is the service well-led?

Requires Improvement

The service was not well-led.

The systems the provider had in place to monitor and asses the service were not being effectively used to improve or monitor the quality of care.

Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted.

People were given the opportunity to have a say on how the service was run.

Not all staff felt they the service was well led by the registered manager.

The registered manager understood their responsibility to inform CQC of incidents within 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 site visit took place on 9 August 2016 and was unannounced we returned announced on 10 August 2016.

The inspection team on the first day consisted of an inspector, a specialist nurse advisor and an expert by experience. A specialist nurse adviser is a qualified nurse who has experience of working with this service user group. This nurse specialist worked in a number of areas with older people and had an understanding of people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had expertise in understanding services for people living with dementia. On the second day the team consisted of two inspectors.

At the time of our inspection there were 38 people using the service. We were able to speak with 11 people living at Westroyd Care Home, three visitors, nine members of the care staff, the activities coordinator, a domestic, the regional manager and the unit managers for the House and the Lodge. The registered manager was unavailable during the inspection.

Before the inspection we reviewed the information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law. We contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had concerns about the service.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not

people were comfortable with the support they were provided with. We also used the Short Observational Framework for Inspection (SOFI) in both the Lodge and the House. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. This included seven people's care plans, four of which were looked at in detail. We also looked at associated documents including risk assessments. We looked at three staff files including their recruitment and training records, staff duty rosters and the quality assurance audits that the management team completed.

Requires Improvement

Is the service safe?

Our findings

We last visited this service in July 2015 where it required improvement in the management of medicines and delivering care and support in a safe and timely manner to people.

Aspects of medicine management were not safe. When we arrived at the Lodge we found an unidentified tablet on a chair in the quiet area near the dining room. The unit manager did not know whose tablet it was, but identified it as Risperidone. Risperidone is a antipsychotic medicine. This meant a person may not have received their medicines as prescribed.

The service managed the medicines separately in the Lodge and the House. In the Lodge we found one person was prescribed Mirtazapine and this was being given in the morning. It is used to treat major depressive disorder. It is typically given at night owing to common side effects of drowsiness and dizziness. The senior carer could not give us a rationale for this atypical prescribing and no rationale was found in the care record. Three other people who received this medicine were prescribed it at night. We brought this to the regional manager's attention to be investigated. The registered manager contacted the GP following our inspection and they said that the timing of this prescription was perfectly safe and did not need to be amended.

Two people prescribed insulin did not have a recovery plan should the readings be outside the normal range. Diabetes in older people is often unstable as they are at risk of a number things that can upset diabetes such as infections dehydration, erratic diet and general fragility. This meant should the person's diabetes become unstable the care staff would not have the information they needed to support the person safely.

In the Lodge three people who were prescribed pain relief by trans dermal patch had a patch rotation chart. A rotation chart is used to ensure that patches are not placed in the same area to reduce the risk of the person developing a rash. It was not fully completed with removal and new application site clearly stated. This meant there was potential for the person to develop a rash if the same site was repeatedly used.

A person's chart had been marked indicating when their Buprenorphine seven day patch was next due, this had been incorrectly filled out only leaving a six day gap. This was brought to the attention of the senior carer for amendment to reduce the risk of over sedation as the patch may have been replaced to early.

A number of residents were prescribed PRN (as and when required) pain relief their records did not evidence how their pain levels were to be monitored or assessed. Research states it is estimated that about 50% of people with a dementia have pain on a regular basis and at high risk of being under treated due to the individuals capability to express, describe pain owing to cognitive decline or word finding difficulties. The home used the Abbey pain scale which is a tool used with people living with dementia or where there are barriers to verbal communication. These were not completed for three people. This meant care staff did not have the information they needed to ensure people's pain relief was managed appropriately.

Where people required creams to be applied this was not always being recorded. We found that the records were locked in the unit manager's office and so care staff did not have regular access to the record sheets. This practice was not happening in the House where the records were stored in people's bedrooms. We brought this to the regional manager's attention.

The security of the medicine room in the Lodge was not suitable. There were no bars on the windows. The purpose of the room, which was on the ground floor, was clearly visible from the outside, as there were no blinds and the glass was not frosted. The glass was also thin and therefore easy to break. The window was a sash style which had a single restrictor which was easily accessed from outside and there were no blocks in the frame to prevent the window from being fully opened. We brought this to the regional manager's attention to take appropriate action.

These were breaches of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager was unable to find a medicines audit on the day of the inspection. This meant we did not know if the registered manager had checked the management of medicines and not identified the shortcomings we had or had not carried out an audit. The regional manager told us they would discuss this with the registered manager when they returned. Following our inspection visit the regional manager told us the registered manager found the relevant audits in her desk drawer.

By contrast medicine management had significantly improved in the House. Medicines in current use were stored in a locked trolley which was located in a locked room and secured by a chain to the wall when not in use. The key was held by the senior carer. Additional stock medicines were stored appropriately in locked cupboards and these were in date and for current residents. Medicines no longer needed were returned to the pharmacist promptly ensuring that large stocks of unwanted medicines were not kept by the service. We looked at medicine administration records for three people and there were no gaps indicating that people had received their medicines. We checked this against the medicines in stock and found that there were no errors.

The senior carers in both units told us that they had attended medicines management and administration training provided by the company when they started. They had their competency assessed and they attended regular updates. Training records confirmed this.

The provider's recruitment procedures had not been followed. Required checks had been carried out prior to a new member of staff commencing work. This included obtaining suitable references and a check with the Disclosure and Barring Scheme (DBS). A DBS check provides information as to whether someone is suitable to work at this service. However we saw that a member of staff had received a DBS check that showed they had previous spent convictions. There was no associated risk assessment in place to ensure this person was suitable to work in the service. We brought this to the regional manager's attention who said they would take the necessary action.

People told us they felt safe. We asked people what does safe mean to them. One person told us, "Hmmm, what does safe mean to me? Being taken care of. Knowing that I have all the help I need right here, if I need it, but especially if I am poorly or I fall again." Another person said, "I like living here, they do everything for me and the girls (staff) are so nice to me. I have nothing to worry about really." One person did tell us, "Sometimes a resident might get in your face (up close) but the carers are soon on it and then lead them away. I have never felt scared. A little startled for a moment maybe."

A visitor we spoke with told us there had been concerns about a person living at the service who had extreme behavioural issues. They felt that this had placed their relatives at risk. They told us, "We spoke to the senior here (the Lodge) and then to the manager. It was affecting all the residents here and it is such a happy, calm place normally it just wasn't fair on [person using the service]. My sister and I were very unhappy." We asked what had happened, they added, "After they tried to control the person's behaviour and just couldn't, as there are not enough staff here for that, the manager did eventually concede and applied to have them moved. It didn't happen soon enough for us, but everything is back to normal now and peace has been restored."

Another visitor told they thought the home was wonderful and the staff made sure their relative was safe. They told us, "My [person using the service] is very poorly but staff make sure they are cared for and they have everything they need."

We spoke with the regional manager regarding staffing levels at the Lodge. We were told that they use a staffing level calculator and this had meant that due to the number of people now living in the Lodge they had reduced the number of staff. The calculator showed that they needed two carers plus a senior for the Lodge. Both staff and relatives told us they did not feel there were enough staff to meet people's needs. All the care staff we spoke with reported that they did not have enough staff to do anything other than basic care for the residents and sometimes they struggle with covering the basics particularly in the afternoons and evenings. We were told they used to have an extra member of staff to cover that period which did make a difference. We were told that this was stopped a couple of weeks ago without communication or explanation.

A staff member told us, "We've have two staff in the morning and two in the afternoon; nobody to deal with falls, the door, vomiting, showers etc. because once you start using that hoist you can't leave them. We had a third person who started by 2 pm which used to cover us for showers, that has now been taken off." We asked how many less people live in the Lodge now that they have lost the extra person. We were told by staff, "One to two residents, the activities coordinator sometimes helps with sitting with people and answering doors." We discussed this with the regional manager who told us there were two carers and the unit manager each day. They would look at how staff were deployed to ensure people received their support safely.

On both days we saw people's needs being met in a timely manner, call bells did not ring excessively indicating staff responded promptly. Staff told us that they made sure people received their care but that this meant they did not always have time to sit and chat to people. Staffing levels were regularly assessed but they were not always deployed in the most effective manner.

The staff team were aware of their responsibilities for keeping people safe. They knew the different types of abuse to look out for and explained the procedure to follow if a concern was identified. This included informing the registered manager. They knew how they could report concerns directly to the local authority safeguarding team, the police or the Care Quality Commission.

People's care plans included risk assessments of activities associated with their care and support. However risk assessments were generic in nature and were not personalised to the individual. All risk assessments were worded the same and only the names were changed. Care plans were not always reviewed by staff following changes or incidents to help reduce risk. For example, a person was reported as having lost 11 kilos in weight in 18 months. The care plan was not reviewed in light of this unplanned weight loss. However we did find evidence that medical advice from the GP had been sort and was commenced on a food and fluid chart which was discontinued when their weight had stabilised. Another person was reported to have

had a fall on the 5 July 2016 but the falls risk assessment and care plan was not reviewed until the following month. This meant that preventative action to reduce risk was not put in place in a timely manner.

The regional manager told us that the new care plan format included risk assessments and that they should be moving away from generic risk assessments and this would be discussed with the registered manager on their return.

During the meal time we observed a person starting to choke. Staff responded swiftly and appropriately. We asked staff about this and were told that the person is prone to choking. When we looked at the person's care plan they were identified as being at low risk of choking so there was no care plan to say what action for staff to take if they were to choke. This meant that staff did not have the correct information to keep the person safe.

We saw that audits of equipment and the premises had taken place. An audit had identified that the Legionella risk assessment was not up to date, however when we checked it had not been updated. Legionnaires' disease is a potentially fatal form of pneumonia and everyone is susceptible to infection. The risk increases with age but people with impaired immune systems such as older people are at higher risk. It is therefore very important that risk assessments are regularly reviewed and updated. We discussed this with the regional manager who told us they would discuss it with the registered manager on their return.

The continuity plan for the service was stored in a emergency grab bag held in the reception. Continuity plans identify what action to take in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding. The plan was out of date, having not been updated since 2008. This meant the list of people using the service was out of date as well people to contact in the organisation should an emergency occur. The regional manager updated this during the inspection visit.

Requires Improvement

Is the service effective?

Our findings

We last visited this service in July 2015 where it required improvement in managing people's nutritional needs, providing sufficient detail in care plans to meet people's needs effectively and mental capacity assessments were not consistent.

During the midday meal a person refused their meal. No alternative was offered and no pudding was offered. The person asked for some ice cream and this was provided. We asked staff how often that happened and they told us, "Oh [person using the service] has not been feeling that well and does often refuse to eat. Their GP has been in and they have Fortisip as well." We spoke with the person they told us, "Oh I have always been a bit of a fussy eater. My mother had to convince me to eat sometimes as well." We asked them whether they had lost any weight recently as a result and they told us, "Funny you should say that, my daughter said earlier, what is happening to all the weight?" We looked at this person's care plan. Records indicated they had lost 11 kg in 18 months. We saw that the GP had been involved but we found no record of Fortisip being prescribed. The care plan did not indicate how the person should be encouraged to eat or what alternatives they may enjoy to tempt them to eat. We brought this to the regional manager's attention. Following the inspection they told us they had spoken with the registered manager who had said the person was not on Fortisip. This indicated that the staff who supported the person with their midday meal did not have a reliable understanding of the person's nutritional needs.

We saw that people had food and fluid charts. Charts indicated how much a person had drunk or eaten but not how much they should drink. For example, a person was recorded as having drunk 200 mls of juice at lunch and cups of tea throughout the day. There was no total to indicate that they had drunk sufficient to ensure they remained suitably hydrated. If dehydration is not identified and treated, the consequences to health are significant, including reduced or even loss of consciousness, rapid but weak pulse, and lowered blood pressure.

People gave us mixed views about the meals served at the service. We saw care staff ask people what they wanted for lunch. People were offered a choice of meals. We heard one person when asked if they beef stew or macaroni cheese reply, "Hmmm. No thank you. Last time I had macaroni cheese it was not made properly and just tasted of cheese flavoured flour." Another person told us, "The food is not bad. The cook is not a trained cook though. It's just home cooked food, but not as good as I used to cook." We asked people if they had been involved in the development of the menu. People were unable to recall if this had happened.

We saw both the morning tea trolley with biscuits and the afternoon tea trolley with cake being offered to people. We also saw that people had jugs of water or juice next to them and staff offered drinks during the day. A choice of drinks were available to people with their lunch. A relative told us, "The staff are very good and will wake mum to ensure she gets enough fluids and eats something, especially on her sleepy days."

We did note that in the Lodge the menu was displayed on the table but it was for all four weeks of the menu cycle, in small print and not in format that people living with dementia would find easy to understand. There were pictures on the notice board showing what the meal was for that day, which would have been easier to

understand. The service did not offer choice to people in a meaningful way.

Care plans lacked sufficient detail to show how care was to be provided. Staff we spoke with knew how to provide care as many of them had worked at the service for a few years. However, we were told that agency staff were often employed where there were staff shortages. If an agency staff read a person's care plan they would not have the information they needed to provide personalised care. Staff told us that when agency staff are on a shift with them they spend a lot of time telling them how to care for someone.

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 were able to demonstrate a good understanding of the principles of the MCA and DoLS. One member of staff told us, "We always ask people what help and support they want."

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 our visit the registered manager had submitted applications for some people using the service. However when we looked at the care plans for other people it was clear that they too needed applications made. The regional manager sent us an action plan that confirmed that applications would be made for a further 15 people identified in the two units.

Care plans showed that some people had a DNAR (do not resuscitate) in place. We saw that for two people the appropriate form had been completed and signed by the GP, it recorded that family members had been informed. Records did not evidence that the wider national guidance had been adhered to or applied consistently. One person did not have a supporting capacity assessment and the section on capacity was not completed. Whilst the form indicated that their relative had been informed there was no detail as to the nature and content of the discussion and their end of life plan was not completed. In another care plan we saw that the GP had suggested a DNAR be created but there was not a plan in place nor could we find any evidence that it had been followed up with the GP.

Care plans we looked at did identify whether a person had capacity and where a person was assessed as not. We also found that similar statements that we had seen in care plans at the last inspection still appeared. For example all the care plans stated 'Diagnosis of dementia. Able to make non complex decisions any complex decision discussed with family and health professionals.' Care plans were not personalised, nor did they give staff clear guidance as to what this meant for the person. We brought this to the regional manager's attention who told us that new care planning was being introduced and they would be amended in line with the new guidance.

People were supported to make their own decisions and their consent was sought before care was provided. Care staff checked with people that they were happy with the support being provided on a regular

basis and attempted to gain people's consent. Care staff waited for a response before acting on people's wishes. Care staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them.

Care staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role safely and effectively. Care staff provided us with information about people's care and support needs and how they met these. We observed care staff when they were helping people to move around the home or assisting them when transferring using a hoist to a chair and this was done effectively and according to best practice. This showed staff were using their training in practice.

Care staff told us they found the training very useful but it had caused frustration. Due to staffing levels care staff told us they did not feel able to implement what they had learnt, particularly with people who were living with dementia. The provider's records confirmed that all staff had received mandatory training such as safeguarding adults; dementia awareness; diabetes awareness; administration of medicines, health and safety and infection prevention and control, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People told us that they were able to see a healthcare professional when they wanted to. A relative commented, "They call a doctor when they need to see one, staff are marvellous." Records showed that healthcare professionals were contacted when people needed to see one and staff acted on any advice given.

Good

Is the service caring?

Our findings

We last visited this service in July 2015 where it required improvement in supporting people's dignity.

People told us they were supported with their privacy and dignity. One person told us, "They look away or hold the towel up, so I don't worry about getting embarrassed."

We saw staff promoted people's privacy and dignity. Staff knocked on people's doors, even if they were open and waited to be asked in. Any care and support was conducted behind closed doors. Staff told us when supporting people with any personal care they would always ensure this was done with the person's door closed and the curtains drawn. They would always explain what was happening and encourage the person to do as much for themselves as they could. They said they would always ensure that people were covered when supporting with intimate tasks.

The provider had developed a new care plan that included a booklet on personal information for each person using the service. We found that not all of these had been completed. We were told by the regional manager told us that the unit manager's were in the process of writing plans and this information would be collected form people and their families to help staff understand people and develop meaningful relationships. However staff we spoke with who had worked at the service for some time were able to demonstrate what was important to people. For example, how a person liked to be dressed or got up in the morning.

People told us that care staff were kind. One person told us, "Oh yes they are good to me." Another person said, "Mostly they are lovely, some can be a bit grumpy," We asked the person to elaborate, they added, "Some people you get on with better than others." Other comments included "Staff are kind and caring", "I can't fault the staff at all." A relative told us, "The staff always make me feel welcome when I come and offer me a drink." Another relative said, "They sometimes ask if I am ok if I haven't managed to come as often or miss a regular day. It's nice that they notice really."

We saw lots of friendly interaction between people and care staff, both in the Lodge and House, however more so in the Lodge especially when care staff assisted people transferring using the hoist. Care staff were more friendly engaging with people, explaining tasks and reassuring people throughout transfers. Staff had received dementia awareness training in both units but appeared more skilled at putting it into practice in the Lodge.

We saw staff comfort people when they became distressed, they gave gentle reassurance and stayed with them until they were content.

We saw positive interaction between people and care staff in the House during lunch. They used people's names, spoke gently and encouragingly to them when needed and there was one care staff in particular who provoked a lot of laughter amongst people with their banter. People were happy and laughing which showed they were enjoying being in the company of care staff.

We also saw a staff member in the House sitting with a person going through their photographs as they explained what they all were. The staff member was interested and attentive and seemed to enjoy the interchange.

Care staff were knowledgeable about the care and support people required. They respected people's choices. For example if people preferred a bath or shower or what clothes they liked to wear. People told us they were not involved in reviewing their care plan or could not recall being involved. A relative told us, "They keep me posted about what is happening, either by phone or when I visit, but it is the GP who decides on what the care plan entails."

Relatives told us they could visit any time they liked. One relative told us, " I come at different times of the day and week and they always make me feel welcome." Another said, "I can visit when I want to, there is no restriction." Entries in the visitor's signing-in book showed that relatives visited throughout the day.

Requires Improvement

Is the service responsive?

Our findings

We last visited this service in July 2015 where it required improvement in providing personalised care and meaningful activities.

The provider had a complaints procedure that was displayed in the reception area of the home. We reviewed the complaints log and noted that no complaints had been received in the last twelve months. However, when we looked at other records we found information that clearly referred to a relative having made a complaint. There was no information to say how this complaint had been managed and what the outcome was for the person.

We spoke with a person who was staying at the home for a short period of respite and was due to return home. They told us that they were worried as care staff had taken their medicines and were administering the medicines to them. We discussed this with the regional manager, as this would potentially deskill the person who was going to return to their own home. We looked at the person's care plan the risk assessment did not explain why the person was not safe to manage their own medicines.

We saw that people were assessed prior to moving to the service. These assessments provided basic information about people and it was used to create a basic care plan. Care plans we looked at were not personalised and provided general statements on providing people's care, there was little information on how a person wished to receive their care. For example, if the person preferred to receive a cup of tea on waking then for staff to return to assist with personal care.

Care plans were not easy to navigate for staff and agency staff would struggle to find salient pieces of information on how to provide personalised care to people. Care staff told us they were getting used to the new plans but they were complicated.

Care plans for people who were living with dementia did not have a communication passport. A communication passport would normally go with a person when transferring into another care setting such as a medical admission, where verbal communication maybe difficult due to their health condition or dementia. It would assist staff to better understand the person.

The provider had introduced a new care plan format but these were not being made full use of. There was a booklet that should have been used to provide personal information such as people's preferences for times of getting up or going to bed. We saw that in most care plans this was either not filled out or it lacked relevant information. We discussed this with the regional manager who told us that the unit manager's of the House and the Lodge would be given supernumerary hours so they would now have time to develop personalised care plans. We spoke with a unit manager who told us they had received training and the regional manager had also given further guidance on how to complete care plans. They said, "I have been given 11 hours supernumerary a week so I should be able to create care plans as I was trained. I feel more positive about it now."

Where care plans were reviewed by staff there was no evidence of the person or their representative's involvement. One person told us, "I don't think I have reviewed a care plan, no I don't think so."

Care staff told us they completed a handover session after each shift which gave them the opportunity to share information about any changes to people's needs. This may be a change in people's medicines, healthcare appointments or general messages to staff. Daily records were completed to record each person's personal care given. We did note records did not always reflect what actually happened in the person's day. For example, a person had left the building unaccompanied on two occasions. The care plan had not been reviewed in response to these incidents and the daily record did not contain any information about the incidents or describe how they were in the period after their return.

We also saw that care staff had recorded that a person had refused a bath or a shower for two periods of two months each. There was nothing to say why this person was making this choice or what. We brought this to the regional manager's attention, they said they would investigate why this happened.

We saw that people living in the Lodge were encouraged to take part in activities. There was a dedicated activities person who, on the morning or our inspection visit, was sitting in the dining room with people using photographs to encourage conversation. People were fully engaged and there was a lively discussion going on.

We were told by care staff in the House that the activities organiser had left some months ago and had not been replaced. We were told that the manager's daughter had been covering the post but was returning to university soon. We saw that during our inspection visit people were sitting in the lounge and the television was on. We saw that very few people were watching this. One person told us, "There is not much to do really. Haven't been any activities for ages. I don't even know what happened to them. They just disappeared one day. It must be 18 months ago now." Another person commented, "When I get up, when I go to bed. All my choice. A bit stuck in the middle of the day though as not a lot to do."

Staff told us that people who use the service only really go out into the community if relatives visit and take them out. We did not speak with anyone who had been encouraged to keep up contact with outside groups that they used to belong to. This meant that people were not encouraged and supported to develop and maintain relationships with people that matter to them and avoid social isolation.

People did not receive the support they needed, in terms of their religious beliefs. A person told us, "I have always been a Catholic but they only have Church of England services here. I still go, because God is God after all, but since I have not been able to go to church the visits seem to have stopped." We asked the person if they could ask staff to arrange a visit for them, they told us, "Oh they would just think I am moaning. I am known as the moaner here you know."

People and their relatives knew how to make a complaint. One person told us, "I would probably speak to a carer." Another said, "If I had a problem I would tell my daughter and she would deal with it." One person commented when we asked if they would raise a concern with the registered manager, "I know who she is, but I don't think we have ever had a conversation, so I wouldn't feel that I could speak to her about something like that."

Relatives told us that there had been relative meetings in the past but they had not been held for a while. We saw minutes of a meeting held on 21 March 2016, only two relatives attended, prior to that a meeting was held January 2016. Records showed that a variety of topics were discussed including activities offered and meals. We were told by a relative the meetings had stopped. We asked why this had happened. They told us,

"With some of the residents passing away recently, there were fewer and fewer families attending the meeting until it just became just two of us and staff (the registered manager). The last one got cancelled and there has never been another one since."

The provider has an electronic feedback system in place. An electronic tablet was in the reception area for people using the service, visitors and staff to add their views about the service provided. Outcomes of these surveys were available in the reception. The provider included any action they took as a result of any suggestions.

The environment in the Lodge was not dementia friendly and there was a lack of directional signage to communal areas and the stairs, lift or bedrooms. Although there were signs to say what a room was used for. We saw a bus stop sign in the quiet area and a sign post saying Shepshed and memory lane these could be disorientating or cause distress for people living with dementia. Clear sign posting is important to promote orientation and independence. We discussed this with the unit manager who told us that a person using the service had regularly said they wanted to get the bus so they had installed the sign and bench. This person no longer lived at the service and they were planning to remove it.

There were no memory boxes or other personalisation on the doors to aid orientation to peoples personal space. A calendar clock had the wrong date "Monday the 8th August " (at 10.15 am). The actual date was Tuesday 9 August.

In the lounge it was noted that the seats were all of the same height and the same fabric design. This did not give people choice and lacked consideration of how different styles can add to comfort, taking into consideration individuals height, leg length or posture.

The National Institute for Health and Care Excellence (NICE) guidance states that care managers should ensure environments are enabling and aid orientation and include attention to lighting, colour schemes, floor coverings, signage, garden design and access to and safe external environments.

We had received information of concern that care staff were routinely getting people out of bed at 4 am and this was not in line with their care plan. We discussed this with the regional manager. As a result the regional manager and a registered manager from another service visited Westroyd Care Home at 4 am on 10 August 2016. We arrived at 7.45 am. We found no evidence that people were being got up early. Where people were up we spoke with them. They told us they either had chosen to get up early that day or they were naturally early risers so always chose to get up early. The regional manager also said they found no evidence that staff were getting people up early. We did note that care plans did not give suggested times for when people liked to get up and go to bed. The regional manager said this would be addressed when care plans were rewritten.

Requires Improvement

Is the service well-led?

Our findings

We last visited this service in July 2015 where it required improvement in the consistency of management between the Lodge and the House.

The registered manager was not present during the inspection visit. However, staff contacted the regional manager and they were present for both days of the inspection visit. A registered manager for another service was also present on the second day of the inspection visit to support the regional manager during their early morning visit.

We received mixed views about the registered manager. People using the service told us they did not really know who they were. A relative told us, "I really don't know the current manager well, I am told she is leaving soon anyway, but is staying on until they find a replacement." Another relative said , "Communication with management is not great, but we are more than happy with the care [person using the service] gets here (the Lodge), so we just hope that continues really. The senior here is very good and we can always speak with them." However another relative told us they thought the registered manager was "excellent".

Care staff's views of the registered manager were also mixed. There were care staff who thought the registered manager was good, whilst others did not find them supportive. One member of staff told us they thought they might improve now the new regional manager had started. Four staff member told us they did not find the registered manager approachable. Staff also told us they did not think communication with the registered manager was good. We were told that a recent staff meeting was called where the only agenda item was the registered manager was leaving. We asked the regional manager if the registered manager was leaving. We were told they were not.

Staff told us they received supervision regularly and records confirmed this was happening. Supervision was provided by the seniors, the unit manager or the registered manager, depending on what your role was within the service. For example the unit managers were supervised by the registered manager and care staff were supervised by the seniors. Staff told us they found supervision useful to discuss training needs.

Quality assurance system in place had not always identified the shortfalls in the records for people. We were unable to locate the audits for medicines and where audits had identified risk assessments out of date, for example the Legionella risk assessment no action had been taken. Audits were not robust or effective enough to identify missing or lack of up to date information recorded. For example the business continuity plan. There were inconsistencies with the information in care plans and what staff thought was in them. For example, where care staff believed people to be on dietary supplements.

During the inspection we asked the regional manager how the service was monitored. The regional manager told us that the registered managers of services were responsible for conducting a range of audits which were then sent to the regional manager. The regional manager then highlighted any trends, patterns or issues and these were reported to the senior management team. In addition to this regional managers completed a visit to each service to assess the quality of care and to complete additional audits. The

regional manager shared their most recent visit report. This highlighted a number of shortcomings that we had found during our inspection visit. However it did not identify that the continuity plan was out of date or that risk assessments in people's care plans were generic. The report included the actions they expected the registered manager to take.

We saw records of accidents and incidents that occurred every month and an analysis of the falls was carried out by the registered manager. The analysis identified a number of issues but not what action would be taken as a result to reduce future risk. The regional manager said they would discuss this with the registered manager.

Services are required to display the rating of their service to people and visitors. We saw this had been displayed in the lobby of the home and on their website. However the report on display was out of date. The unit manager removed it.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the home. Events had been informed to the CQC in a timely way.

We asked care staff what their understanding was of the aims and objectives of the service. Staff did not give a consistent reply. Some staff did not know, whilst one staff member thought it might be "To make residents as comfortable as possible; as at home as possible." We discussed this with the regional manager who told us that Four Seasons Health Care as an organisation had met to discuss its organisational values. Following this event all registered managers had been sent information to distribute to staff and put information up in the service to inform people using the service and their relatives. This information was not in the reception. We eventually found it still in its box in the registered manager's office. This meant staff were not informed of the providers value and aims. The regional manager said she would discuss this with the registered manager on their return.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use service were not protected against the risks associated with unsafe management of medicines. Regulation 12(1)(2)(g)