Woodlands Manor Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 14 and 15 June 2017. When we last inspected in June 2016 there were three breaches of legal requirements. One of the breaches was rectified immediately however we issued rectified enforcement notices. The provider submitted their action plan in respect of the further two breaches and told us what action they planned to take. We have checked during this inspection that the proposed actions were taken.

Woodlands Manor Care Home is registered to provide accommodation and nursing care for up to 40 people, however two bedrooms that were registered as shared rooms were only used by one person. At the time of our inspection there were 33 people in residence. One of these people was having a short stay at the home,

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was one of the two directors, who runs the home.

The service was not safe. The nursing staff did not ensure that stocks of medicines were always available and this meant there were occasions when people did not receive their medicines as prescribed. The records regarding how often some medicines were to be administered were not always correct. Not all medicines were stored correctly and clinical supplies and equipment was not checked to make sure it was fit for purpose.

Not all staff had received safeguarding training and told us they relied upon the nurses, the clinical lead nurse and registered manager to report any concerns. There have been recent occasions when neither the nurses or the registered managers have reported concerns to the local authority safeguarding team. The service has been the subject of organisational safeguarding monitoring since May 2016.

The measures in place in respect of infection control and prevention were not adequate. No checks had been undertaken to ensure people and the staff team were safe. People had to share some equipment, for example hoist slings and commodes. We found the storage areas for the bins to be littered with rubbish and the clinical waste bins to be open and faulty.

The registered provider did not ensure the staff received the training they needed to do their jobs effectively. New staff were uncertain what the plans were for their induction training. The new training package we were told was being introduced last year in June 2016 had not been implemented and the registered manager and clinical lead were unsure how far they had got.

We were provided with examples where the staff had not treated people with respect. We saw where one person's bedroom had been left open whilst they were sat on the commode and we had seen this

happening when we visited last year. We had to ask the care staff to respond to requests for assistance from people who had rung their call bells. The staff were task orientated and did not have a person centred approach towards the people they were looking after.

Improvements were required with the standards of care delivered to those people who were receiving palliative or end of life care. The qualified nurses did not demonstrate their competence in ensuring that people would be kept comfortable and their death would be peaceful. There are further details in the main body of the report.

Assessment and care planning required improvement to ensure that each person received the care and support they needed. Before admission, the service should ensure a person's need for any specific equipment was identified. Changes in people's health care needs were not always acted upon by the nursing staff and when advice from specialists was required, this might not be done in a timely manner. People did not consistently receive person-centred care that met their own specific needs.

Whilst some improvements had been made to the care records for each person we still found that not all records were accurate. Where people's health care status required greater monitoring, the records kept were not complete and did not evidence that the care had been delivered.

The management of complaints was not in line with the providers own complaints procedure. Relatives had raised complaints with the nurses and with the registered manager but had not received a satisfactory response. This meant people and their relatives cannot be assured that any concerns they had about the way they were looked after would be listened to.

The procedures in place to monitor the quality and safety of the service remained inadequate. Any audits and checks that were completed were brief and superficial. The audits were not always carried out by the most appropriate member of staff. The registered manager did not use information from any accidents, incidents and complaints to identify trends. This meant the opportunity to make any changes to prevent a reoccurrence was missed.

The procedures in place to recruit new staff were safe. Pre-employment checks were completed to ensure unsuitable staff were not employed. The service did not use a specific formulae to calculate their staffing numbers per shift but these appeared to be adequate at the time of the inspection. There was a plan in place for staff supervision however this needs to be strengthened.

Staff were aware of the need to gain consent from people before offering care and support The registered manager worked within the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted to the local authority where people were unable to consent to live at Woodlands Manor. .

People were provided with sufficient food and drink, or dietary supplements to meet their requirements. They were complimentary about the food and were given choice about what they would like to eat. Each person was registered GP and arrangements were made for them to see the GP and other healthcare professionals as and when they needed to do so.

The registered manager had received many complimentary letters and cards and we did see positive interactions between staff and people. Care staff spoke about the people they were looking after nicely but need to ensure they maintain their need for respect and dignity.

People's were able to participate in a range of different activities. There was a mix of group activities and external entertainers visited the service regularly. The activity staff team now consisted of three staff with the aim of increasing social and emotional support, on an individual basis, for those who were confined to their rooms of their bed.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The management of medicines was unsafe therefore the risks of unsafe practice and errors being made was increased. There was potential for people to be harmed.

Risks to people's health and welfare were assessed but improvements were required with the reviews and measures to reduce the risk.

Nursing staff had not reported safeguarding concerns when these had been reported to them. The staff team had not all received safeguarding training.

Appropriate safety measures were not in place to ensure people, visitors and staff were protected from the risks associated with unsafe areas. Infection control and prevention measures were not in place.

Staff recruitment procedures were on the whole safe and ensured unsuitable staff were not employed.

Is the service effective?

Requires Improvement

The service was not effective.

The care of people who were at the end of their life was not consistently adequate because of the lack of skills and competencies of the nursing staff.

Staff training was not adequate which meant care staff and nurses may not have the necessary knowledge and skills to be able to look after people effectively. Staff did not receive regular supervision.

People's rights were properly recognised, respected and promoted. The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and had made the appropriate applications to the local authority.

People were provided with enough to eat and drink and any specific dietary requirements were catered for. Improvements were required with records kept to monitor how much people eat and drink.

People's health care needs were met and staff ensured the GPs and other healthcare professionals were involved in people's care when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not looked after with respect for their dignity. They and their relatives said some staff were rude unkind and uncaring.

Staff did not always provide the support people needed and did not have the necessary skills and competencies to deliver good end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The assessment and care planning processes did not ensure that people received individualised care. The staff did not always respond appropriately to a change in their care needs. Care records were not consistently accurate, detailed enough or complete.

Complaints were not consistently handled according to their own complaints policy.

People were able to participate in a range of different activities.

Is the service well-led?

Inadequate

The service was not well-led.

There was poor leadership and management of the service and those in senior positions were not fulfilling their responsibilities.

The quality assurance systems were ineffective and did not identify shortfalls in the service.

The outcomes of accidents, incidents or complaints were not used to drive forward improvements changes which meant the event may happen again.

Woodlands Manor Care Home Limited

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 follow up on the actions we asked the provider to make following the last inspection. We also checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of three inspectors (two adult social care inspectors and a CQC pharmacist inspector) and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. The provider had submitted an action plan following the last inspection in June 2016 telling us what they were going to do to rectify the breaches of regulations.

The home had been the subject of organisational safeguarding monitoring for the last year. Therefore we had received much feedback from healthcare and social care professionals who were involved with the home. Their feedback was considered during the planning process and our findings have been incorporated in to the main part of the report.

During the inspection we spoke with 13 people who lived at Woodlands Manor and nine relatives who were visiting their loved ones. Some people were not able to talk with us about their care. Therefore, we also used the Short Observational Framework for Inspection (SOFI2). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager , the clinical lead nurse, plus nine other members of staff (care staff,

activities staff, catering and housekeeping staff).

We looked at six people's care records in full and other care records in order to check out specific details. We looked at three staff recruitment files, training records, staff duty rotas and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At this inspection we looked at the safe and proper management of medicines to follow up on the breach identified at the inspection in June 2016. We found that whilst some improvements had been made the management of medicines in the service continued to be unsafe.

We looked at the medication administration records (MARs) for 31 people and at the care plans and daily records associated with medicines for eight people. We also looked at the medicines stored at the service, the storage facilities, the policies and procedures for managing medicines and the audits carried out by the service.

We found that the MAR charts had been completed correctly and that people were receiving their medicines as prescribed when stock was available. We did however find that for some people medicines were not available to be administered as prescribed and the service did not have records to show that these medicines had been ordered in sufficient time to allow delivery before the existing medicines ran out or that the service had followed up on the delivery of these medicines. This meant that some people may have had their health and well-being put at risk.

We found one medicine that was being administered at a different frequency to that directed on the label. We asked the service to confirm the dose frequency which they did whilst we were present. It was confirmed that the frequency on the label was incorrect and this was documented in the person care notes. No harm had occurred as the person had received the medicine at the correct frequency.

When we looked at the storage facilities we found that whilst the current temperature of the fridge was being monitored the provider could not provide assurance that the temperature range was maintained in order to store these medicines as directed by the manufacturer. The medicines fridge also contained a large amount of ice and there were no records available to show when the fridge was last defrosted. This meant the medicines stored in the fridge may not work in the way they are intended to. We also observed a large number of medicines where the manufacturer specified a reduced expiry date when opened that did not have the opening date recorded. This meant the provider could not provide assurance these medicines were safe and effective to administer.

The service had three syringe drivers (devices to administer medicines automatically over a set period of time), two of these belonged to a local NHS trust and the third belonged to the provider. This third syringe driver was labelled as requiring testing August 2016. The use of this piece of equipment could mean that people received their medicine at an incorrect rate.

When we read the providers current medicines policy and procedures we found that these were not always followed or that it did not reflect current practice.

This is a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told all staff completed safeguarding training as part of the mandatory training programme. However the training records were out of date and it was not possible to evidence that all staff had completed this. A number of the staff we spoke with said they had not done safeguarding training recently and one who had worked at the home for several months said they had not done this training yet. We were told that the records were not updated until certificates of attendance had been received. The registered manager was unsure how far they had got in ensuring each staff member had completed the certificated training. When we inspected in June 2016, we reported there was a significant number of the staff team who needed to complete refresher training in safeguarding. At this inspection the service could not evidence this had improved.

The care staff we spoke with had a good awareness of safeguarding issues and would report any concerns they had about people's safety to the registered manager or the nurse in charge. They felt it was the responsibility of the nurses and managers to report safeguarding concerns to the South Gloucestershire Council safeguarding team. There was one occasion when the qualified nurses had not raised a safeguarding alert despite being informed by family of their concerns regarding the care of their loved one. Since the last organisational safeguarding meeting on 9 May 2017, three alerts have been raised by health care professionals who had visited people. Each of these cases were now subject to individual safeguarding investigations and, meetings were being held with the registered manager/provider. The service has been the subject of organisational safeguarding monitoring since May 2016.

There is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control and prevention measures were not adequate and meant people may not be protected from infection. Some people required assisting with moving and handling which involved the use of hoisting equipment. When these hoists are used, people require individual assessed slings of the correct size and type. These are then fitted to the hoist to keep the person safe. These slings can pose an infection control risk if shared between people.

We found that the slings were shared between people as well as commodes. The registered manager said there was no infection control lead and no infection control audit had been completed. Because the risks of infection had not been considered, the potential of impact on people was not mitigated. Hand sanitizing gel was placed by the front entrance but no where else in the home. We saw wound management photographs where the member of staff holding the person's limb was not wearing protective gloves. The storage areas for the bins outside were littered with rubbish and the clinical waste bins were open and faulty. The service told us a new clinical waste bin had already been ordered and the weekly collection of the domestic waste had been missed. However, the area around the domestic waste bins was littered with rubbish and the staff should have cleared this up.

There is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in June 2016, we found that the provider had not screened off unsafe areas of the grounds to prevent unauthorised access. We also found that measures were not in place to mitigate the risk of scalding from hot water. Hot water temperatures had not been monitored at the point of delivery in the bedrooms in one part of the home. We issued a warning enforcement notice at that time and the breach (of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014) was rectified immediately.

Building works were still in progress at the service. To the right of the premises a new extension was being built to accommodate additional bedrooms. To the left of the premises there was the car park, storage areas for the general and clinical waste bins and areas not cordoned off where building materials were stored.

At this inspection we noted there was an area in the back garden that could be considered as a risk to people who were mobile and able to access the garden on their own. This was because of uneven surfaces, discarded equipment and furniture and other trip hazards. We were advised that none of the current people living at the home were independently mobile. The provider should consider this area as a possible risk to people's health and welfare as the paving was uneven and the ground fell away into a ditch at the back. The area was primarily a staff smoking area. We felt this posed a potential risk to any person moving into the home who accessed the outside space independently. The area also posed a potential risk to visitors to the home and also to the staff members who used the area. These risks had not been identified by the provider.

When the inspection team had looked around the premises with the registered manager we noted some concerns. The door into the laundry room was wedged open. This is a high fire risk area therefore the service had significantly increased the risk of harm to people and the staff team. We also saw in the upstairs corridor an electric flex plugged in and dangling from the handrail and supplies of cat food stored in main reception area. These concerns were shared with the registered manager during the inspection and action taken to mitigate those risks.

Risks assessments were completed for each person in respect of the use of bed rails to maintain a person's safety, eating and drinking, moving and handling tasks, the likelihood of developing pressure ulcers and continence. Some improvements were required with these risk assessments as the reviewing of them lacked consistency. An individual moving and handling plan was written for people who needed assistance however they did not always include enough detail. For example, the plans did not specify what type of hoist or sling was to the used. During the inspection we observed many occasions where people were being moved using a range of different equipment. These transfers were completed competently. Four members of staff had completed a train the trainer course to enable them to assess people's moving and handling needs and write safe moving and handling plans. However, those plans we looked at had been written by the registered manager or the deputy (the deputy had completed the train the trainer course).

Personal emergency evacuation plans (PEEP's) had been prepared for each person: these detailed what support the person would require in the event of the building needing to be evacuated in the event of fire or other emergency. The plans contained a sufficient level of detail. These documents were kept in the red grab box located in the office and available to the staff member in charge should any emergency occur.

There was a regular programme of checks in place of the premises, facilities and equipment. These were either completed on a weekly, monthly, quarterly or six monthly basis. The post of maintenance person was currently being recruited in to, but in the interim, the existing maintenance person was doing part time hours and being supported by the provider. The fire checks had been completed as per the programme and the last fire drill had taken place on 27 May 2017. Regular hot water checks had been completed and some were higher than the recommended safe limit. We checked with the registered manager what action had been taken as a result of this and were shown separate records where the provider had re-tested the water temperatures. The registered manager should ensure that one set of records be kept which evidenced any shortfalls identified, the remedial action taken, when and by whom.

The provider had a service level agreement in place for the servicing and maintenance of nursing equipment. Lifting and moving equipment had last been checked for compliance with the Lifting

Operations and Lifting Equipment Regulations 1998 (LOLER) in May 2017 and was next due in November 2017. There was a procedure in place for staff to report any maintenance requests and this was checked each day. There was a fire risk assessment in place and this had been reviewed and updated by an external contractor since our last inspection in June 2016.

We checked the files of newly recruited staff in order to check that safe recruitment procedures were followed. Each file contained an application form and an interview assessment. The application form for one member of staff contained little information and two of the interview assessments only recorded brief detail. Each file evidenced that pre-employment checks had been undertaken. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check an applicant's police record for convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. For one member of staff there was only one reference on file and the information had been provided verbally to the registered manager. It is recommended that the registered manager record greater detail in respects of their assessment of a candidates suitability for employment.

The service did not use a safe-staffing assessment tool to calculate the number of staff needed for each shift. The registered manager explained they worked on the basis of one member of staff to five people. This did not take account of each person's specific care and support needs. At the last inspection we advised the provider to implement a dependency scoring tool however this had not happened. A 'residents needs identifier' exercise had been completed on 16 May 2017 which looked at how many people had specific care needs such as needing to be assisted to eat their meals and prevent pressure damage for example. However, there was no outcome from the exercise or indication in how this was going to relate to staffing levels. The service should be able to demonstrate on what basis they have decided on staffing numbers per shift.

The registered manager worked their hours from Monday to Friday. The clinical lead nurse (deputy) had supernumerary hours where they completed management tasks but also did at least one shift per week. A qualified nurse was on duty each shift including weekends and overnight. On a Tuesday morning two nurses were allocated to be on duty because the GP did their 'ward round' that day. On the first day of our inspection there were seven care staff on duty, two activity organisers and one qualified nurse. The care team were supported by the catering, housekeeping and maintenance staff in meeting people's daily living needs. We looked at six weeks of staff rota's and these confirmed that staffing levels were maintained consistently as stated by the registered manager.

Staff said the staffing numbers were sufficient however at key times of the day, they were stretched. The midday meal was a particularly busy time because of the number of people who needed assistance with eating their meal however the activity staff would assist at this time. The service only had four qualified nurses to cover all shifts throughout the week and weekends plus the clinical lead nurse. Nurses and care staff were asked to pick up any unfilled shifts and a care agency provided care staff whenever required. The registered manager said there was one vacant post for weekend nights care staff and a maintenance person.

Requires Improvement

Is the service effective?

Our findings

Although we did not ask people directly if they thought the service was effective they made the following comments. "We get everything done for us", "I only have to ask and the girls will come and help me" and, "The home is good, clean and tidy and the staff help me".

The service looked after people who were at the end of their lives. Because of concerns about the quality of nursing care to people who were funded by the clinical commissioning group and continuing health care (CHC) team, on going monitoring was in place. There were concerns about the competency of the qualified nurses and their ability to provide good end of life care. In the recent past, the nurses had failed to adequately check the function of a syringe driver, used to deliver pain relief medicines via a continuous subcutaneous infusion. The nurses had failed to take the appropriate action when the device was leaking. This meant the person had not received adequate pain relief. No-one was receiving treatment using a syringe driver at the time of the inspection. For one person their indwelling catheter had not been changed as instructed in the hospital discharge notes and there were concerns around the availability of 'end of life' (anticipatory) medicines for people. We were told the CHC nurses had instructed the nurses to organise additional medicines.

We found that the qualified nurses were not challenging the GP on behalf of people, in order to ensure the person's comfort was not compromised. The GP advised us they tended not to prescribe anticipatory medicines because a lot of people did not need them. The GP said the nurses could contact him at any time to arrange these. However the nurses had not considered the practical arrangements of obtaining prescriptions out of hours or when the local pharmacy did not have the relevant stock.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

The measures in place to support new staff working at the service needs to be more robust. For one new member of staff who had previously worked in another care establishment, a skills check list had been completed. However they did not know what further training would be planned for them. Another 'new-to-care' staff member said although she was well supported by colleagues she was uncertain about an induction training programme or the Care Certificate. The Care Certificate was introduced for all health and social care providers in April 2015 and consists of 15 modules to complete.

A new training package had been introduced since the last inspection and the plan was that staff had to attend training sessions and complete workbooks. These were then marked and certificated and enabled there to be a knowledge check of the staff members understanding. However, the registered manager said that not much headway had been made in getting the staff to complete the training. The deputy/clinical lead nurse had been given delegated responsibility of organising staff training but this had not been achieved successfully. The lack of training records did not provided evidence of how much had already been delivered. The training package consisted of care planning, dementia awareness, safeguarding, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), moving and handling, health and safety including infection control for example. There had been a record keeping training session on 5

June 2017 and end of life training on 15 May 2017.

There was little opportunity for the qualified nurses to do any clinical training in order to meet the conditions of their registration with the Nursing & Midwifery Council (NMC). Since the last inspection there had been syringe driver and end of life training only. It was evident during our inspection that the nurses required wound care management training, person centred care planning training and 'leadership training' in order to be able to lead a shift and teams of staff.

The provider had put together a programme of staff supervision (this is where a member of staff meets one to one with their line manager and is able to discuss their performance and any training needs) and this was shared between the registered manager and the clinical lead nurse. The qualified nurses did not do any of the supervisions of the care staff. We also observed that the qualified nurses did not work alongside the care staff to monitor their work performance. Staff we spoke with said supervisions were sporadic. Some said they had not had an individual supervision meeting for "ages". We saw some supervision records but these did not support that there was a robust plan in place or that supervision was an effective means of improving standards. The registered manager should ensure there is a robust programme of effective staff supervision in place in order to drive forwards the improvements that are required.

There is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised.

The registered manager had completed training regarding the MCA and DoLS and had an adequate knowledge of the legislation. They had put systems in place to monitor those people who were subject to DoLS restrictions and knew when each authorisation expired. At the time of our inspection11 applications had been made are were awaiting consideration by South Gloucestershire Council. The registered manager was aware CQC needed to be notified when DoLS authorisations were granted.

Improvements to the assessment process for new people had been instigated to include an assessment of their mental capacity. The registered manager was aware that if the person did not have the capacity to make a decision to live at Woodlands Manor a DoLS application would be required.

Staff asked people to consent before they provided care and support. During the inspection we heard the staff offering people choices. Examples included being asked what they wanted to eat or drink, where they wanted to sit, whether they wanted to go back to their bedroom and whether they wanted to participate in social activities. As part of the care assessment and planning process a person's capacity to make decisions was recorded. Where the person lacked capacity a record of best interest decisions made on their behalf were recorded.

Care staff were encouraged to complete recognised qualifications in health and social care. Ten care staff had achieved this qualification at level two and nine had completed their level three. Seven care staff were in the process of working towards level two and two staff who already had a level two were working towards level three. The registered manager and the clinical lead nurse had just started working towards the level five award in leadership and management.

People's needs in respect of food and drink were assessed as part of the assessment of their care needs. Risks regarding malnutrition and dehydration were identified and then reviewed on a monthly basis. Body weights were re-checked on a monthly basis however where people had lost weight, they were re-weighed on a weekly basis. At the time of the inspection there were four people who were being weighed weekly. In one person's file there was information included from the SALT team regarding the use of thickening agents to add to drinks. Their nutrition plan however made no mention of the use of this agent, neither did the care reviews. A member of care staff told us the person would not tolerate thickened drinks and they were no longer used. This means the plans and reviews were correct but the presence of the 'out of date' information was misleading.

The kitchen were informed of food allergies, any specific dietary requirements and preferences. They provided fortified foods for those people who had significant weight loss. Food and fluid charts were maintained where a person's eating and drinking needed to be monitored. We found there was no evidence that the charts had been checked at the end of a shift by the nurse in charge. There were gaps on food and fluid charts. For one person on 14 June 2017 there were no drinks recorded after 3pm. For another person there was no recorded food eaten until supper time on 11 June, and on the 12 June no breakfast of supper was recorded. The registered manager should improve the completion of these charts to evidence how much those at risk were eating and drinking.

The service had a two week menu plan. People made choices about their lunch time meal the day before but were able to change their mind if they wanted to. There was a choice of two cooked options each day and two puddings or cheese and biscuits. Other options were made available if people did not want either of the choices.

People made positive remarks about the food and drink they were given. They said, "The food is very good", "I look forward to my meals", "There is always plenty to eat and we are offered lots of drinks" and, "At the weekend there was a lovely party. We had a hog roast and pimms to drink. Just lovely". The dining room was well used for the lunch time meal and people were encouraged to join the others and eat their meals. Others had their meals served in their own room. We noted that the meal time was a social occasion, the tables were laid up nicely 'hotel-style' and there was good interaction between people and the staff team.

The majority of people who resided at Woodlands Manor were registered with one GP who had an agreed contract in place (called a local enhanced service) and provided medical cover. The GP visited the home each Tuesday morning and did a 'ward round'. They saw those people who the nurses felt needed a medical review. The GP did not see every person each week but said there were some who needed to be seen each week. During these visits the GP would review changes in people's health, review prescribed medicines and make decisions on future treatment plans. The GP did not raise any concerns with us however we received one other concern from a family member regarding the competency of the qualified nurses to recognise changes in their relatives health.

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The home worked alongside community and hospital social workers, occupational therapists and physiotherapists in order to make sure people were well looked after.

Woodlands Manor is a purpose built care home with level access from the car park. All bedrooms rooms were furnished to a high standard including the provision of nursing profile beds and the majority of rooms had en-suite facilities of a toilet and wash hand basin. Bedrooms were fitted with a telephone socket, TV point and a nurse call bell system. There were sufficient assisted bathroom facilities to meet people's needs and toilets were sited near the lounge areas. There were two lounges and two conservatories. The main

conservatory looked out over a large pond filled with koi, and the landscaped gardens. The grounds were also home to peacocks and white doves.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with respect and some staff were unkind and lacked compassion. Relatives who were visiting at the time of the inspection told us of their experiences regarding whether the service was caring. They told us about their concerns regarding staff conduct. One relative said certain members of staff had been very rude and insulting towards them and they had on one occasion been shouted at. Another referred to named members of staff who they described as having a poor attitude and being unhelpful. Health and social care professionals reported there was a culture of gossiping between the qualified nurses and a disregard to confidentiality. Nurses and care staff also made comments to us about gossiping. These incidences were reported to the registered manager during the inspection.

During our visit we observed one person who was using the commode in their bedroom but the bedroom door had been left open and they were in full view of others passing their bedroom. Looking back at the inspection report following our visit in June 2016, we referred to a similar occasion when a person's dignity had been compromised because they had been sat on the commode with their bedroom door open. We heard call bells ringing and on three separate occasions had to ask for the care staff to respond to requests for assistance. The care staff were task-orientated in their response and said they had not been allocated to look after that person during their shift. This does not evidence that staff were being respectful to people's requests for assistance. It is evident that staff routines and preferences took priority in their work. We noted the staff were pre-occupied with taking their breaks and often went on break together leaving an area of the home unattended.

These are examples of a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, some people did make positive comments to the inspection team. They said, "I find the staff caring and I am treated with respect and dignity", "The staff are very good to me", "The staff are wonderful and supportive" and, "The staff are considerate and helpful". Relatives said, "I find the staff very supportive" and "the staff are friendly and welcoming". One relative described the staff team as having a good relationship with their mother and added that the staff team had also supported them through a very difficult time. They described the staff as "lovely and very patient" and were touched that some of them had attended the cremation ceremony. Whilst we were having a private discussion with this relative the interview was disrupted by a member of staff. We saw this same member of staff interrupting care staff whilst they were carrying out a moving and handling procedure. This was not a respectful interaction.

Some staff we spoke with seemed kind and caring. We saw a number of occasions where there were positive interactions between staff and people. Staff talked about people's different needs and wishes and generally referred to them by their first name. People were asked by what name they wished to be referred by and this preference was recorded in their care plan.

The registered manager told us about two examples where the staff had 'gone above and beyond' what was expected of them. They had purchased flowers for one person and taken them to the cemetery on the

anniversary of their spouses death. Another member of staff was due to escort a person to a family wedding, staying with them and providing any support the person needed during the day.

The registered manager kept all letters and cards of compliment that were received and we looked at the last five that had been received. Comments included, "Thank you for your kindness. We were so pleased she spent her last days in comfortable and familiar surroundings", " (named member of staff) went out of his way to make mums meals appetising for her", "Mum would have been overwhelmed that so many staff attended her funeral", "Knowing that mum was so well looked after gave me peace of mind" and "Your support and friendliness to me (relative) gave me strength". There were many other cards but none of them were dated. The registered manager should consider writing the date of receipt on each of the correspondences.

Requires Improvement

Is the service responsive?

Our findings

We received both positive and negative comments from people who lived at Woodlands Manor and their families. Our findings have concluded that the service is not always responsive to people's care and support needs.

We were told by two different families they had raised a complaint with the nurses and the registered manager regarding concerns they had about the care of their loved one. Both families told us they had not received a response. When we looked in the complaints log, neither of them had been recorded. We discussed this with the registered manager during the inspection who felt that because both 'complaints' were subject to safeguarding investigation, they did not need to be recorded as a complaint. Both these case should have been recorded as complaints so that the issues raised could addressed following the providers complaints procedure. The registered manager said people were asked to share their views or make comments about things during their care plan reviews, resident and relative meetings and at any time they wanted to make comments.

The complaints log only referred to one complaint that had been raised on 14 May 2017. This had been responded to and action taken by 25 May 2017. In this complaint the family had raised concerns about their loved ones care and said they had reported issues to two of the day nurses but "did not know what action had been taken". Since the registered manager was not handling complaints about their service in line with their policy, they were missing the opportunity to resolve issues, identify any trends in complaints and then take corrective action.

This is a breach of regulation 16 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to being offered a place at Woodlands Manor to ensure the service was able to look after them and respond to their specific care and support needs. The assessment took account of any specific equipment needs. However, one newly admitted person had found that the comfortable chair in his room had been too low and the family had needed to provide chair raisers. This person's exact care and support need had not been identified during the pre-admission assessment. The relative told us they had needed to have a meeting with the registered manager to iron out a few problems.

We were told that family members had reported concerns regarding a health matter because the nurses had not identified a problem and responded to a change in the person's needs. The person had sustained pressure damage. The first photographic evidence of the wound was taken on 21 April 2017 but referral to the specialist tissue viability nurse was not made by the nursing staff until 15 May 2017. Subsequent photographs showed a healing wound. Another family said they had raised concerns regarding their relatives mood, this had not been identified by the nursing staff. As a result the person had been prescribed medication which had significantly improved their mood. Our findings have concluded that people were not consistently receiving person-centred care and treatment that was appropriate and met their needs.

These are examples of a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For those people who lived at Woodlands Manor long term, their care needs were re-assessed on at least a yearly basis. Information gathered in the assessment process was used to develop care plans for each person. The plans we looked at included people's likes and dislikes and what was important to that person. They also provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, managing continence and wound care management (where required) for instance.

When we inspected the service in June 2016 we found that improvements were required with the care records because these were not always accurate, complete or contemporaneous. The amount of detail in the plans did not ensure that people would receive the exact care and support they needed. The registered manager and clinical lead nurse had only just commenced looking at care plans and rewriting them but the qualified nurses were not involved in this task. External healthcare professionals were reviewing people whose care was funded by the health service. They had raised concerns with us regarding the lack of detail the provider had put in the original plans. These concerns were raised with the nurses at Woodlands Manor on 1 June 2017. For one person their care plan had not been updated since April 2017 and did not reflect the person's current care needs. The plan also contained conflicting instructions for the care staff to follow. Following the healthcare review the nurses at Woodlands Manor were asked to address issues they should have identified themselves and acted upon. For another person, there were inconsistencies around the recordings of the reviews of risk assessments and where these were recorded in two places these did not always match. Our findings during this inspection supported their findings.

We looked at the individual moving and handling profile for one person that had been completed in September 2015. Each month just a review date had been recorded and initialled and these had continued up until 31 December 2016 no changes had been made to the profile during this time. On 14 February 2017 a new profile had been written which showed a marked deterioration in the person's ability. A date of review had been initialled each month until 31 May 2017. On this form the person's weight and height had been recorded. On the 14 February 2017 assessment the same weight and height had been recorded as that on the 28 September 2016 form. However on other documentation where 'residents monthly weights' were recorded there was a 4kg difference for February 2017. This is another example of the inconsistencies in the documents relating to peoples care needs.

Some people had food and fluid charts and repositioning charts in place. The mobility plan for one person stated they should be repositioned every two hours. Their repositioning charts showed a five hour gap between 2300 and 0400 hours on 10 June 2017 and a five hour gap from 2100 to 0200 hours on 13 June 2017.Those food and fluid charts we looked at were also incomplete and some of the recordings were inappropriate. For example we saw 'juice by bed' written several times but this did not indicate the fluids had been drunk.

In one person's care notes on 1 June 2017 one of the nurses had written that the person's sacral area was at risk of the skin breaking down. Between the 2 - 8 June there was no further reference to the person's skin integrity and on the 9 June 2017, cream had been applied to the sacrum. On the 11 June 2017 staff had recorded the wound had been redressed. The care plan written on the same day referred to a grade two sacral pressure sore. This is further evidence that the staff were not being pro-active and responding to changes in people's health care needs. Records kept were inadequate.

These are examples of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a repeated breach.

Daily records were completed by the care staff and another set was completed by the nurses. Those completed by the care staff had improved since our previous inspection in June 2016 and there was more meaningful details recorded. The care staff also completed a record of personal grooming. The registered manager should ensure the recordings made by the care staff are counter-signed by the qualified nurses at the end of their shift. The registered manager planned to do away with the two sets of records and just have the one, completed by both care staff and nurses.

Where decisions had been made regarding a person's wishes in the event of a sudden collapse, a do not resuscitate form was placed in their care file. The service used the formal nationally recognised Resuscitation Council forms approved for use across all care settings. Only one of the forms had not been countersigned by the person's GP who was responsible for their care. Where people had appointed a member of the family to have power of attorney, this was recorded in their care files, and the registered manager had applied for a copy of the document.

Since the last inspection the service had increased the number of staff employed to arrange a programme of activities. The third member of the team was primarily going to do individual activities with people who were confined to their beds or their rooms. The activity staff wore bright pink polo shirts and were visible in the communal areas of the home throughout our inspection. Once a month an activity was provided at the weekend – the weekend prior to our inspection there had been a garden party with a hog roast and pimms.

Examples of activities that had been arranged recently included a 'flash back theatre', reminiscence using a memory box, visiting musicians and singers, arts and crafts sessions, quizzes and bingo. During the inspection several people helped decorate small cakes, there was a bingo session and also a visit from a company who brought along small exotic animals. The activity staff organised a 'mobile shop' each Wednesday and people were able to purchase sweets, drinks and toiletries. The hairdresser visited every Monday. A trip was arranged to Weston super Mare at the end of June and 'as many people as possible' would have the opportunity to go on this. People's birthdays were always celebrated and also any other anniversaries. Recently the home had celebrated a 90th, 101st and 102nd birthday and a 66th wedding anniversary. The service used the Daily Sparkle. This is a daily magazine that care providers can subscribe to. It has stories of days gone by, quizzes and items of interest to the older generation. The activities and care staff can use the daily sparkle to generate conversations.

We received extremely positive feedback from people and their relatives regarding the activities that were arranged at Woodlands Manor. Comments included, "There is always something going on", "I sometimes just sit and watch but it passes the time of day", "I love the music and singing" and "If I am well enough I would like to go on the trip that is being arranged".

A copy of the complaints procedure was included in the homes brochure. We were told this was given to each person/family and a copy was also displayed in the main reception area. The procedure stated all complaints would be acknowledged, investigated and responded to within a 28 day period.

Inadequate

Is the service well-led?

Our findings

Leadership within the service was weak and inconsistent. Since the registered manager did not have a clinical background they had employed a clinical lead nurse. Tasks that the clinical lead and the nurses were asked to complete were not addressed. The nurses did not lead their shifts and did not monitor adequately that people received the care, treatment and support they needed.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In May 2017, the provider had commissioned a healthcare consultant to look at the service and help them meet the fundamental standards and the Health and Social Care Act 2008 (Regulated Activities) 2014. It was however, too early to assess the full impact of their involvement with the service and to see sustained changes.

The registered manager shared their quality assurance (QA) policy with us. This stated their primary aim was 'to create a warm, homely environment for all our residents and to provide a high standard of professional nursing care to each individual'. The policy stated they would maintain an effective and efficient system of checks to ensure quality was maintained. Whilst there was a programme of audits and quality checks the system was not being used to ensure the quality of their service. There was a programme of audits and quality checks in place but the registered manager did not understand the principles of good quality assurance. We found that those audits we looked at were very superficial and had not identified many of the shortfalls we found during this inspection.

The QA programme included room temperature monitoring, call bell audits, various audits of the premises, facilities and equipment, unannounced visits during the night time, care records and the managements of medicines. All the records of these audits were brief and it was difficult to see what remedial actions had been taken as a result of the findings.

The administrator assists with the completion of the care plan audits. In April 2017 the audit document showed two areas of improvement had been identified but there was no record of action taken. This was discussed with the registered manager and the action required had been recorded elsewhere and then ticked as completed. When we relooked at those records we found that the missing care documents had been completed and placed in the person's care file.

On 22 May 2017 three peoples care records were reviewed but there was no check that the previous shortfalls had been remedied. This review had not identified any areas of concern. We recommend that the registered manager reconsider the appropriateness of the administrator completing these checks as it is a task more suited to nursing staff.

Any accidents and incidents that occurred were collated on a three monthly basis. The task was completed by an administrator and the information passed to the registered manager. . We looked at the records from

the reviews in December 2016 and April 2017. We noted that three events had involved the same person with their feet slipping off the footplates of their wheelchair. There was no evidence of any analysis of the results or action taken to minimise future risks. This meant the service was missing the opportunity to make changes to reduce or eliminate a reoccurrence.

This is a repeated breach of Regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

A number of staff meetings had been held since the beginning of 2017. A meeting had been held with the two day nurses on 17 January 2017 and there had been discussions around the recent safeguarding concerns, the Mental Capacity Act 2005, call bells and the shift handover process. There had been a reminder about staff 'gossiping' – this has been reported by relatives and staff to inspectors, as being an area of concern and still a problem. A full staff meeting held on 30 May 2017 had also discussed the handover report, 'daily routines' and care records kept in people's rooms. The previous care staff meeting held on 25 January 2017 there was an instruction to ensure the external bin lids were kept shut, people were not to be told not to use their call bells and calls bells were not to be disconnected.

Since the last inspection the registered manager, through no fault of their own, had been unable to progress with their level five health and social care diploma in leadership and management qualification. They had however signed up with a new training provider, along with the clinical lead nurse.

The registered manager was aware when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. The CQC use information sent to us via the notification process to monitor the service and to check how any events had been handled. The service had submitted notification forms in respect of expected deaths that had occurred and also to tell us they had raised one safeguarding alert with South Gloucestershire Council.

The provider had purchased a set of policies and procedures from a company and had amended them to the requirements of Woodlands Manor. They were all kept in the policies and procedures manual kept in the registered managers office. We looked at key policies and found these had been reviewed in the last year. The safeguarding policy had been reviewed in October 2016 and contained the correct protocol to follow should safeguarding concerns be raised.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider has failed to ensure that people are treated with respect and dignity at all times. Regulation 10 (1) and (2) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has failed to ensure that each person receives the care and support they need and takes account of changes in their needs. The registered provider has failed to ensure people receive appropriate end of life care as their needs change Regulation 12 (2) (a-d). The registered provider has failed to have systems in place to assess the risk of, prevent and control the spread of infection. Regulation 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider does not have systems

and processes in place to ensure that allegations of abuse are reported properly and acts of neglect are investigated.

Regulation 13(3) and (6) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider has failed to ensure that complaints made about the service are handled in accordance with their complaints policy. Regulation 16 (1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider has failed to ensure that staff are suitably qualified, competent, skilled and experienced in order to meet people's needs. Regulation 18 (1) and (2) (a)..

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has failed to have proper procedures in place to ensure the safe management of medicines. Regulation 12 (2) (g).

The enforcement action we took:

A warning notice was issued and the registered provider was told to take action by 30/11/2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has failed to make the necessary improvements to ensure there is an effective system of processes in place to monitor the quality of their service. Regulation 17 (1) and(2) (a). The registered provider has failed to make the necessary improvements to ensure that an accurate, complete and contemporaneous record is maintained in respect of each person. This is to include a record of the care and treatment provided and of any decisions made. Regulation 17 (2) (c).

The enforcement action we took:

A warning notice was issued and the registered provider was told to take action by 22/10/2017.