Westwood Lodge Ltd

Westwood Lodge Care Home

Inspection report

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Tel: 01912733998

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 January 2017 and the first day was unannounced. This means the provider did not know we were coming. This was the first inspection of this service following a change in its registration in December 2015.

Westwood Lodge is a care home providing accommodation and personal care for up to 44 people. The service is primarily for people with mental health needs and also provides nursing care. At the time of this inspection 37 people were living at the home.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Systems were in place to keep people safe from harm. Staff were aware of their responsibilities for recognising and reporting any signs of abuse.

Staffing levels were based on occupancy levels within the home and we observed there were sufficient staff deployed to safely meet people's needs. Staff were deployed flexibly throughout the home to enable them to respond to people's changeable needs.

Processes were in place to assess the risks to the health and safety of people, staff and visitors. Actions had been taken to mitigate and manage the majority of risks identified. However, the service did not have robust plans in place to continue the service in the event of an emergency and timely action was not always taken to maintain the home to an acceptable standard.

People were assisted to take their medicines safely by staff who had been appropriately trained, although there was a lack of oversight of medicines management. Staff were supported in their roles through the provision of regular training, supervision and annual appraisals. Staff told us they felt well supported and enjoyed working in the home.

The service worked within the principles of the Mental Capacity Act 2005 although care records we reviewed did not capture people's consent to their care and treatment. Records also did not accurately reflect people and their representative's involvement in their care planning and treatment.

People were supported with their nutrition and hydration needs and to access healthcare services in order to maintain good health. Appropriate and timely referrals were made to other healthcare professionals, who told us the service was proactive and that staff responded promptly and appropriately to any advice or guidance given.

The service had a well-established staff team, and staff had developed positive, caring relationships with people using the service. Staff were kind, caring and patient in their interactions with people using the service and showed genuine warmth and empathy.

People were encouraged to retain their independence and staff respected people's privacy and dignity. Care was person-centred and based on people's individual needs and preferences. The staff team reviewed people's care plans on a regular basis to ensure they remained appropriate to people's needs. Where changes were required these were made promptly.

Systems were in place for the service to identify, receive, record and respond to complaints. People we spoke with told us they had no complaints about the home or the staff who cared for them.

The registered manager had worked at the home for approximately 10 years and was very knowledgeable about people living in the home. Staff were complimentary about the registered manager and their leadership of the service, as were external healthcare professionals we spoke with.

Although some systems were in place to monitor and review the effectiveness of the service, these did not provide full oversight of the service and were limited in scope. Records maintained by the service were not always complete and lacked details of actions taken. This meant we could not always be assured the processes and procedures adopted by the service were appropriate or protected people using the service from potential harm.

We found breaches of the regulations relating to the premises and equipment and good governance. 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 always safe. Whilst the arrangements in place for the ordering, storing, administration and recording of medicines appeared appropriate, there was a lack of oversight of medicines management within the service.

Staffing levels were based on the occupancy levels within the home and our observations and feedback from people indicated these were appropriate in order to safely meet people's needs.

Staff were aware of their roles and responsibilities for protecting people from harm.

Although risks to people, staff and visitors were assessed and measures were put in place to keep people safe from harm, not all risk assessments were updated on a regular basis. The service also did not have robust plans in place to continue the service in the event of an emergency. Timely action was also not always taken to ensure the environment was safe for people.

We found areas of the home were in need of updating and did not always provide a therapeutic environment for people.

Is the service effective?

Good

The service was effective.

Staff were provided with support in terms of training, supervision and appraisal in order to perform their roles effectively.

The service worked within the principles of the Mental Capacity Act 2005 to protect people's rights.

People were encouraged to maintain a nutritious diet and to access other healthcare services in order to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they cared for and

had developed positive, caring relationships with them.

People were encouraged to be involved in making decisions about their care and treatment and assisted to access advocacy services where required.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to them joining the service. These needs were evaluated and reviewed on a regular basis and care plans updated to reflect any changes in people's needs.

The service had a system in place for recording and responding to complaints. No complaints had been received since the change in the service's registration in December 2015.

The registered manager had started to introduce additional measures in order to obtain people's feedback about the service.

Is the service well-led?

Requires Improvement

The service was not well-led. Robust systems were not in place to assess, monitor and improve the quality and safety of the service.

Records were incomplete and lacked detail and did not always support the actions taken by the service.

The service had a registered manager who was well thought of and described as providing good leadership.

Westwood Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 January 2017 and was unannounced. This inspection was undertaken by one adult social care inspector and an expert by experience. An expert by experience is a person who had personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries, which the provider is legally obliged to send us within required timescales. We also contacted other agencies such as local authorities and Healthwatch to gain their experiences of the service.

During the inspection we toured the building and talked with five people who lived in the home and two visitors. We also spoke with staff including the registered manager, two Nurses, three care assistants, the cook and two members of ancillary staff. We reviewed a sample of five people's care records, four staff personnel files and other records relating to the management of the service. We also undertook general observations in communal areas and during mealtimes.

Following the inspection we contacted a number of external healthcare professionals to obtain their views on the home and the care provided to people.

Requires Improvement

Is the service safe?

Our findings

We looked at how the service assessed and managed risks to establish whether systems were in place to manage or mitigate risks and protect people from harm. Risk assessments had been undertaken in relation to tasks and equipment used by staff as well as general environmental risks to people, staff and visitors. These documented preventative and protective measures in place in order to manage and mitigate these risks. Individual risks to people using the service were also assessed. For example in relation to their skin integrity, their food and fluid intake as well as specific risks such as from smoking or engaging in violent behaviour. We saw evidence where a risk was identified a corresponding care plan had been introduced to manage this risk and help keep the person safe. However, we found not all of these risk assessments were being reviewed and updated on a regular basis.

We asked to see the service's business continuity plan, which is a document which outlines the actions to be taken in order to continue a service in the event of an emergency. For example, the loss of utilities such as gas or water to the building or staff shortages as a result of sickness. The registered manager told us the service did not have a business continuity plan. We were informed the service had an informal agreement in place with another local service allowing people to be accommodated there as a temporary measure should the home need to be evacuated. However, this was not formally documented and no other plans were in place to continue the service in the event of other emergency situations. Following the inspection the provider wrote to us providing a copy of the formal business continuity plan they had introduced. This showed potential emergency situations had been risk assessed and measures introduced to continue the service in the event of an emergency.

The service maintained a fire check list which provided information to staff or emergency services about the assistance people required in order to evacuate the service. However, when reviewing care files we found people's moving and handling risk assessments had not been reviewed on a regular basis. For example in one of the records we reviewed we found the moving and handling risk assessment had last been completed in April 2013. As a result we could not be assured that the information included on the fire check list was up to date or provided accurate information about people's personal evacuation needs. The registered manager acknowledged these risk assessments were not being updated on a regular basis. Following the inspection they wrote to us to advise action had been taken to review the documentation used to complete these risk assessment. They provided us with a copy of this documentation. This showed staff were now directed to review people's moving and handling needs on at least a monthly basis.

The service had contracts in place for the routine maintenance and servicing of equipment. Regular checks and tests were also performed of equipment and systems such as fire alarms and emergency equipment. However, we found timely action was not always taken to resolve issues identified. For example we found a test of the emergency lighting system had been performed in July 2016 during which a number of emergency lights had failed and a recommendation made to replace these. However, at the time of the inspection we found action had still not been taken to replace all of these lights. Following the inspection the registered manager informed us action had been taken to replace all of the remaining lights.

We inspected communal areas and bathing and toilet facilities within the home. We found these areas were not always maintained to a suitable standard and several hazards were identified. The doors into the smoking lounge, located on the first floor of the home, were both open on the first day of the inspection. As a result there was a strong smell of cigarette smoke throughout the top three floors of the home. Walls in the communal areas of this part of the home were also heavily stained as a result. In general, walls throughout the home were marked and damaged and in need of repair and decoration. Paint was flaking on handrails and the carpet in the smoking lounge was in need of replacement as was the carpet leading from this lounge to the dining area. Some furnishings, such as armchairs were either, worn, damaged or stained and required replacement. The easy clean surfaces within the shared bathroom, shower and toilet areas had started to break down in places making these difficult to keep clean and potentially posing an infection control risk. There were exposed hot surfaces (uncovered radiators and pipework) and in one toilet the cap was missing from the end of one of the radiator valves. This left an exposed piece of metal which posed an impalement risk. One of the radiator covers on the first floor was damaged and the fire escape outside the home was covered in leaves and standing water. There was also a capped off gas pipe protruding from the floor of one of the dining rooms. Dirty laundry was also being stored in one of the communal showers.

We highlighted these issues to the registered manager who told us immediate action would be taken to fix the radiator cover and to replace the radiator cap. On the second day of the inspection the doors into the smoking lounge had also been closed and we were assured by the registered manager that they would now be kept closed to prevent smoke from permeating the rest of the home. We asked the registered manager about scheduled maintenance and refurbishment of the home. We were informed this was something they were currently discussing with the owner. The registered manager informed us they were currently looking at replacing the carpet and the chairs in the smoking lounge. They also advised they had spoken to the owner about the possibility of updating some of the facilities and were currently exploring whether some of the bedrooms in the home could be converted into en-suites. Despite this, at the time of the inspection we found the general environment of the service did not provide a therapeutic environment for people and was not being maintained to a suitable standard. Following the inspection the registered manager informed us a decorator and carpet fitter would be attending the home to start work on improving the environment. We will check the progress of this at our next inspection.

These issues constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding policy and procedure in place. This provided information to staff about the actions to take if they suspected someone was being abused. Staff we spoke with were knowledgeable about safeguarding procedures and were aware of their responsibilities for recognising and reporting any concerns or suspicions of abuse. Leaflets were also on display on the noticeboards throughout the home which provided information about the process for reporting concerns to the local authority.

We reviewed the service's safeguarding records. Although the service had a safeguarding alert register which was used to record all safeguarding alerts this was not being kept up to date with details of the outcome of alerts or actions taken in response to these alerts. Although individual records were maintained these also lacked detail and basically consisted of a copy of the notification the service had sent to the local authority. Although we found the service was reporting incidents to other agencies, we found notifications were not always being submitted to the Care Quality Commission. We highlighted this to the registered manager and reminded them of their responsibilities for notifying the Commission of incidents of alleged abuse. We followed this up in writing with the provider following the inspection and will monitor the service's compliance in this area.

We spoke to the registered manager about staffing levels in the home. We were informed staffing levels were based on occupancy levels. A two week rolling rota was used and the registered manager prepared rotas at least one month in advance to provide staff with sufficient notice of the shifts they were allocated to work. The registered manager explained there were minimal staffing levels for the service based on the current occupancy levels. We were informed agency staff were only used where the service was unable to meet these staffing levels with their own staff. The registered manager told us the service had a relationship with a specific agency and where agency staff were used requests were submitted for staff that had previously worked at the service to provide continuity of care for people. Staff members we spoke with confirmed staffing levels were always maintained at appropriate levels and none of the people we spoke with raised any concerns about the staffing levels within the service.

We reviewed the staff files for four members of staff who had been recruited by the service since the change in its registration. Potential staff members were asked to complete an application form providing details of their qualifications, experience and previous work history. References were sought to verify information provided by applicants and checks were also performed with the Disclosure and Barring Service to ensure applicants were not barred from working in a social care service. In two of the records we reviewed we found gaps in the applicant's employment history. This was despite the fact the application form asked for a full employment history including an explanation of any gaps. We highlighted this to the registered manager who told us they had spoken to both staff members about these gaps and had been satisfied with the response provided. However, they confirmed these discussions had not been recorded and as such there was no documentary evidence to confirm this or to document the explanation given. In addition to this, we found one staff member had a criminal record however there was no evidence a risk assessment had been undertaken to determine whether or not they were safe to work with vulnerable people. The registered manager again assured us they had discussed this with the staff member but no documentary evidence existed to confirm this. Overall we therefore found the records kept in relation to the recruitment of new staff members were incomplete and did not accurately reflect the actions taken by the service to verify staff member's suitability. This is discussed further in the well-led section of the report.

The service was appointed to manage a number of people's finances and also held cash on behalf of other people for safe keeping. We found records held in relation to people's finances were not clear and easy to follow. Although individual records were maintained along with receipts, these could not be easily reconciled. We found multiple receipts corresponded to one entry on people's individual records but that this was not being clearly recorded and was difficult to check. Receipts from a number of years were all stored together and were not archived with the records they corresponded to. Although monthly checks were being performed by the registered manager and the administrator these were limited in scope. From the records held it was difficult to be satisfied that people's finance were being managed appropriately. This is discussed further in the well-led section of the report.

We looked at the arrangements for the ordering, recording, storage and administration of medicines to ensure these were safe. We observed part of the lunchtime medicines round and spoke with one of the nurses and the registered manager about the support provided to people with their medicines.

During the medicines round we observed the nurse checked people's medicine administration records (MARs) prior to administering their medicines. MARs featured a photograph of the person using the service for identification purposes as well as details of any allergies and any specific support the person required. Overall we found MARs were clear although we identified a couple of unexplained gaps on one of the records we reviewed. We highlighted these to the nurse who confirmed they would query these with the staff member who had completed the medicine round on those occasions.

Medicines were stored in a dedicated medicines storage room. Temperature checks were performed to ensure the temperature of the room and the medicines fridge remained within safe ranges. Controlled drugs, which are drugs which are liable to misuse, were stored securely in a safe within the medicines storage room. Appropriate records were held of controlled drugs and regular checks were performed by nursing staff to ensure these drugs were not being misused.

Staff members responsible for administering medicines had received training and their ability to safely administer medication was also checked on an annual basis through the completion of competency checks. Whilst we found the arrangements for ordering, storing, recording and administering medicines to be appropriate, there was a lack of oversight. Regular audits were not performed by the registered manager or a member of senior staff to ensure people were receiving their medicines as prescribed. This meant there was the potential that issues, such as gaps identified in the medicine administration records during the inspection might not be identified and rectified. This is discussed in more detail in the well-led section of this report.

Good

Is the service effective?

Our findings

With the exception of one person, people we spoke with felt the service was effective. People were complimentary about the food they received, describing it as "Good" and "Spot on". One of the people we spoke with told us how the service had ensured they were still able to receive Holy Communion by arranging for a sister to visit the home on a regular basis.

We looked at the support given to staff in terms of training to determine whether this was sufficient to enable them to perform their roles effectively. New staff received an induction when they first joined the service. This involved an overview of the service, familiarisation with relevant policies and procedures and an introduction to people and staff. Following this, new staff members were provided with the opportunity to shadow an experienced member of staff in addition to the completion of a variety of training courses in areas such as moving and handling, fire safety and first aid. All new staff were enrolled to complete the Care Certificate, which is a standardised approach to training for new staff working in health and social care which was introduced in April 2015.

All staff received a package of training in both mandatory topics, such as safeguarding and health and safety as well as role specific training in areas such as challenging behaviour, end of life care and nutrition and hydration. Staff training was refreshed on a regular basis and this was monitored by the registered manager. Staff we spoke with also told us they were supported to undertake additional training and qualifications relevant to their roles.

The provider's policy for supporting staff included a commitment to providing six supervisions and an annual appraisal each year. Records we reviewed showed staff members were receiving regular supervision sessions in line with the provider's policy. We found supervision records to be quite limited, consisting mainly of a series of closed questions during which there appeared to be very little opportunity for staff to discuss any concerns or support they might require. Despite this, the majority of the staff members we spoke with felt they were well supported in their roles. Staff reported that their regular supervision sessions provided them with the opportunity to openly discuss any concerns or challenges they were facing and to request additional training or support. Records also showed staff were receiving annual appraisals.

The registered manager had delegated responsibility for the completion of supervisions to the nurses. Each nurse was responsible for completing supervisions for a group of named staff members and the registered manager monitored the completion of these. The registered manager had retained responsibility for the completion of annual appraisals for all staff members and supervisions for the nurses. Although the service did not have an overall matrix to provide oversight and monitor the completion of supervisions and appraisals, records demonstrated these were happening in line with the provider's policy.

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

possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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.

We were informed of the 37 people currently living at the home, 31 were subject to DoLS. When people joined the service, a best interest assessor and section 12 approved doctor, who is a doctor with the necessary training and knowledge to be able to conduct a mental health assessment, would visit the person. This was to assess the person's capacity to make decisions about their care and treatment and to determine whether a DoLS authorisation was in the person's best interests.

The registered manager maintained individual records of all DoLS applications and authorisations. These were monitored and action taken to update these on an annual basis as required.

We reviewed the records for one person using the service who received their medicines covertly (without their knowledge). We found this decision had been made in the person's best interests and had involved all relevant parties.

In the care records we reviewed we found very limited evidence that people or their representatives had been asked to formally consent to their plan of care and treatment. We discussed this with the registered manager. We were informed where possible people were involved in their care planning. However, the registered manager explained careful consideration was given as to the potential impact this could have on people's mental health. Where it was felt involvement would have a negative impact on the person's health, decisions were made in people's best interests. The provider accepted the documentation available did not always reflect this. The registered manager also confirmed where possible people's family members were involved in their care planning although they acknowledged this was not always captured within people's records.

Although formal consent to care and treatment was not captured in people's care records, staff we spoke with were aware of the need to seek people's consent prior to providing care and treatment. Staff told us they would always explain what they planned to do and seek the person's consent before providing any form of care. If people refused staff told us they would respect this and make one of the nurses aware. We observed good practice throughout the inspection with staff asking for people's consent both before and during any intervention.

The service had systems in place to identify people at risk of poor nutrition or hydration. People's nutritional needs were reviewed on a monthly basis. We saw evidence where there were concerns about any aspects of a person's nutrition or hydration needs a corresponding care plan had been introduced. For example we saw one person was identified as being at risk as a result of fluctuating food and fluid intake. Their records contained a care plan with advice for staff on how to assist them to maintain good food and fluid intake and their intake was monitored and recorded by staff.

In the records we reviewed we saw people's weight was being monitored and referrals were being made to relevant healthcare professionals, such as dieticians and speech and language therapists where there were concerns about people's health. One of the healthcare professionals we spoke with told us the home was very proactive in this respect and made prompt referrals and took immediate action in response to the

advice they received.

We were advised food was served at two different sittings to enable staff to give people the individual support they required. During the inspection we observed people who required assistance with their nutritional needs were supported sensitively by staff. Where possible, we also observed people were encouraged to maintain their independence in this area rather than have staff intervention. The mealtime experience within the service was quite relaxed and staff did not rush people to finish their meals.

We spoke with the cook who told us when people first joined the service an assessment was undertaken to establish any dietary needs they may have as well as their likes and dislikes. This information was held in the kitchen for staff to refer to and also included details of any allergies. The cook confirmed staff updated them in a timely manner if there were any changes to people's needs or preferences. Although we were informed the service used a four week rolling menu the cook told us they also catered for requests and people could have what they wanted. Feedback was obtained from people about the food and the cook explained how they used this to vary the menu accordingly. For example they told us they had recently received some feedback about the hot winter deserts. Not all of the people in the service wanted a warm desert. In response to this the cook explained how they had reintroduced cold deserts to better cater for everyone's preferences.

People's care records contained details of relevant healthcare professionals involved in their care and treatment. Care records also contained records of any visits from other healthcare professionals such as GP's, opticians and chiropodists. This included details of any treatment or advice given. We found people were supported to access a full range of healthcare services. This included a weekly GP 'ward round' as well as visits from a variety of healthcare professionals.

All of the external healthcare professionals we spoke with told us the service made appropriate referrals to other healthcare services on people's behalf. They were also very complimentary about the service's receptiveness to advice and guidance.

Good

Is the service caring?

Our findings

Although not all of the people we spoke with were happy living in the home, they told us this was due to their frustration with the wider health and social care system and not with the home or the staff. People we spoke with were complimentary about the staff who cared for them and told us they were well cared for. Comments included; "I am happy here, staff are very good to me" and "The staff are very good to me, I will stay here forever."

External healthcare professionals we spoke with were very complimentary about the caring nature of staff and the service in general. One told us "Overall Westwood Lodge provides great care in my opinion." They felt that whilst the service often catered for people who displayed behaviour that could be challenging, they still managed to provide excellent care and "Provide a true home for these people." These views were shared by another healthcare professional we spoke with who also commented on the kind and caring nature of the staff team. They told us; "Although the surroundings can make it seem shabby or dated, staff really make it a home for people, they even have their own armchairs."

A high proportion of the staff team had been employed at the home for a number of years and as a result had developed positive, caring relationships with people living there. Staff were knowledgeable about the needs and preferences of the people they supported and were attentive to their needs. People appeared relaxed in the presence of staff.

During the inspection we noted a warm, inclusive atmosphere within the home. Staff were polite, friendly, patient and caring in their approach to people. Staff took time to sit and talk to people in the communal areas and to check on people who chose to spend their time in their bedrooms. Staff got down to people's eye level when communicating with them and pulled up a chair or kneeled beside people while speaking to them.

We found staff were deployed flexibly throughout the day in order to cater for people's sometimes changeable needs. We found mealtimes were staggered to ensure that those people who required support received the undivided attention of staff. Staff worked as a team to ensure people's needs were met and were flexible in their approach to their work. We observed staff members were always present in communal areas to supervise people and provide assistance when required.

People's care records included a social profile which provided detailed information about people's life histories, their life experiences, their personality and any interests or hobbies they may have. People's preferences around their care and treatment were also captured in their records. This information was used to inform the various care plans that were in place to support people.

People were able to make everyday choices. For example what they had to eat and where and how they spent their day. We observed staff encouraged people to make choices for themselves and to involve them in their care and treatment. Staff were aware of the importance of seeking people's consent and of the actions to take where people declined support.

Staff we spoke with were aware of the importance of maintaining people's privacy and dignity and were able to give examples of how they did this. We observed good practice throughout the inspection with staff members knocking on people's doors prior to entering their bedrooms and asking people discreetly if they required assistance to go to the toilet. Staff also took people to the comfort of their own bedrooms when providing personal care.

A guide to the service was provided to people that informed them about what they could expect from living at the home. Information was also on display throughout the service for people to refer to.

We spoke to the registered manager about advocacy services for people. We were informed advocacy services were available to everyone who lived in the home and that a number of people had Independent Mental Capacity Advocates (IMCA) who they saw on a regular basis. These IMCA's were primarily involved with assisting people living at the home who were challenging their DoLS authorisations with the local authority.

Good

Is the service responsive?

Our findings

With the exception of one person, people we spoke with told us they liked living in the home and they did not have any complaints. Comments included; "I don't want to leave here it is my home", "I have never needed to complain" and "I have no complaints at all, I wouldn't like to leave here."

The external healthcare professionals we spoke with felt the service was very responsive to people's needs. Staff were described as being proactive in contacting other healthcare services for advice and guidance about people's care and treatment. Where changes were needed, the external healthcare professionals we spoke with told us these were made promptly and one commented that they were "Very happy with Westwood Lodge's execution of advice given."

Pre-admission assessments were undertaken before people joined the service to establish whether their individual needs could be catered for by the service. These assessments included an overview of the person's details, their current health and well-being, information about their support network and contact details for healthcare professionals involved in their care and treatment. In addition to this, information was captured about the areas where people were independent as well as areas where they required support.

Following a person's admission to the service, a further, more detailed assessment was undertaken. Information gathered during this process was used to produce detailed, person-centred care plans. These provided advice and guidance to staff about the support that people required in each different area of their care and treatment. For example we saw people had care plans in place for areas of their care such as personal hygiene, communication, work and play as well as eating and drinking. These provided an overview of the person's current health and well-being, their aims or goals, details of any preferences as well as any intervention required by staff.

Care plans were detailed and person-centred. They provided information to staff about areas where people were independent as well as areas where people required support. Details of any risks to either people or staff were also documented in people's care plans and guidance provided around how to manage these risks. For example in one of the records we reviewed the person was noted to be at risk of social isolation, as a result this person's care plan read; 'Staff to interact with [name]. At every opportunity attempt to get them involved with the on-going activities with the home.' In another of the records we reviewed we saw there was a risk the person may display hostile behaviour whilst receiving personal care. The care plan advised staff of the actions to take in order to protect both themselves and the person should this occur.

People were encouraged to maintain their independence and their care records supported this. Each person using the service had a communication care plan which provided information to staff about how to effectively communicate with people and involve them in the care and treatment. For example one of the records we reviewed advised staff to; 'Always speak slowly to [name] in a clear voice using only simple words and phrases'. Another record directed staff to 'Initiate reality orientation on a daily basis with [name], repeat time, place and person often'.

Care records were evaluated on a monthly basis to ensure they continued to meet people's needs. We saw where there was a change in a person's needs existing care plans were either updated or new care plans introduced. More formal reviews of people's care and treatment were conducted on a six monthly basis. We saw limited documentary evidence to show that people or their representatives were involved in this process. We discussed this with the registered manager. They assured us that where it was appropriate, people were involved in these reviews, as were their representatives. However they accepted that records did not support this and assured us that they would in the future.

The service had an activities co-ordinator, although they were on annual leave at the time of the inspection so we were not able to speak with them. We therefore spoke with the registered manager about the support offered to people to prevent them from becoming socially isolated. The registered manager told us this tended to be done on an individual basis and that the activities co-ordinator's main focus was on getting people out into the community. In addition to this, we saw people were encouraged to partake in other activities which took place within the service, for example there was a pizza night and a bingo night as well as games nights. People were also offered the opportunity to go for a walk with staff one day a week. Throughout the inspection we observed staff spent quite a lot of time sitting and interacting with people on a one-to-one basis.

We asked about the processes in place to obtain feedback from people using the service. The registered manager told us that in addition to the annual questionnaires that were issued to people to obtain feedback, she had also introduced residents meetings. Although we noted there had only been one of these in 2016, the registered manager told us they planned to hold three a year going forward. We reviewed the minutes from the meeting and saw people had made some suggestions for improvements to the home. The registered manager was able to demonstrate the action they had taken in response to this feedback. We were also informed by the registered manager that they had tried to set up relatives meetings but that there had not been any interest in this.

We reviewed the results of the annual quality assurance questionnaire that had been completed by people in May and June 2016. Overall the results were positive with people confirming they were happy with the care they received from the service. The only negative response had been from someone raising their frustrations with the system rather than the home itself. This was reflective of the feedback we received from people during the inspection.

The service had a complaints policy and procedure. This provided information about the process that the service would follow in response to a complaint being raised. It also included details of other agencies people could contact if they were not satisfied with the action taken by the service. We asked to see the service's complaints records but were advised by the registered manager that no complaints had been received since the change in the service's registration in December 2015.

Requires Improvement

Is the service well-led?

Our findings

We looked at the systems in place for monitoring the quality and effectiveness of the service. We were informed an annual audit was completed. We reviewed the results of the audit completed in August 2016. We found this was based on the outcomes and regulations the Care Quality Commission had previously used to inspect services and therefore needed to be updated to reflect the revised regulations and inspection process. We highlighted this to the registered manager who assured us this would be addressed following the inspection. In addition to this we found the audit was too generic and high level. There was no indication the registered manager had reviewed individual records as part of this audit. It was therefore not possible to verify its accuracy or appropriateness. The audit appeared to be an overall assessment of whether the service was meeting each outcome. There was no evidence of the records that had been reviewed to support the findings of the audit. We also saw no evidence that this audit had identified any of the issues discovered during the inspection and as such concluded that it was not robust.

Overall we found robust systems were not in place for monitoring the quality and effectiveness of the service. The registered manager did not complete regular audits of areas such as medicines administration, infection control or people's finances. As such, we could not be assured that issues such as the gaps in the medicine administration record which we identified during the inspection would be identified and rectified.

We also found general record keeping within the service to be poor. For example, the registered manager had not documented the actions they had taken to verify staff member's suitability to work with vulnerable people where there were gaps in their employment histories. People's involvement in their care planning and reviews had not been documented and people's financial records were unclear and difficult to follow.

Following the inspection the registered manager wrote to us to advise they had taken steps to improve the systems to monitor and review the quality and effectiveness of the service. We were informed additional audits had been introduced in relation to medicine administration and health and safety and these would be completed on a monthly basis. We will review the effectiveness of these at our next inspection.

These issues constituted a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A registered manager was in post and had been employed at the service for approximately 10 years. Prior to taking on the role of registered manager in 2016, they had been employed as a nurse. This meant they knew people and staff well. The registered manager was supported by a well-established staff team, many of whom had also worked at the home for a number of years. The registered manager had started to delegate responsibility for the completion of some tasks to other senior members of staff, such as staff supervisions, to assist them in the smooth running of the service.

Staff spoke highly of the registered manager, they were described as approachable and "Firm but fair." All of the staff we spoke with felt well supported in their roles and enjoyed working in the home. When asked about the strengths of the service staff commented specifically about the good communication and

teamwork and that this was something which was driven by the registered manager. We were informed by staff that the registered manager was still very hands on within the home. For example, we were advised they started work early during the week so that they could be present for the daily handover. This provided them with the opportunity to keep staff informed of anything happening within the service as well as to keep up to date with people's health and well-being. It also made them accessible to staff should they wish to raise any concerns. We were also told that the registered manager still worked at least two shifts per month providing care to people using the service.

The external healthcare professionals we spoke with were also very complimentary about the registered manager's leadership of the service. One told us "I have found the service to be extremely well led by [name]." Another explained how the registered manager always had people's best interests at heart and would challenge decisions made by other healthcare professionals if they did not feel these were appropriate. They told us; "[Registered manager] constructively challenged views of clinicians if she felt regimes would not be in the best interest of the resident." We were also informed that the registered manager still took responsibility for the weekly GP 'ward rounds' that took place in the home. The external healthcare professionals also felt the registered manager was very knowledgeable about people living in the home.

The ownership of the service had also changed since our last inspection. We spoke to the registered manager about the support they received from the new owners. They informed us the owner visited on a monthly basis and was always available should they need anything. Records were maintained of these visits and showed the owner reviewed areas such as staffing levels, occupancy and feedback. We saw evidence the registered manager had discussed feedback they received and areas for improvement with the owner.

We looked at the processes used to keep staff informed. The registered manager told us there had only been one staff meeting in 2016 and that this was something they were looking to increase the frequency of. We were however informed that in the absence of regular staff meetings, the registered manager used alternative methods, such as attendance at the daily handover, to keep staff informed. Despite the lack of regular staff meetings, staff we spoke with felt communication within the home was good and that staff worked together well as a team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had not ensured the premises used were clean, secure and suitable for the purpose for which they were being used or were properly maintained. Regulation 15(1)(a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured systems or processes were established and operated effectively to ensure compliance with requirements. Systems were not in place to assess, monitor and improve the quality and safety of the service or to mitigate the risks relating to the health, safety and welfare of service users. Accurate, complete and contemporaneous records were not being held in respect of each service user and records relating to the employment of persons carrying on the regulated activity and the management of the service were incomplete. Regulations 17(1)(2)(a)(b)(c)(d).