Barchester Healthcare Homes Limited

The White Lodge

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The White Lodge provides accommodation which includes nursing and personal care for up to 80 older people, some of who are living with dementia. At the time of our visit 58 people were using the service. The home has three floors, with the top floor being divided into two units. There were communal lounges and dining areas with satellite kitchens on each floor with a central kitchen and laundry. The White Lodge is part of Barchester Healthcare Homes Limited.

The inspection took place on the 28 and 29 June 2016. The first day of the inspection was unannounced. At our last inspection at The White Lodge in February 2015 we found the provider did not meet some of the legal requirements in the areas we looked at. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had not undertaken all the necessary improvements required to fully meet people's needs.

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

People using the service, their relatives and staff did not always feel there were enough staff available to meet the needs of people using the service. Staff told us they felt "rushed" and that people only received the correct care and support because staff were "Going above and beyond their duties".

People's medicines were managed and administered safely. However during our inspection we found that three resident's medicines had not been received from the pharmacy when expected. Medicines were securely stored in line with current regulations and guidance.

There was a general activity programme in place. However, there were not enough meaningful activities for people to access in groups or as individuals to avoid social isolation.

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. Where people were still awaiting a best interest assessment to authorise their deprivation of liberty, we found that best interest decisions had not always been recorded, for example where people were refusing personal care.

Whilst most people spoke positively about the care and support they received there were some differences between how people felt about support they received during the day and night. Staff were genuinely concerned about people's well-being. Staff knew the people they were caring for including their preferences and personal histories. People were supported to follow their preferred routines.

The provider had quality monitoring systems in place. Whilst the registered manager had an action plan in

place to address any areas that required improving areas of improvement from the last inspection still remained outstanding.

People were protected from the risk of harm and abuse by trained staff who knew how to recognise abuse and what actions to take to keep people safe.

Staff told us they had received the relevant training to support them in their role. The staff we spoke with were positive about the training and felt it supported them to be able to carry out their duties effectively. Comments from care staff included "I feel I get enough and the training here is good" and "I have access to the right training".

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours. Regular maintenance of the home was undertaken to ensure the safety and suitability of the premises. A call bell alarm system was in place to ensure people who use the service could call for help when required.

The registered manager investigated complaints and concerns. People and their relatives were able to share their views on the service and knew how to make a complaint. People and their relatives told us they could raise any concerns they had with the registered manager or any staff member. They were confident their concerns would be listened to and appropriate action taken. Accidents and incidents were investigated and discussed with staff to minimise the risks or reoccurrence.

We found breaches 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

This service was not always safe.

People using the service did not always feel safe. People, their relatives and staff did not always feel there were enough staff available to meet the needs of people using the service.

Whilst people's medicines managed and administered safely during our inspection we found that three resident's medicines had not been received from the pharmacy when expected.

People were protected from the risk of harm and abuse by trained staff who knew how to recognise abuse and what actions to take to keep people safe.

Is the service effective?

Requires Improvement

This service was not always effective.

Where people were still awaiting a best interest assessment to authorise their deprivation of liberty, we found that best interest decisions had not always been recorded.

The staff we spoke with were positive about the training and felt it supported them to be able to carry out their duties effectively.

People were supported to have sufficient to eat and drink. A variety of food and snacks was on offer with alternatives being provided at people's request.

Is the service caring?

Requires Improvement

This service was not always caring.

Whilst most people spoke positively about the care and support they received there were some differences between how people felt about support they received during the day and night. Some people did not feel they received the care they needed at night.

Staff were genuinely concerned about people's well-being. Staff knew the people they were caring for including their preferences and personal histories.

We saw staff promoted people's privacy and dignity. Staff knocked on people's doors before entering. Any care and support was conducted behind closed doors.

Is the service responsive?

Requires Improvement

This service wasn't always responsive.

People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. Information within care plans was sometimes contradictory.

There was a general activity programme in place. However, there were not enough meaningful activities for people to access in groups or as individuals to avoid social isolation.

People and/or their relatives said they were able to speak with staff or management if they had any concerns or a complaint. They were confident their concerns would be listened to and appropriate action taken.

People were supported to maintain relationships with people that mattered to them. People told us their relatives and friends could visit anytime. We saw visitors arriving throughout both days of our inspection.

Is the service well-led?

Requires Improvement

This service was not always well-led.

Audits to monitor the quality of the service provision were carried out periodically throughout the year. Whilst the registered manager had an action plan in place to address any areas that required improving areas of improvement form the last inspection still remained outstanding.

The registered manager had identified areas that required improvement and had an action plan in place to address them.

People and their relatives were encouraged to share their views about the service. There was a strong commitment by both the management and staff team to provide a high standard of care and support to people using the service.

The White Lodge

Detailed findings

Background to this inspection

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

We carried out this inspection over two days on the 28 and 29 June 2016. The first day of the inspection was unannounced. Two inspectors, a specialist nurse advisor and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last inspection in February 2015 we found the provider did not meet some of the legal requirements in the areas that we looked at.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We used a number of different methods to help us understand the experiences of people who use the service. This included talking with nine people who use the service and thirteen relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 15 care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, the deputy manager, five registered nurses, 12 care staff, and the activities coordinator. We spoke with housekeeping staff, administration staff and staff from the catering department. We also spoke with two health care professionals who work alongside the service and two visiting healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 3 February 2015 the provider was not meeting the requirements of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitable qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

Following the inspection the provider sent us a plan of what actions they would take to make the necessary improvements. These actions included the implementation of rotas planned four weeks in advance to ensure staff awareness and adequate time to provide cover for planned absences. External recruitment would take place to reduce agency usage within the home. Barchester's 'DICE' dependency tool, which monitors the dependency levels of residents and calculates staffing requirements would be revisited and actions required implemented accordingly. However, whilst these actions had been undertaken people using the service, their relatives and staff still raised concerns relating to their not being enough staff.

People using the service, their relatives and staff did not always feel there were enough staff available. Comments included "It can be very stressful as there are minimal staff numbers. We do our best but there is no time to spend with residents. We do the bare minimum", "There's never enough staff around. I can usually find someone but not very quickly" and "Sometimes I can be there an hour visiting before I see any staff". Some visiting relatives told us said they visited daily and supported their family member during lunchtime. They said at times they also helped other people when staff were under pressure.

Staff said they were "Very stretched" to meet peoples' needs. One staff member said the only reason people were kept safe was because the staff were "Going above and beyond their duties". Another member of staff said people were safe because "They were doing the best they could for people". They told us there were times when they couldn't take their break because they needed to support people. Staff told us some people were unable to use their call bell and needed hourly checks, however they didn't have sufficient numbers of staff to do this. We reviewed people's records and found gaps in the monitoring sheets for hourly checks. Some people needed repositioning at least every four hours and we also found gaps in these monitoring sheets. The nurse told us staff were repositioning people as needed, but they didn't always have time to record it. Whilst people looked well cared for lack of recording of this care increased the risk of people not receiving the appropriate care and support.

Night care staff told us it was sometimes difficult to respond to people's request for support due to the number of people who required assistance from two staff members to meet their individual needs. They felt an extra member of staff would help. Nursing staff told us they sometimes had to stop giving medicines to go and support staff with assisting people. This meant people were at risk of not receiving their medicines on time and that mistakes could be made due to the nurses being distracted and interrupted. There were two nurse on duty at night who were actively involved in supporting people to have their personal care needs met. There was one member of staff on shift during the night on the top floor and two members of staff on the ground floor. Both these floors had the support of one nurse. Staff on the top floor told us if anyone needed turning or assistance to use the toilet during the night, another member of staff would come

up to assist from other floors. One staff member told us "It can be very busy sometimes and people have to wait. If the nurse has to go upstairs it can be really tough if people are ringing their call bells".

We observed the lunchtime meal on the first floor on the first day of our inspection. Some people were already in the communal lounge/dining room from the morning, whilst others were supported to move there. Some people had their meal in their rooms. We observed in the dining area there was not enough staff to support those people requiring assistance to eat their meal at the same time. The lunch trolley was brought to the dining room at 12.30pm and we saw that one person had still not received their lunch by 13.20pm due to them requiring assistance and staff supporting other people. This meant the person had to sit and wait for their lunch whilst others ate theirs.

We spoke with the registered manager regarding staffing levels. They explained that as they were new in post reviewing of people's care and support needs was on their action plan and they were looking to review all people using the dependency tool to ensure staffing levels were correct to meet people's care and support needs.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people's medicines managed and administered safely during our inspection we found that three resident's medicines had not been received from the pharmacy when expected. Whilst the pharmacy was contacted by the nurse one person was without their medicines for four days. This information and actions taken had not been recorded on the person's medicines record or their daily records. There was no record of advice being sought form the GP regarding these people not receiving their medicines. There was also no incident form completed. We spoke with the registered manager who immediately spoke with the nurse who contacted the GP and ensured records were brought up to date.

Medicines were stored securely. Fridges were available to store those medicines that required it and the temperature was checked and recorded daily. Medicines were administered by the qualified nurses who had received training in this area. People's photographs were attached to their MAR sheets to aid identification and any medicine allergies were recorded. Processes were in place to ensure medicines that were no longer required were disposed of safely

Medicine Administration Records (MAR) were found to be up to date with all signatures in place and appropriate codes used when medicines had not been administered. For example, If people had refused. Protocols were in place for PRN (as required) medicines. Staff had documented when these medicines were administered. We saw one person who was prescribed pain relief being given this on a regular daily basis even though it was prescribed as PRN. We spoke with the nurse who reported that the person would become aggressive if they were not given the pain relief. However there had not been a review of this undertaken to see if there were any other interventions that could be used or any evidence of further investigations as to whether this medicine should remain as PRN or was required more regularly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe living at The White Lodge. Comments included "During the daytime I feel safe as the staff are friendly and reassuring. During the night I feel nervous as the night staff seem to be different each week. Some don't talk to me", "Yes I do feel safe. The day staff often visit to ask if I need anything", During the night time I don't feel safe. There is a member of staff who makes me feel nervous. She does not talk nicely to me" and "Yes I do feel safe. The staff are friendly towards me and visit me regularly

when my husband is not here". The concerns raised about the night staff are being looked into.

People were protected against the risks of potential abuse. Policies were in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken. Records showed staff had received training in safeguarding adults. This was also part of new staff member's essential training during induction. Staff were aware of their responsibilities and they were able to describe to us the different types of abuse and what might indicate that abuse was taking place. All the staff we spoke with had a good understanding of the correct reporting procedure. Staff said they felt supported to raise their concerns and were confident the registered manager and deputy would take any action required. They also told us they would take their concerns to senior managers or external organisations if they felt appropriate action had not been taken. One staff member told us "Any concerns I might have would always be reported to the nurse. I know they would take me seriously and would do something." Another staff member said "Safeguarding is about protecting people from harm and keeping them safe. I feel confident that I could raise my concerns and management would take action."

We saw safe recruitment and selection processes were in place. We looked at the files for seven of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had also been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Care records showed that people's individual needs were assessed before admission into the home and where risks were identified appropriate guidance was in place to minimise potential risks. For example, the provider had carried out assessments in relation to falls prevention, pressure ulceration, nutrition and the safe moving of people. Personal fire evacuation plans had been completed for people using the service. We found one care file had two contradicting evacuation plans in place, one stating the person was able to walk and the other stating the person was bedbound. We have spoken with the registered manager regarding gaps in the recording of people's support needs. This is covered in the responsive domain of the report. Staff had received training in how to respond to emergency situations such as fire.

Measures were in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which all housekeeping staff followed to ensure all areas of the home were appropriately cleaned. The home was free from odours and appeared visibly clean with evidence of on-going cleaning during our inspection. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. We noted that there were some chipped skirting boards and stained toilet seats. The registered manager explained they had a refurbishment plan in place and these areas were being addressed by maintenance.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 found that where people lacked the capacity to consent to their care and treatment, the provider had completed mental capacity assessments. We found the capacity assessments mentioned family members had been consulted, however it did not state the name of the family member.

The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. We found that some applications had been authorised but some were still waiting for an assessment from the local authority. The applications which had been authorised, had best interest assessments in place, and where no family or representatives had been identified to represent the person, we found people had been visited by an advocacy service. The registered manager had systems in place to ensure they were complying with conditions applied to the authorisation. Where people were still awaiting a best interest assessment to authorise their deprivation of liberty, we found that best interest decisions had not always been recorded, for example where people were refusing personal care. Another example was of a married couple where a best interest decision was made for them not to have contact; however this decision was historical and had not been reviewed since the couple had been resident together in White Lodge.

Administration staff were in the process of compiling information about who had Lasting Power of Attorney (LPA) to make decisions on peoples' behalf, for example who had lasting power of attorney for finances or welfare and health. This information was not fed back to staff, for example staff were discussing decisions about people's care and treatment with family who only had power of attorney for finances. Decisions included for example consent to flu vaccinations.

Staff had received training in the Mental Capacity Act and demonstrated a good understanding of supporting people to make choices and decisions about their daily living. The use of restraint was not practised within this service. For example staff told us if people refused to have personal care, they would not force them, but go back later.

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

2014.

People using the service felt most staff knew how to support them effectively. Comments included "The day staff know how to look after me and do the job well. Night staff are not so kind and they rush my personal care", "Yes the staff seem to know what needs to be done to look after me, I have no problems with my personal care " and "The day staff come in and always ask if I need anything". Relatives told us they felt their family member was cared for by staff who had the necessary skills and knowledge. Comments included "We have no concerns with the staff. (Relative) always seems comfortable and relaxed when we visit her" and "I feel that staff know what they are doing without question. In the short time my relative has been at the home I have been very impressed with the standard of care she has received".

Staff told us they had received the relevant training to support them in their role, for example safeguarding adults, manual handling of people, dementia awareness, choking and dysphasia. New staff received an induction during which they also shadowed an experienced member of staff before working on their own. The staff we spoke with were positive about the training and felt it supported them to be able to carry out their duties effectively. Comments from care staff included "I feel I get enough and the training here is good" and "I have access to the right training".

Staff they told us they received regular supervision meetings with their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meeting would also be an opportunity to discuss any difficulties or concerns staff had.

People and relatives told us there was sufficient food and drink. Comments included "I get offered hot and cold drinks on a regular basis and I do enjoy a biscuit with my tea" and "I like the food here, I get good choices. I appreciate the fact the chef will do something ad hoc for me if I want it". We observed people had a choice of what they wanted to eat and were offered an alternative if they didn't like what was on the menu. People who were living with dementia were shown two plates of food to support them in choosing a meal. There were snacks and drinks available throughout our inspection and relatives were able to access the satellite kitchens to make drinks. They were also able to eat with their relative if they wished to do so. Staff on the top floor told us they used to have a hostess to support with dishing out food at meal times and supporting people with drinks, however this was no longer available. This meant that care staff had to take on this role. Staff told us this took them away from providing sufficient care to people during meal times. They said this meant people were left waiting for their lunch whilst they provided assistance to other people. We observed during lunchtime people who were in their rooms were left unattended whilst staff supported other people. People who required personal care had to wait for staff to become available to provide assistance.

Care plans included an assessment of the person's nutritional needs. Where risks had been identified, we saw people had been referred to specialists such as speech and language therapists (SALT) or dieticians. Staff followed the advice provided to minimise the risks. For example, to minimise the risk of choking, staff used thickeners in drinks or ensured that people had access to 'soft' diets.

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering staff; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes which staff would let them know each day. They explained that people had a choice of meals. They said if people did not like what was on the menu or had changed their mind about their choices then they were able to request alternatives.

The chef explained that when he first came in to the role people were complaining about the food. As a result of this he had written to residents about what they would like including on the menus and had incorporated their feedback in the menu planning. Since this change he had not received any complaints regarding the food. The chef had also been nominated by people, relatives and staff for a national award within the company for their achievements and high standards within catering.

The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance. The kitchen had been award a Food and Hygiene rating 5 by the food standards agency. The food standards agency is responsible for protecting public health in relation to food in England, Wales and Northern Ireland.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals, such as a chiropodist, physiotherapist, tissue viability or Parkinson's specialist nurse. Care plans confirmed people had access to health care professionals. Visits from health care professionals were recorded and any outcomes of these visits. People also had advanced care plans in place to identify what medical treatment they wanted to receive in the home or when they wanted to be admitted to hospital. This also included who they wanted to be involved in any decisions in an emergency if they were unable to do so.

Requires Improvement

Is the service caring?

Our findings

Whilst most people spoke positively about the care and support they received there were some differences between how people felt about support they received during the day and night. Most people spoke more favourably about care and support received during the day. Comments from people about night time support included them not feeling safe. For example "The night staff are not very kind to me, they rush my personal care needs and do not seem to want to talk to me", "They (staff) are always less friendly on a morning and are in more of a rush to get me washed and ready for breakfast", "I have heard shouting matches between staff. They argue about who is doing what and where they want to" and "I do feel safe at times but I'm not sure I want to be here at 11pm with staff shouting at me".

One person told us "Some staff are a delight but a small proportion are less customer focused. One or two individuals throw my towel at me and say "Dry yourself". Another person told us "I never seem to see the same member of staff twice as the night shift is mostly agency staff, they always seem to be far too busy to talk with me and care is rushed. A relative told us whilst care plans were in place "I do not feel they are being adhered to regularly". They stated that paperwork was not being completed correctly.

During our inspection we observed people who use the service had good relationships with staff members and those who were able did not hesitate to frequently to ask for help or support. One person said "It's all good here. I can't fault the carers." Another person told us "Some staff are excellent and one or two have become real friends". A visiting relative told us "I am very happy with the home and my wife's care. I come to visit her every day and spend hours with her. She is settled and we both enjoy spending time together knowing that staff are around to assist but they also respect our privacy.

Staff knew people well and were able to tell us about some of their life history. For example they told us about one person who used to regularly travel on the bus. The person would walk up and down the corridor asking to go places and waiting at a 'bus stop'. The staff member had suggested to management to get a bus stop made to put down the corridor as this would reassure the person. The bus stop had been put in place.

Staff were knowledgeable about the care and support people required. For example if people preferred a bath or shower or what clothes they liked to wear. One staff member told us "I always ask people what they would like to do. If they don't want to do something then I respect this but will go back later to check they haven't changed their mind. Another member if staff said "There's lots of information in people's care plans about their likes and dislikes which helps me to get to know them". Care plans contained information of what people were able to do for themselves and what support they required. For example, in one person's care plan it stated they liked to clean their own teeth but also included areas of personal care the person required support with. Another person's care plan included "Y likes to get up around 10am. She likes to go to the toilet before washing and dressing herself". This care plan also promoted the person's independence, for example stating what the person could do for themselves "Y can wash and dry her face and upper body with little assistance". Some people used equipment, such as walking frames, to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use

it. Another example of promoting independence was documented in one person's nutritional care plan, which stated "P is able to eat independently using thick handled cutlery and plates with heightened rims."

We saw staff promoted people's privacy and dignity. Staff knocked on people's doors before entering. 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 said they would encourage the person to do as much for themselves as they could. Staff said they would always ensure that people were covered when supporting with intimate tasks. One staff member said "I always make sure the person is happy before I go in and explain what is happening". Another member of staff said "If I'm supporting someone with personal care then I will always make sure they no one else enters the room". Staff did also comment that they are under a lot of pressure and sometimes are unable to encourage people to be as independent as they would like. One person told us "Staff always knock and ask if I'm ready". Care plans included information on how to promote people's privacy by ensuring staff closed curtains and doors.

During our SOFI observation we saw people were offered choices of drinks, food or where to sit. People were asked if they wished to join activities and where people chose not to this was respected. We saw staff asked people's permission before they undertook any care or activity. Examples included asking people if they required support with their meal and if they needed support with personal care.

We spent time observing the lunchtime meal. People were offered the choice of where they wished to sit and were offered a choice of drinks. Where required people were supported to eat and drink sufficient amounts to meet their needs. We saw staff offering people appropriate encouragement to eat their meals. Other staff were observed providing 1:1 assistance to help people to eat their meals. Staff supported people to eat at a pace appropriate to them and were heard asking "Are you ready for some more" and "Is your food ok". We saw staff gave people choice and supported them in making a decision about what to eat. For example a choice between soup or salad. People who were living with dementia were shown two plates of food to assist them to choose what they wanted to eat.

We saw staff responded in a caring way to difficult situations. For example, when a person became agitated during lunch, we saw staff sitting with them and talking with them in a calm and quiet manner which helped to settle the person. They explained what was happening and offered the person reassurance. Another person became anxious about where they were going to sit and what was happening. Staff explained it was lunchtime and offered the person a drink. They asked if the person if they would like to sit at a table just outside the dining area as it was quieter.

Requires Improvement

Is the service responsive?

Our findings

At our inspection on 3 February 2015 the provider was not meeting the requirements of Regulation 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We reviewed people's records and found gaps in the monitoring sheets. People did not have access to activities that interested them.

Following the inspection the provider sent us a plan of what actions they would take to make the necessary improvements. These actions included the auditing of care plans, senior carers checking that daily monitoring charts had been completed and care reviews being completed at least every six months. The plan stated that a programme of meaningful and varied activities would be developed. At this inspection whilst improvements had been made there were still gaps in recording with some care plans containing contradictory information. People remained at risk of social isolation.

Care, treatment and support plans were personalised and detailed. The care plans reviewed contained detailed information and reflected people's needs and choices. An example of this was where a person was bedbound and had limited communication. The care plan identified likes such as "X likes staff to play soft music from her radio". We found however that what was on the care plan was not always reflected in the person's daily living. During the two days of inspection we did not hear the person's radio. Another person's activity plan stated they liked staff to read the paper to them. We found this had last been reviewed November 2015 and staff told us they did not have time to sit with the person to read the paper. One person's moving and handling care plan stated the person needed repositioning every four hours, however we found gaps in the monitoring sheet. During the inspection we observed the person was alone in bed with their only interaction coming from staff when they provided personal care or repositioned the person. We also found some hand written care plans difficult to read which we were unable to decipher what care and support was required.

Where people were at risk of weight loss or malnutrition, people were assessed using the Malnutrition Universal Screening Tool (MUST) and people's weight was monitored monthly. However some care plans contained conflicting information. For example, one care plan we looked at stated the person was able to stand and walk a small distance, however staff told us the person was no longer able to do this. We found this care plan had not been updated to reflect this. In another person's care plan there was evidence that a multi-disciplinary team meeting had taken place. Recommendations had been made but these had not always been followed and updated in the person's care plan. For example, a fluid monitoring chart had been recommended by the nutritionist stating the person was to have staggered fluids throughout 24 hours and the amount they should have. Records showed the amount of fluids given varied from day to day. We spoke with the nurse who told us they gave fluids based on their assessments of the person's hydration. This was not recorded in the person's care plan or monitoring chart. There was no reference to it in daily records as to how decisions had been made regarding required fluids each day.

Most care plans we looked at had been reviewed monthly, however only with a signature and a date, stating no change where required. It was not clear who was involved in the care reviews. Relatives we spoke to had not been aware of any care reviews. We saw evidence of relatives involved in a care profile review once a

year, which was a general review about their satisfaction with the care their family member was receiving. Staff also used a "Resident of the day" system where they would identify a different resident each day and complete all their observations, such as blood pressure, weight, tidy their bedrooms/drawers and clothing and ensure their care plan was up to date.

Health care professionals we spoke to said they had only been visiting the home the past few weeks, but felt welcomed when they visited. They said staff were polite and helpful and knew the people they cared for well. They told us there had been some discrepancy in the relatives' views about their family members continence and the staff opinion. Relatives identified concerns regarding continence, however staff had not been recording that the person had been incontinent. The health care professionals told us staff had taken this on board and were investigating it further.

Occasionally people became upset, anxious or emotional. We found there were strategies in place to manage most people's anxiety, for example guiding staff on how to talk to the person and what kind of questions to ask. However one person frequently asked to go home and we found there was no guidance for staff on what to say to the person. Sometimes people refused to have personal care or to eat and drink. Staff recorded refusal of care in the daily notes, however did not record how they supported the person, for example if they returned later to offer support again. Daily notes only stated the refusal of care and no further information about how staff managed this.

Staff supported people who could become anxious and exhibit behaviours which may challenge others. For example, some people would bite or hit out at staff. Staff were able to tell us how they would manage these behaviours, however we found there was no written guidance for staff to follow on how best to support the person. One staff member told us they had made suggestions to the management team to support people with certain behaviours, such as biting, however the suggestions were not responded to. We fed this back to the registered manager and deputy manager who said they were not aware of who this person was and any suggestions made.

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

A new activities co-ordinator had recently been appointed and was reviewing the availability of activities within the home. There were two activity co-ordinators who were responsible for providing activities across all three floors.

Whilst group activities were on offer daily the activities co-ordinator told us they currently only had one day where they offered people 1:1 social stimulation. We observed during our two days of inspection that there were many people who remained in their room. Those who remained in their rooms were only visited when staff were providing a care task. Staff we spoke with told us they did not have time to sit and chat or undertake activities with people. This put people at risk of social isolation. One member of staff told us "It's people's choice to join in activities. Some people don't want to and they can be socially isolated. It's getting a bit better with the new activities co-ordinator who is doing more 1:1s". Another staff member said "Sometimes there is not enough of us to make sure the residents in the lounge are ok if we have to go off and support someone with their personal care". We were not assured that people had access to sufficient activities and social stimulation to meet their needs.

One relative told us their family member was not interested in attending any activities, however staff would still try and encourage the person. They said staff were very proactive in their approach, for example when their family member was first admitted to the home, they were very quick in making safety arrangements,

such as putting a sensor mat in place. They also felt they initially had some complaints, however they found management to be approachable and things got sorted.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure. People told us they knew what to do if they were unhappy with any aspects of care they were receiving. They said they felt comfortable speaking with the registered manager, deputy manager or a member of staff. Comments included "No I have not felt the need to make a complaint, my daughter talks with the care staff a lot when she comes to visit me and I've not felt the need to make a complaint" and "I don't have any complaints with regards to my needs being met".

Relatives spoke positively about the care and support their family members were receiving. Comments included "Staff are not just supportive to my mother, but also to me (relative)" and "I can't fault the care my wife is receiving". One relative told us his wife had recently been moved from another care home, which was not meeting their needs adequately. He said since being at White Lodge he had seen a transformation in his wife and the way she is cared for.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and deputy manager carried out a wide range of audits periodically throughout the year. These included health and safety, infection control, care planning, call bells and audits of the medicine administration systems. Whilst the registered manager had an action plan in place to address any areas that required improving areas of improvement from the last inspection still remained outstanding.

At our inspection on 3 February 2015 the provider was not meeting the requirements of Regulation 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we reviewed people's records and found they still had gaps in the monitoring sheets and contained conflicting information relating to care and support needs. People still did not have access to activities that interested them.

At our inspection on 3 February 2015 the provider was not meeting the requirements of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection the registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitable qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

Staff spoke positively about the support they received from the registered manager, deputy manager, nursing staff and their co-workers. Comments included "Management are very supportive and approachable. I feel that I can raise concerns and we discuss issues at our team meetings", "I feel supported. I raised my concerns about staffing and the management told me what they are trying to do" and "When I first started working here the support I got was really helpful".

Concerns or issues could be discussed in staff's one to one meetings or raised at team meetings. Team meetings were in place where staff said they could share their ideas for improving the service or discuss any concerns they had. Staff were supported to question the practice of other staff members. Staff had access to the company's whistleblowing policy and procedure. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received. Staff knew and understood what was expected of their roles and responsibilities.

Staff members' training was monitored by the training manager and registered manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when it was due to be refreshed. Staff told us they received the correct training to assist them to carry out their roles.

Clear procedures for recording and reporting accidents and incidents were in place and these were reviewed monthly by the registered manager and deputy manager and a trend analysis completed to identify if there were any reoccurring themes.

People and their relatives were encouraged to give their views about the service they received.

Questionnaires were given to people using the service and their relatives periodically throughout the year. 'Resident's, family and friends' meetings were held were to discuss service developments and offer people the chance to share ideas and thoughts to enhance the care provided. We saw minutes of a meeting held in February 2016 where updates were given on the changes happening to improve service delivery. Relatives and people had commented that they didn't know who the management team were. We saw a notice board had been put up in response to this containing pictures identifying senior staff and their roles.

The registered manager told us they was passionate about ensuring people received high quality care and was actively seeking ways of improving the service. This had included introducing daily meetings with heads of departments to discuss what was happening in each area, addressing issues with facilities within the home and recruiting permanent staff to reduce the use of agency.

The registered manager fostered links with the local community. This included visits from the local brownies group, corporate volunteer groups who attended to complete a specific project of improvement to the home, such as decorating or gardening and links with the local angling club who would visit the home to do talks.

The management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised. There were procedures in place to guide staff on what to do in the event of an emergency such as fire.

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 9 HSCA RA Regulations 2014 Person-centred care There was a general activity programme in place. However, there were not enough meaningful activities for people to access in groups or as individuals to avoid social isolation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people were still awaiting a best interest assessment to authorise their deprivation of liberty, we found that best interest decisions had not always been recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Whilst people's medicines were managed and administered safely. During our inspection we found that three resident's medicines had not been received from the pharmacy when expected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. Information

within care plans was sometimes contradictory.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People using the service, their relatives and staff did not always feel there were enough staff available to meet the needs of people using the service.