Barchester Healthcare Homes Limited

Woodhorn Park

Inspection report

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Ratings

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

Overall summary

Woodhorn Park is a care home located in Ashington which can accommodate up to 60 people. At the time of our inspection 51 people received care from the service, some of whom were living with dementia.

This inspection took place on 15, 16 and 17 September 2015. The inspection was unannounced.

The last inspection we carried out at this service was in July 2013 when we found the provider was meeting all of the regulations we inspected at that time

A registered manager was in place. 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.

Risks were not always appropriately managed. Some risks had been assessed and action taken to minimise the impact of those risks. However, during our inspection we

Summary of findings

saw people were at risk of tripping due to tools which had been left in a communal area of the home. Risks to people's safety and skin integrity had also not been mitigated.

People we spoke with told us they felt safe living at the home. Staff had undertaken safeguarding training in how to recognise and respond to any potential abuse.

Accidents and incidents were analysed to determine where action should be taken to reduce the likelihood of reoccurrence. Medicines were well managed.

There were enough staff to meet people's needs and recruitment processes had been followed to confirm new employee's identities and previous employment details.

Staff training was up to date. Staff received basic training in dementia care. However, observations showed this training was not consistently put into place. Staff met regularly with their supervisors to discuss their role and personal development.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff we spoke with, including the registered manager had a good understanding of the MCA. Deprivation of Liberty Safeguards had been applied for and approval granted.

People who were able to communicate their views spoke highly of the food provided in the home. However, we saw food served to some people who were cared for in bed was not always appetising. Whilst the chef was aware of people's individual nutrition needs, steps had not been taken to ensure these were met.

Some adaptations had been made to the environment to take into consideration the needs of people living with dementia. However, visual signage around the home was poor.

People told us staff were very caring and kind. Care records were personal and included information about what was important to people. We saw that the majority of staff responded well when people were distressed.

Relatives told us they always felt welcome at the home and people described how staff supported them to maintain relationships with their family and to be independent.

Staff had received training in end of life care, and those people who wished to, had considered and planned for how they would like to be cared for as they approached the end of their lives.

People's needs had not always been met. We saw examples where planned care, related to people's continence and moving and handling needs was not delivered as it was described their care records. Records showed some people received inconsistent care.

Records were not always accurate, complete or stored securely.

A range of activities were available in the home, and people we spoke with told us they enjoyed taking part in these. Complaints records showed complaints had been fully investigated and responded to. People's feedback on the quality of the service they received was welcomed through satisfaction surveys and regular meetings.

People and relatives spoke highly of the registered manager. They told us she was approachable and that the service was well-led. Staff confirmed this, telling us she was a visible presence in the home and always available for them to talk to.

Feedback from staff was valued. They were asked to share their views on the home during regular staff meetings.

A range of audits were carried out to assess and monitor the quality of the service, however these had not identified the shortfalls in care delivery or in record keeping that we had found during our inspection. The manager acknowledged that care records audits should be carried out more frequently.

The home had built relationships with the local community.

We found three breaches of regulations. These related to the Safe Care and Treatment, Person Centred Care and Good Governance. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service not always safe.

Risks to people's safety and wellbeing had not always been identified and action had not been taken to minimise the impact of these risks.

Staff had received training in keeping people safe from abuse. Accidents had been monitored and where possible action had been taken to reduce the likelihood of reoccurrence. Medicines were well managed.

The provider had robust recruitment procedures in place and there were enough staff available to meet people's needs.

Is the service effective?

Requires improvement

The service was not always effective.

Staff training was up to date. However observations showed training was not always put into practice.

We saw evidence the Mental Capacity Act 2005 (MCA) had been followed and that applications were made in line with Deprivation of Liberty Safeguards (DoLS).

People told us the food in the home was very good. However, we saw the same standards were not provided to some people who were cared for in bed.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff team at the home. They told us how they were kind and helped them with not only their care needs, but to remain independent.

Staff had received training in end of life care, and those people who wished to, had considered and planned for how they would like to be cared for as they approached the end of their lives.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care planning, delivery and recording was not consistent. We saw some people's needs were not met. Some records related to people's personal care were not stored securely.

People told us they enjoyed taking part in the activities available to them, and that there was plenty on offer.

Complaints had been fully investigated and responded to.

Summary of findings

Is the service well-led?

The service was not always well-led.

A range of audits were carried out to assess and monitor the quality of the service. However they had not identified the shortfalls in care delivery and records which we had identified during our inspection.

People, relatives and staff told us the service was well managed and that the registered manager was approachable.

Requires improvement

Woodhorn Park

Detailed findings

Background to this inspection

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

This inspection took place on 15, 16 and 17 September and was unannounced.

The inspection was carried out by two inspectors and an analyst. Before the inspection we reviewed all of the information we held about the service. This included reviewing statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We reviewed information we had received from third parties. We contacted the local authority commissioning and safeguarding teams. We also contacted the local Healthwatch. We used the information that they provided us with to inform the planning of this inspection.

During the inspection we spoke with five people who used the service and four people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Throughout the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them. With consent we looked in three people's bedrooms. We spoke with a district nurse and a two GPs, who visited the home regularly, to discuss their views on the service provided

We spoke with the registered manager, the deputy manager, five care workers, a cook and two laundry assistants. We reviewed seven people's care records including their medicines administration records. We looked at seven staff personnel files, in addition to a range of records in relation to the management of the service.

Requires improvement

Is the service safe?

Our findings

People had not always been protected against risks to their health and wellbeing as some risks had not been managed appropriately.

On the first day of our inspection, we saw that some tools had been left in one of the lounges on the ground floor. The tools included a large saw, two spades and a bucket containing remnants of cement. The lounge was in use and accessible to all of the people on the ground floor, where some people living with dementia were being cared for. The tools represented a tripping hazard and, if used inappropriately could have posed a risk to people's safety. The deputy manager told us these tools had been left in the lounge overnight following the maintenance staff carrying out some work. They initially told us the tools would be moved later that day, but following a discussion around the potential risk they posed the deputy manager agreed they would have the tools moved immediately to a secure area of the home, which was not accessible to people.

During our inspection the service ran out of soft wipes, used to effectively support people with their intimate personal care. Providing this care without access to soft wipes could put people's skin integrity at risk. A senior care worker showed us the storage cupboards on both floors of the home and confirmed there were no soft wipes available. They advised us an order for wipes had recently been placed, and should arrive at the home within a few days of our inspection. They told us in they could contact a nearby residential home, operated by the same provider, and use some of their stock of soft wipes. We discussed the shortage of wipes with the manager three hours after speaking with the senior care worker, but at that point the manager had not been informed of the shortage and additional supplies had not been arranged. After discussing the shortage with the manager, she arranged for a member of staff to collect soft wipes from the nearby home. She advised she would review the regular order of supplies to increase the amount ordered to ensure there were adequate supplies in future.

Evacuation plans were not detailed or up to date, which could put people's safety at risk in the event of an emergency. People did not have their own personal emergency evacuation plan (PEEP). PEEPs are used so that staff and emergency services can understand the ability of each person to evacuate the building, taking into account physical mobility and mental capacity. The manager told us that instead they used a consolidated evacuation plan, with a colour coded system to indicate the support each person needed to leave the building in an emergency. In addition to the evacuation plan, each person' name was printed on a coloured sign on their bedroom door. The background colour of this sign represented their level of need in an evacuation, such as red if they were immobile and would need full assistance to leave. However, the consolidated evacuation plan had not been updated for over two months and during this time a number of people had moved into the home. This meant their information was not included on the evacuation plan and the level of support they needed was not detailed on this record. We also saw one person occupied a room without their name on the door and therefore without the visual sign about their ability to mobilise in the event of an emergency. We discussed this with the manager who advised us she would update the evacuation plan and ensure it was updated with every new admission. They also arranged for a colour coded door sign to be printed for the occupied room.

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

People and relatives we spoke with told us the home was a safe place to live. One relative told us their family member "feels safe and happy here." Another told us their relative had not been at the home long and that staff had helped them to settle in. They said, "Staff here are very pleasant. I have no concerns at all on that score." During our inspection we saw people appeared relaxed and comfortable with staff.

All five of the care workers we spoke with were able to describe appropriate steps they would take if they had any concerns over people's safety or welfare. Staff received training in recognising and responding to safeguarding concerns on a yearly basis. In addition to this training they were required to undertake knowledge checks on the safeguarding process every six months, to ensure they were aware of the correct procedure.

Staff were aware of the whistleblowing policy. Information about how staff could share any concerns anonymously was detailed on a poster in the manager's office. Staff told us they felt any concerns they raised with the manager would be taken seriously.

Requires improvement

Is the service safe?

Regular checks were carried out by maintenance staff to ensure the premises and equipment within it was safe. Fire alarm and fire doors were checked weekly. Call bells were tested monthly to make sure people could call staff for assistance if they needed them. Records showed the boiler, lift and hoists had been serviced regularly to ensure they were in working order. External contractors had undertaken assessments of asbestos or legionella risks and the electrical installations within the premises had been tested and certified as safe.

Contingency plans were in place to address any unforeseen circumstances. A manager's handbook had been produced by the provider which detailed the steps to follow if particular incidents occurred, such as an outbreak of infectious disease or the breakdown of essential equipment. The handbook listed important telephone numbers, such as emergency services, utilities companies and representatives from the provider who may need to be contacted, depending on the nature of the incident.

Where accidents or incidents had occurred, detailed information had been recorded by staff and reviewed by the manager to ensure appropriate action had been taken and submitted to the provider's head office for monitoring. Documentation prompted the manager to record whether the incident should be reported to various external organisations such as the local authority or CQC. We saw records detailed the action taken to prevent accidents recurring or to minimise the risk of harm in the future.

People and relatives we spoke with told us there were enough staff available in the home to meet their needs. During our inspection we noted there was a good staff presence. Staff were available in communal areas. When people used their call bells these were responded to quickly. Staffing rotas showed the staffing level was consistent. One member of staff told us the staffing number had been reduced when occupancy in the home had fallen, but felt it should be increased as a number of people had recently been admitted to the home. We discussed this feedback with the manager who told us staffing levels were determined following an assessment of people's needs as opposed to the number of people using the service. She showed us the analysis tool she used to ensure there were enough staff to run the service safely. We saw this had been updated to include the needs of recent admissions to the home.

Staff personnel files showed recruitment policies had been followed and employment checks, such as the uptake of references and Disclosure and Barring Service (DBS) checks, had been carried out to determine if staff were suitably qualified and fit to work with vulnerable people.

Staff responsible for administering medicines had undertaken training in how to do so safely and had their skills and knowledge assessed through regular competency assessments. We watched staff administer medicines and saw good practice standards in hygiene had been adhered to, such as washing their hands before preparing medicine and wearing disposable gloves when administering ear drops. Where people were prescribed an 'as-needed' medicine a care plan was in place, describing why the medicine had been prescribed and how staff should determine if people needed it, which was particularly important where people could not verbally communicate their needs. However, we saw some examples where this information was not available and fed this back to the manager who advised us they would ensure these care plans were put into place. Clear records had been maintained to show when people had taken their medicines.

Requires improvement

Is the service effective?

Our findings

People who were able to communicate with us told us they enjoyed the meals at the home. One person said, "The food here is excellent and there is plenty for me. If I ever want more I only have to ask." We saw people who were able to eat in the dining rooms were served their food from hot trollies and it was plated up to their requirements. Where people requested more or less of some food items this was accommodated. The food looked appetizing and was served hot.

However, people who were being cared for in bed were not always given a choice of meal. One person, who was cared for in bed, had been identified as at risk of developing malnutrition. Their food and fluid care plan stated they should be encouraged to eat as much as possible to increase their weight, and that they should be offered seconds of desserts as they had a sweet tooth. We saw staff prepared their main and desert at the same time. Their desert, which was rice pudding, was left uncovered for thirty minutes before it was taken to them and would have been cold. This meant this person's food had not been presented to them in a way which was appetising or appealing. We saw this person ate only half of the portion. We spoke with relatives whose family member was being cared for in bed. They told us they often came in at meal times to support their family member to eat, but told us they regularly 'had to wait a while' for their relative's meals. We noted that people who were cared for in bed were brought their meals after staff had supported people in the dining rooms. One person was brought their meal an hour and a half after it had been served in the dining rooms.

We spoke with the cook, who was able to tell us about people's dietary needs but could not explain how these needs were met. People's dietary needs were displayed on a white board in the kitchen, including some people who had been assessed as requiring a fortified diet. A fortified diet is one where additional nutrients have been added to meals through foods such as cream, butter, milk and milk powder. The aim of fortified diets is to provide meals which have a higher nutrient density without increasing portion size. We asked what adaptations were made for people who had been assessed as requiring a fortified diet. The cook was unable to tell us. They told us that they fortified lots of foods, such as mashed potato or rice pudding by adding cream or full fat milk. However, they acknowledged that this food was prepared in the same way for all of the people in the service, irrespective of their individual needs.

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

We fed these observations back to the manager who told us she would request that staff support people to eat who were cared for in their beds before the meals were served in the dining rooms instead of afterwards. She told us this would mean hot trollies would still be available if people wanted second portions and hot deserts could be left un-plated until they were required. She also told us she would speak with the chef about adaptations which could be made for people who required fortified diets.

People and their relative's told us they felt staff had enough skills and expertise to meet their needs. One person said, "The staff are canny. They know their stuff." A relative told us, "The staff seemed switched on. Particularly the seniors, I've been very impressed."

The provider had identified a set of mandatory training for staff. This included care and safety related training in areas such as moving and handling, mental capacity and health and safety. Training records showed completion in mandatory training modules was high, with 90% of this training complete. Areas where this training was still required was usually due to long term staff absence.

Training records showed most staff had undertaken basic training in dementia care awareness. The manager told us she had identified that staff needed more in-depth training in dementia care and showed us evidence she was in process of arranging this training for the months after our inspection.

Care workers met regularly with senior staff in supervision and appraisal sessions. Staff spoke highly of the sessions, telling us they found it useful to be able to discuss their role and the needs of the people they supported. One staff member said, "The supervisions are really good and help you keep your caring top rate." However, whilst records showed these meetings were held regularly, documentation recorded during the meetings was often brief and usually only one or two lines.

The manager, deputy manager and staff we spoke with displayed a good knowledge of the Mental Capacity Act

Requires improvement

Is the service effective?

2005 (MCA). The deputy manager had training qualifications and delivered training in mental capacity to staff from a number of the provider's organisations. The MCA protects and supports people who may not be able to make decisions for themselves. Where people lack the mental capacity to make their own decisions related to specific areas of care, the MCA legislation ensures that decision making in these areas is made in people's 'best interests'. The manager told us that no one in the home was subject to any 'best interests' decisions at the time of our inspection, but was able to describe to us the process she would follow if people did not have the capacity to make their own decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider acted in accordance with DoLS. Timely applications had been made to the local authority to grant authorisation where people did not have the capacity to remain safe if they left the home unaccompanied. Staff we spoke with were aware of who was and was not subject to DoLS authorisation. People and relatives we spoke with confirmed that those people who did not require DoLS authorisation were able to leave the home whenever they chose to. One person told us that they regularly visited a local club for a meal and that staff supported them to do this by arranging their taxi. A relative said, "I can turn up and take [Relative's name] out whenever I want. We'll go shopping or for something to eat."

People told us their choices were respected and gave us examples of this. One person said that they liked to sleep in their chair rather than their bed. They told us that staff encouraged them to sleep in their bed at night time, but understood it was their choice to make. They told us staff turned down their bed so they could get into it later if they choose to. We saw people were able to choose where they wanted to spend their time and that when one person requested sandwiches for their lunch, so they could eat in the garden, this was quickly arranged. During mealtimes we saw staff showed people a plated up meal of the two menu choices available that day. This provided people with meaningful choice, as they were able to see and smell the food available to them. Dessert choices were not presented in this visual way, we fed this back to the manager who told us she would arrange for staff to show people the desserts available when asking for their choice.

Some adaptations had been made to the environment to take into account the needs of people with dementia. Handrails had been painted a contrasting colour to the wall, so people could see them easier. Additionally, there were some activity stations in the wide corridors so people could engage with tactile activities or reminiscence materials. However, there was poor visual signage in the home. There were no signs directing people to the various lounges or dining rooms. Visual signs only had been used on toilets and bathrooms doors and the signage used for these rooms was exactly the same. This made it difficult for people living with dementia to use the toilet independently, as some of the doors which looked like they were the entrances to toilets did not contain a toilet, but instead only a shower or bath.

We saw people had been supported to access healthcare professionals, such as GPs, district nurses and chiropodists. We spoke with three health professionals who visited the home regularly. They told us the service made appropriate, timely referrals and followed instructions they gave them well. One health professional said, "The contact they make with us is reasonable. Sometimes we'll be able to provide advice over the phone and they seem capable to carry out instruction." However outcomes of medical appointments or contact had not always been documented. For instance, one person had an 'investigation record' sheet in their care plan that stated a urine sample had been sent off. The entry did not state what the sample was for or what the results were.

Documentation was kept in people's care records where they, or their medical team, had made advance decisions to refuse resuscitation in the event of a cardiac arrest. These documents should be reviewed yearly, but we saw one such refusal of resuscitation had not been reviewed since December 2013.

Good

Is the service caring?

Our findings

People and their relatives told us staff were very friendly and kind. People told us staff treated them well. One person said, "The staff are very nice. You cannot possibly have any complaints about the staff if you live here." Another person said that they were content at Woodhorn Park. They said, "I'm happier here than I've been for a long time." Relatives told us how they were warmly welcomed when they visited the home. One relative said, "I sometimes bring the grandkids in and staff spoil them. Make a bit of a fuss of them."

People told us staff were quick to reassure them if they were feeling down. One person got upset as they spoke with us, they said, "Look at me being silly; they'll be along in a minute to cheer me up." A relative said of their family member, "Most of time she is happy, but she has had a cry today. The staff are very kind to her when she gets like this."

During our inspection we spent time in the communal areas and carried out a formal observation over lunchtime. Staff responded to people in a caring way, reassuring people if they were distressed. We saw one staff member spent a lot of one on one time with a person when they showed signs of agitation. They engaged the person in conversation about their family and suggested a number of activities they could carry out with them to distract them, such as asking if the person would like their nails or their hair done. The person accepted a cup of tea and we saw they visibly relaxed during their conversation with the staff member.

People's care records included information on their life history such as important people in their lives, and happy and unhappy memories which staff could use to build relationships with people. Staff appeared to know people well. We saw staff dispensing medicines demonstrated skill and compassion in asking and assessing people's need. For instance, they understood that one person may need paracetamol for pain but did not like to think that they were being a burden to anyone. To ensure they met the needs of the person, they spent some time chatting with them on a one-to-one and discreet basis, asking if they were okay and if they had enjoyed their lunch, before asking if they needed a painkiller.

People told us that staff upheld their privacy and dignity and our observations supported this. We saw that staff knocked on people's doors before they entered their bedrooms and spoke to them politely.

People were supported to remain independent. One person showed us their room, including a mini fridge and a kettle which had been provided by the manager. They explained that staff filled the milk jug in their fridge daily and provided them with tea bags. They said, "I like the independence of being able to make my own tea." Other people told us how staff had supported them to maintain relationships with their family or purchase items they were interested in. One person told us a staff member was taking them to a local pub one day that week to meet their relative for a lunch, as it was their birthday. Another person described how staff were going to help them to buy a new TV. They said, "One of the staff will fetch me an Argos catalogue so I can choose what I like and they will go and get it for me. They are all so lovely and I can ask them for anything."

Care records included an end of life care plan. People had been asked whether they wanted to make decisions about how they would like to be cared for towards the end of their lives, such as if they would like to go to hospital or to remain in the home. The manager told us they worked closely with the district nursing team to have equipment and medicines available in advance, to keep people comfortable when people approached the end of their lives. The manager also told us families were welcome to stay in the home around the clock and whenever possible were provided with a room, so they could stay overnight if people's conditions deteriorated.

The manager described how she maintained links with people who used the service even after they had returned to their own homes. She told us one person, who had received some respite care at the service, visited weekly to have lunch at the home and to get their clothes cleaned, as they did not have any other access to a washing machine. They also told us they had applied to the Barchester foundation, a charitable branch of the provider, for a grant for another person who again had received respite but had now returned to their own home. This person had recently moved and had very few personal belongings. The manager told us she was hoping that they would be approved for a grant from the Barchester foundation which could be used to furnish their new home.

Requires improvement

Is the service responsive?

Our findings

The majority of records we reviewed showed care had been planned to meet people's individual needs. However, evidence showed that some needs had not been fully assessed and care had not been planned. We also found evidence of inconsistent care.

Most care plans, which described how staff should deliver each person's care, were specific and detailed. For instance, one person's communication plan stated that they liked to talk but preferred staff to initiate conversation with them first. It also stated that if the person repeated what had been said to them it demonstrated their understanding of the conversation.

We saw evidence that staff generally carried out the care as described in the person's care plan. Another person's plan indicated that staff understood the cause of their anxiety and had explored techniques to overcome these. For instance, staff knew to get the attention of the person visually before communicating verbally with them and that by smiling and gently touching their shoulder during a conversation the person would remain calm. We saw that these techniques were applied in practice by staff.

However, we saw evidence that some people's assessed needs were not always met. One person's care plan detailed how they needed support from staff to meet their elimination needs. This person used incontinence products and their care records stated continence aids should be changed every four hours, or more frequently if needed. On the second day of our inspection, at 1:30 pm we noted this person was emitting a strong odour of urine. We saw this person again at 3pm and noted the odour remained. We saw their care records indicated that their incontinence product had been changed at 10am and 2pm that day. We alerted a member of staff to their personal care needs and they assisted the person to be changed. When questioned, the staff member told us the person's incontinence product had needed to be changed. When asked if the smell of urine and the need for the pad to be changed supported the record kept; namely that the person's pad had last been changed an hour previously, the member of staff replied, "To be totally honest no. I think that pad has been on for a lot longer than that. It was overdue being changed." This represented inaccurate record keeping and a risk to the person's skin integrity, comfort and dignity.

Staff had been provided with information about how people should be supported to mobilise around the home through care plans and had undertaken training in how to deliver this safely. However, observations indicated this support was not always provided as detailed. We saw one person, assessed as requiring two staff to move around the home, being supported to mobilise from the dining room to the lounge. Two staff did support this person, standing on either side of them. We saw one staff member supported their elbow and forearm and gave them their full attention as they moved. However, the other staff member held them with one hand under their armpit, which looked very uncomfortable. As this staff member supported this person they also stretched with their other hand to close a door. This resulted in the person being pulled to one side of the corridor and was not in line with the person's detailed moving and handling plan.

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

People's care had been reviewed on a monthly basis, or when their needs changed. We saw reviews were personalised and detailed including information about how care had been delivered in the previous month and whether it met people's needs. However, these reviews indicated that the care provided to people was not always consistent or based on assessment tools. For example, one person's care review stated they needed full staff assistance in all aspects of personal care. In a review two months later a member of staff had stated that they could wash and dress themselves and that staff should be 'assertive' with relatives in communicating this. However, risk assessments had not been amended to reflect this change in care and their personal care plan detailing that they needed full support had not been re-written.

Reviews of care also highlighted where some care plans did not provide staff with enough detail to meet people's needs in a consistent way. One person sometimes displayed behaviours that could be challenging to staff. One of their reviews stated, "There is no distracting [Person's name] when [Person's name] is like this. I have found just to ignore him ranting on and he quickly changes his tune. I have seen staff running after him and this just makes his behaviour continue." We reviewed the person's care plan relating to their mental health. We saw that whilst it stated the person could become anxious or distressed, it did not detail any triggers which may prompt these behaviours. Information

Is the service responsive?

had not been provided about how staff should respond if they were distressed, further than to 'offer reassurance'. The care review showed that staff responded to this person in different ways and were not providing a consistency in their approach.

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

Records relating to the care people received were not always accurate, up to date, or stored securely. Care records did not contain complete information about decisions related to people's needs and planned care. One person's care review had not been updated in two months despite there being a significant change in this person's needs during this time, as they had been assessed as requiring end of life care. Despite a significant weight loss, and contrary to their nutrition care plan, this person had not been weighed for three months and a referral made to a dietitian for support with this person's nutrition needs had not been followed up. Staff were able to explain that this was due to the rapid decline in the person's health. They told us they had taken advice from health professionals not to pursue the dietitian referral or to weigh them regularly and to focus on keeping the person as comfortable as possible. However, none of these important decisions had been recorded within the person's care records.

Where people were being closely monitored regarding their food and drink intake, and their positional changes to reduce the likelihood of them developing pressure damage, these records were poorly completed. We saw daily records in place which had not been named or dated. Information recorded by staff was not always accurate. We saw one person's breakfast bowl being removed from their room and it looked over half full. We saw the entry on their nutritional record for that day stated they had eaten 'all' of their cereal. Records were not consistently stored securely. Whilst people's detailed plans of care were stored in a locked room which only staff had access to, details of personal care, such as bathing and elimination records were kept in a file and left in the corridor. The manager explained this was so staff had easy access to them, but acknowledged that in doing so people's information was not being stored securely in a way which protected their dignity.

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

The home employed a full time activities coordinator who planned activities inside and outside of the home and arranged for entertainers to visit the home. An activities board in the reception area detailed the scheduled activities. People told us they enjoyed the activities available, such as baking scones, taking part in quizzes and gardening. During our visit we saw staff encouraged people to take part in activities such as playing games or watching a film on the cinema projection screen.

People were encouraged to share their experiences of the service at regular meetings held within the home. These were planned to coincide with a monthly afternoon tea which relatives and people from the community were invited to, through a large sign on the outside of the home, in addition to posters and leaflets around the home. The manager said, "We like to make an event of it. They enjoy a scone and a chat and then whilst they are there we can ask them about them about any improvements they'd like to see too. People and relatives we spoke with told us they had attended the meetings. Minutes from the meeting showed they were used to discuss the menu and upcoming events.

People's views on the home were gathered through yearly satisfaction sent to them and their relatives. Results from the most recent survey, sent out in October 2014, were very positive. People's comments included, "This is a well-run home, I'd give it ten out of ten." All of the people who had replied had indicated satisfaction across a range of areas such as activities, choice and being listened to. The only area for improvement identified was regarding some of their items of clothing going missing from the laundry. After the survey had been analysed the manager arranged for staff to carry out an inventory of people's clothing. Noting down all the clothing people owned, and ensuring it was well labelled to reduce the likelihood of clothes going missing again.

People we spoke with, and their relatives, told us they had never made a complaint, but that they had been provided with information about how to do. Complaints records showed there had been one complaint received within 12 months before our inspection. We saw records had been kept detailing the nature of the complaint, the investigation which had been undertaken and correspondence with the person who had made the complaint.

Requires improvement

Is the service well-led?

Our findings

Systems were in place to monitor the quality of the service provided, however these systems were not robust in identifying areas for improvement. A range of audits and checks had been carried out to ensure standards in the home met the provider's expected standard, however these audits had not identified the shortfalls in care delivery and record keeping which we found during the inspection

An in-depth audit was carried out on care records twice a year. Records from a sample of care plans had been reviewed and we saw action had been taken where documentation was missing or where the audit had highlighted that a particular record was out of date. However, the manager acknowledged, following our feedback on the standard of record keeping, that records audits needed to be carried out on a more regular basis.

Regular audits were carried out to monitor the health, safety and maintenance of the home, to check that medicines were administered properly and that the accommodation at the home was of a good standard. Representatives from the provider's organisation visited the home and provided feedback on what they had found. Detailed reports were in place from the operations manager visits, where records showed they had spoken with people who used the service and staff, and reviewed records. An assessment was carried out on a yearly basis by members of the provider's regulation team. This was an internal CQC style audit, which focussed on the Key Lines of Enquiry which we inspect against. However again, whilst we saw action points had been created from these feedback reports, the issues we had found during our inspection had not been identified.

During our inspection we saw a number of examples of poor care practices from one staff member. We fed back details of our observations to the registered manager during the inspection, who assured us she would address this. Following the inspection we shared our observations with the local authority contracting team, and wrote to the registered manager and provider to gain assurances this matter had been dealt with appropriately.

Risk assessments were in place to identify and mitigate risks to people using the service. Generic risk assessments from the provider organisation had been used, and had not always been updated to reflect risks within the home. We saw a fire risk assessment detailed that the maximum number of people in the home overnight, including staff, was six, which was inaccurate. Other generic risk assessments had not been completed to take into account risk specifically related to Woodhorn Park. A number of people had patio doors in their bedrooms which lead to outside of the home. During our inspection we saw the main doors to the home were propped open, which allowed people to leave, or visitors to enter the home, without having to input a security code or alert staff. Staff were usually located in this area and therefore would see when people entered or left the building. However, at one point a visitor approached the inspector in one of the lounges to ask for directions to their relative's room. They explained they were visiting the home for the first time. This meant the visitor, who staff had never met before, had entered the home and was within communal areas of the home, without staff being aware they were in the home. We saw the provider's generic risk assessment, related to the security of the home, had not been amended to reflect any risks relating to patio doors in people's rooms or relating to leaving the main doors to the home open.

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

A registered manager was in post and had formally registered with Care Quality Commission in February 2011. The manager was present during the inspection and assisted us with our enquiries. The manager told us she had started working at the home, initially as a laundry assistant, when it opened almost 15 years ago. She told us she had been supported by the organisation to access a wide range of training to broaden her skills in management, including attaining the registered manager award and an NVQ in leadership and management of health andsocial care services.

The manager told us she was proud of the low staff turnover at the home, the relationships she and staff have built with families and residents, offering 'an excellent service and hospitality to everyone that enters Woodhorn Park'.

People, their relatives and staff spoke very positively about the manager. People told us she was available to speak with them whenever they needed to. One person said, "[Manager name] is a lovely lady." Another person said, "[Manager name] deals with everything very well. She's great. I know I can leave everything to her and she will sort

Requires improvement

Is the service well-led?

it all out." People we spoke with thought Woodhorn Park was operated very well. They said, "I can't think of anything that could make the home any better than it is." A relative said, "I can't think of a single thing that would improve it."

Staff told us the manager was supportive and promoted an open culture. One staff member told us, "[Name of manager] is brilliant. She really wants the best for the home, so she treats staff and residents well." Another staff member said, "It seems to be run well. Everything that is meant to happen does."

Staff told us their opinion on the service and how it was operated was sought and valued. They told us they attended regular staff meetings. Meeting minutes showed staff had been asked to contribute ideas for improving the home as well as used to communicate information about staff practice and developments.

The home had strong links with their local community. They had recently been awarded an Ashington in Bloom award for the garden and one person who used the service told us they had attended the awards ceremony with staff and had thoroughly enjoyed it. The home was continuing to make improvements to the gardens and grounds when we visited. Ashington is known for its mining history, and many of the people who used the service worked within the coal mining industry. The home had sourced a mining cart and a pit wheel which they displayed within the grounds of the home. The manager told us they were planning an open day for the pit wheel which had recently been put in place before our visit. They told us relatives, along with people from local businesses and the MP for the area would be invited. The home held a number of events throughout the year, such as summer fayres and participated in the national care home open day, where the community were invited to come into the home and spend time with people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care provided did not always meet service user's needs. Regulation 9 1(b), 3(a)(b)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to the health and safety of service users of receiving the care or treatment had not been assessed and mitigated. Regulation 12 1, 2(a)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records kept in relation to service users were not always accurate, well maintained or stored securely. Systems in place to assess and monitor the quality of the service were not robust. Regulation 17 1, 2(a)(b)(c)(d)