Woodleigh Christian Care Home Limited

Woodleigh Christian Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Woodleigh Christian Care Home on 7 and 8 September 2016. The inspection was unannounced.

Woodleigh Christian Care Home is situated in the Nottinghamshire town of Mansfield. The service is registered to provide accommodation for a maximum of 44 people, who require nursing or personal care on the premises. There is always a nurse within the home and they are also registered to provide Diagnostic and screening procedures and Treatment of disease, disorder or injury. At the time of our inspection, 37 people were living at Woodleigh Christian Care Home.

At the time of our visit the service did not have a registered manager in place. However the manager was progressing through the application process to become registered with CQC. The previous registered manager left the service in May 2016. 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 to people's safety were not always identified and managed and assessments intended to minimise the risk of harm were not always effective or updated when required. The building was well maintained and regular environmental safety checks were carried out.

People did not always receive care and support in a timely way as sufficient numbers of suitably qualified and experienced staff were not always available. Appropriate pre-employment checks were carried out before staff began work at Woodleigh Christian Care Home.

People did not always receive their prescribed medicines when required. Medicines were not always stored safely and records of available stock were not always accurate.

Staff knew how to protect people from harm and referrals were made to the appropriate authority when concerns were raised.

Staff received training and support to enable to meet people's needs but they did not always have the time and opportunity to do so. Ongoing training and assessment for care staff was scheduled to help maintain their knowledge.

Evidence that people had given consent to any care and treatment provided was not always available. Where they did not have capacity to offer informed consent their best interests and rights were not always protected under the Mental Capacity Act (2005) as thorough assessments were not always carried out.

People's wishes regarding their care and treatment were respected by staff.

People were not always supported to have sufficient food and drink to help them maintain healthy nutrition and hydration. People had access to health professionals, however, the service was not always proactive in making referrals and requesting input when required. Staff followed their guidance to ensure people maintained good health.

People were generally treated with dignity and respect, however we noted a number of occasions when people's dignity was not protected. We observed limited opportunities for positive interactions between staff and noted that staff seemed to be task driven in their approach to ensure they were able to meet peoples basic needs.

People did not always receive personalised care that was responsive to their needs. Care staff had an understanding of people's care needs but could not always ensure that the care was provided at the right time. They knew how to raise an issue and were confident these would be listened to and acted on.

There was an open and transparent culture at the service. People, their relatives and staff were encouraged to have their say on their experience of care and their comments were acted on. Quality monitoring systems were in place to identify areas for improvement however these were not effective as their findings were not always acted on.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Sufficient numbers of skilled and experienced staff were not always deployed to meet people's needs.

People were not always supported to maintain their safety as risks were not adequately assessed or managed to reduce risk of harm

People did not always receive their medicines when required. Medicines were not always stored safely and records were not always accurate.

People were protected from the risk of bullying and abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to maintain healthy nutrition and hydration.

Where people lacked capacity to make a decision about their care, their rights and best interests were not always protected as adequate capacity assessments were not always carried out.

The service had not applied for authorisation to deprive people of their liberty to leave the service when required.

Staff did not always receive support and training to help them meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect although generally their privacy was not always protected.

People were not always involved in the design and review of their care.

Staff did not have sufficient time allocated to spend time with people to help provide positive support and companionship.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care people received was not personalised and support was not always responsive to their needs.

People did not always have access to meaningful activities that they enjoyed.

People and their relatives felt able to raise a concern or complaint and were confident it would be acted on. However, where complaints were made they had not always been investigated appropriately

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems were in place but they were not always used effectively to identify improvement at the service.

There was an open and transparent culture in the service.

People who use the service, their relatives and staff were encouraged to give feedback about the service and their feedback was acted on.

There was a clear management structure in place, however, people did not always know who the manager was.

Woodleigh Christian Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 September 2016 and was unannounced.

The inspection was carried out by two Inspectors. Prior to the inspection, we reviewed information we held about the provider including reports from commissioners (who fund the care for some people) and notifications we had received. A notification is information about important events which the provider is required to send us by law.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people who used the service. We also spoke with seven members of staff including; carers, senior carers, nurses, the manager and the care quality manager. We observed staff delivering care, reviewed four care records, six medicine administration record (MAR) charts and looked at the recruitment files of four members of staff.

Requires Improvement

Is the service safe?

Our findings

None of the people we spoke with said they felt enough staff were employed to meet their needs and they all felt this had a negative impact on the care they received. One person said, "There's not enough staff, I have to wait to get up and wait to go to bed." A second person told us, "There are not enough staff. I'm left waiting for what feels like a long time, especially mornings, I call my bell and there just aren't people about." A third person told us, "Staff don't come quickly. I use my call bell it can be half an hour." Another person said, "I sit and wait until staff can get me up, could be half an hour, an hour." A further person commented, "There's not enough staff, if someone is unwell, everyone else is left on their own." Two further people told us they experienced delays in staff responding to call bell requests. "I pull those bells so many times they could break into bits. You have to wait to go to bed, sometimes you wait over an hour to go the toilet, day, night, anytime." The other person commented, "I'm not sure if it's a call bell or just a button to press." A further person told us, "If I could change just one thing, it would be to have more staff."

This opinion was echoed by people's relatives and the majority of staff members we spoke with. One person's relative said, "(My relative) needs two people to take them to the toilet but it's difficult finding staff that aren't busy. We've noticed (in communal areas) that people have a long wait to go to the toilet. You can be sat in the lounge and not see a member of staff and all the people are desperate to go to the loo and asking me."

We saw that one person had submitted a written complaint regarding the lack of staff available which had also been raised by a person's relative. The complaint stated that the person had been left in need of the toilet and sat in soiled clothing as no staff were available. We did not see evidence of the provider or manager's reply to this complaint and the provider confirmed they had not yet done so. Following this inspection the provider told us they had discussed this informally with the local safeguarding board and the complainant although we did not see evidence of these discussions.

One member of staff told us, "No (we've not got enough). Mornings are worse but each day is different. When someone rings in sick we haven't got enough staff. We work our socks off, we just really need more (staff)." A second member of staff said, "No, I think we could do with more, specifically on the morning shift because it seems such a rush. People (staff) don't get a break until very late." However some staff members felt there were enough staff on duty to meet people's needs. One staff member told us, "There's always going to be possibilities where you need more. We have enough staff for the residents we have. It's ok as long as we work as a team." A second staff member said, "Yes, I think we are over staffed." A third staff member said, "I do think we cope and manage with the staffing levels." We looked at the staffing rota for the two months preceding our inspection and saw that the staffing levels identified by the provider were achieved for every shift. The manager told us they used a process for setting staff numbers which was based on the dependency needs of people using the service. We saw that the provider and manager had instigated different shift patterns and an on call carer system to attempt to ensure sufficient numbers of suitably qualified staff were available on each shift. However, people's feedback during inspection showed this did not always happen.

The provider had processes in place to ensure staff employed at Woodleigh Christian Care Home were of good character and had the necessary skills and experience to meet people's needs. We looked at the recruitment files of four of the 47 members of staff. We saw that all contained evidence that the provider had carried out all appropriate pre-employment checks including references from previous employers, proof of

identity and a current DBS Check. A Disclosure and Barring Service (DBS) check allows employers to make safe recruitment choices.
At the time of our inspection, the provider was in the process of updating care plans to a new system. We looked at both versions of these care plans and found that Information about how to reduce the risk of injury and harm was not always available. The assessments we saw did not always include adequate information for staff on how to manage risk and for some we did not find evidence that they were reviewed regularly or when required due to a person's needs changing. For example, one person's care plan identified they were at risk of losing weight. We did not see any evidence of guidance for staff on how to reduce this risk. Where the record showed the person had lost weight no actions by staff were recorded and we did not see evidence of involvement or referral to a dietician. A second person had suffered a fall from their bed. We did not see action taken to minimise the risk of further falls or evidence of referral to a falls prevention specialist despite the person falling from bed a second time. The provider's incident records showed that in the six months preceding our inspection visit 116 falls were recorded of which 95 were unwitnessed. This would indicate that measures in place to monitor the service, identify and reduce risk and ensure sufficient numbers of staff were available to meet people's needs were not adequate.
Records of accidents and incidents were kept in each person's care plan. The manager told us they carried out a monthly assessment and audit of incidents to help them identify any trends or concerns to help manage future risks. However, we saw that this had only been completed for June 2016. We found that records of accidents and incidents were not always updated in a timely way. For example, we reviewed one person's care record on the first day of our inspection and noted they had fallen from bed but no injury was recorded. However, on the second day of our inspection we saw that this person had actually sustained a fractured wrist requiring hospital treatment. When we checked the record again we saw the manager had updated it to reflect the actual incident. When challenged, the manager confirmed they had updated the record during our inspection which was 37 days after the original injury.
This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12. Care and treatment was not provided in a safe way as risks to health safety were not always addressed or mitigated.
Care staff we spoke with were aware of people's needs and the support they required to reduce risk. They told us that they had enough equipment and resources to meet their needs.
People told us they felt the building was clean and well maintained. The provider had taken steps to reduce preventable risks and hazards, for example regular fire and gas safety checks were carried out. We saw records that showed regular maintenance of the building and equipment was carried out including portable electrical appliance safety and legionella checks. A maintenance man was employed by the service and staff told us any requests were dealt with quickly.
Most of the people we spoke with told us they felt safe at Woodleigh Christian Care Home. One person said; "Yes I feel safe , staff are understanding and help." A second person added, "It's absolutely brilliant here." However some people expressed concern, stating, "Yes I feel safe, but I'd be happier with more staff with greater experience." The staff we spoke with demonstrated a good understanding of safeguarding procedures including signs and types of abuse and their role in raising a concern. None of the staff we spoke with had had to raise a concern but all were confident to do so and had faith that the senior staff or manager would act on these. We saw that appropriate referrals were made to safeguarding authorities when required. Training records showed that all staff had completed safeguarding training. Staff we spoke with were aware of the services' whistleblowing policy and told us they could raise an issue without fear of reprimand.

The majority of people told us they received their medicines when required and had not experienced any difficulty with this. However one person said, "I was prescribed a cream and I wasn't given it. Then [a staff member] said 'you'll get it soon', but I never did."
The medication administration record (MAR) charts we reviewed included information about the person including a preferred method of administration for medicines and a photograph and date of birth to help

care staff ensure the correct medicine was given to the correct person. Medicines were stored securely in a locked room and the temperature of the room and medicines fridge were monitored. We noted that not all creams and lotions were marked with the date of opening and records of available medicines in stock did not always tally with what was present at the service. Additionally the recording system for administration of controlled medicines was disorganised and could lead to confusion for staff who were not aware of the system used. We noted that in the month preceding our inspection 29 shifts were filled with agency or bank nurses who may not be familiar with the system in use. At the time of our inspection, we did not find any discrepancies with stock levels for controlled drugs. We highlighted these concerns to the nurse on duty and the manager and provider who told us action would be taken to address this.

Members of staff told us they received regular training on the management and administration of medicines. We observed staff administering medicines to people as indicated in their MAR chart. Staff interacted positively with people, explained what the medicine was for and offered encouragement to take the medicine without rushing the person. Where people required their medication to be administered covertly, we saw authorisation was in place from the person's GP. The decision was discussed with and consented to by their relatives. We noted that the provider did not have a protocol in place to guide staff on the administration of medicines given as required known as PRN which are generally medicines for pain relief. The policy for PRN medicines was a form to be completed by staff and included in the person's MAR chart. We did not see any PRN forms completed and three staff we spoke with were not aware of the policy regarding PRN medicines. We saw regular audits of MAR charts were carried out by the clinical lead and checked by the manager. Additionally we saw that the clinical lead carried out regular competency assessment for staff administering medicines.

Requires Improvement

Is the service effective?

Our findings

We found that people were not always cared for effectively because, although staff were supported to undertake additional training that helped them meet people's needs, they did not always have the time or opportunity to put this into practice . People told us they generally felt care staff did not always have the skills and competency to meet their needs and felt the quality of care provided varied. One person who used the service said, "Some staff are kind but they don't have the expertise that they need." A second person told us, "They [staff] do have training but they aren't all on the same level."

However, staff we spoke with told us they had access to enough training to help them meet people's needs and felt it helped them to support people and understand their requirements. One staff member told us how they had attended further training to help them carry out diagnostic tests which would help people receive treatment more quickly. A second staff member said, "They [provider / manager] give the right amount of training for the staff they've got. They've got good policies in place." Records showed that staff had access to a range training sessions to help them meet people's needs. We also saw that staff classed as 'bank', meaning those who did not have set shift patterns or guaranteed hours and provided cover for staff absences, were invited to attend training sessions by the provider.

Staff told us they felt supported by the manager and other senior staff and were able to talk with them and discuss issues. A staff member said, "[The manager] does try, she really does. They are very supportive." A second staff member said, "Nurses are fantastic, nurses are very supportive." We did not find evidence that care staff had received received a face-to-face supervision meeting in the year preceding our inspection. This was confirmed by the manager who told us, "It's something we know we are behind with. We're planning to do them." Senior staff told us they had received one to one supervision meetings and nurses told us they received clinical supervision from the clinical lead but we did not see a record of this. A senior member of staff told us, "I had one [supervision] not long ago, I think they are every six months." All new members of staff undertook a period of induction upon commencing work at Woodleigh Christian Care Home including shadowing experienced staff and role specific training. During our inspection we observed prospective new staff from both of the provider's services attending a training session. Staff told us they found the induction helpful. One person said, "It was very good, very helpful. It was two weeks and gave me enough time to settle in." A second person told us, "I don't think anything prepares you for it [working in a care setting] really, but it was good."

The provider had begun the process of updating care plans to a new system. Part of this process included asking people's relatives to review the plans and provide comments and consent were the person was unable to do so themselves. At the time of our inspection we did not find evidence of people's consent to care and treatment recorded in all care plans.

Where people lacked the capacity to make a decision the provider did not follow the principles of the Mental Capacity Act (2005) (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that staff had received training about the MCA as part of their induction process and that capacity assessments were included in people's care plans. However, we found that the assessments in care plans were generic and did not take into account people's capacity in different areas. We saw that where an initial assessment that a person lacked capacity in one area was identified, this was used for all areas. Assessments we looked at were not personal or specific to the person or their capacity and included the same phrase copied for each area of capacity assessment, giving a blanket assessment of lack of capacity. This restricted the person's ability to have involvement, independence, choice or give informed consent to care and support and all daily activities.

Additionally, on the first day of our inspection we found that the majority of people had not had their capacity assessment updated for some time and mentioned this to the manager and provider. The manager told us, "They were in the old care plans but they aren't in the new ones. It's something we are planning to do." On the second day of our inspection we saw that after we left the service on the first day, 25 records had been amended stating 'Mental Capacity Assessment Performed', including 23 that had been signed by the quality care manager between 9:24pm and 10:42pm." We asked the care quality manager how they performed mental capacity assessments, how long they took to complete and how many they would normally complete in a day. They told us, "It varies [the time] on each resident. It depends if we involve the family, we also ask the resident if they want. We'll ask them questions then go back two hours later and see if they retain the information. They [assessments] come up monthly so we'd only do two in a day. You wouldn't be able to [carry out multiple assessments], it wouldn't be right, I couldn't do that."

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11. Service users did not always provide consent as the provider had not acted in accordance with the Mental Capacity Act (2005)

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our visit no applications to deprive people of their liberty had been submitted. However, when reviewing care plans and incident records we identified a minimum of three people who staff had prevented from leaving the service to protect their safety and numerous incidents when staff had deprived a person of their liberty in order to protect their safety. We highlighted these incidents to the manager who informed us they were not aware a DoLS authorisation was required and told us they would submit these as a matter of urgency.

This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13. Service users were deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

People were not always supported to maintain healthy nutrition and hydration at Woodleigh Christian Care Home. One person told us, "I don't like the food very much", a second person said, "I get enough to eat, but I don't eat much." A third person said, "The food quality is variable" whilst a fourth said, "The food is quite good." We saw that drinks and snacks were available in each communal lounge kitchenette area throughout the day and people and their relatives were encouraged to access these. We saw that staff were aware of people's dietary requirements and endeavoured to support them with this. For example, one person required a low sugar diet to help manage diabetes and we saw that kitchen staff had cooked a cake specifically for them that contained less sugar.

However, we found that people did not always receive the support they required. For example, one person's care record showed they required a softened diet. We saw their lunch time meal consisted of mashed potato and pureed beans. We noted the meal appeared quite dry and the person regularly coughed whilst trying to eat the meal. A second person had a condition which caused their arm to shake which made it difficult to drink from a standard open cup. We observed two meal times during which the person struggled to drink a cup of tea and eat their soup as adaptive cutlery or crockery was not provided. A person's relative told us, "Some of the mugs are so heavy, they can't pick them up empty never mind full." We highlighted this to the manager and provider during our feedback session and they assured us they would take action to address this. One person's relative told us they were aware that their loved one had not received meals as staff were not available to support them. They told us, "I came in…at 2pm and [my relative's] teeth were still in a pot in the bathroom and [their] dinner was cold. I asked if they had had breakfast but they didn't know. The dinner wasn't even cut up and [my relative] was laid flat on the bed." We saw that where people were at risk of losing weight there was no clear guidance or detail in their care plan for staff to follow. When the person began to lose weight we did not see evidence of actions noted in the care plan or a referral to a dietician for additional advice.

We found that fluid charts used to record the amount a person had drunk during a day were not always completed accurately. Charts did not include a recommended amount the person should be encouraged to consume, were not totalled up to reflect what had been drunk and were not signed by a staff member. This is particularly important as care records showed a number of people had developed or were at risk of developing urinary tract infections.

People had access to health professionals and the service was proactive in making referrals and requesting input when required. A relative said, "When [my relative] had a fall, they [staff] were very good, very supportive." A visiting health professional told us, "They [staff] call for assistance in a timely way." However we noted in people's care plans that assistance was not always requested for example we could not find evidence of referral or involvement of the falls prevention team for people with a high number of falls or referral to a dietician for people at risk of losing weight. People's care records showed evidence of appointments with the optician, dentist, chiropodist and district nurse.

Care records showed that when health professionals were involved in a person's care, staff followed the guidance given.

Requires Improvement

Is the service caring?

Our findings

People gave us mixed feedback regarding their relationship with care staff and whether they felt they treated them with care, respect and compassion. One person told us, "Staff are lovely people, they look after you." However another person told us, "Some of the staff are good, others aren't. The newer staff don't always know what they are doing." One person's relative told us, "It's not that they [staff] are not caring, they are just thoughtless."

During our visit, we observed limited opportunities for positive interactions between staff and people living at Woodleigh Christian Care Home. We noted that staff seemed to be task driven in their approach to ensure they were able to meet people's basic needs. We found that the majority of staff displayed a caring attitude and wished to be able to spend more time with people. A staff member told us, "We'd all love to be able to spend more time with people and get to know them better. I'd love to be able to sit and play cards or talk with them but there is always something to do. We've just not got enough staff." A second staff member said, "I love my job, I love helping people. If I can go home and I've made someone smile that's good enough for me."

People received an assessment before they came to the service including recording of their preferences for a male or female carer, support needs, treatment plans and dietary requirements. Staff we spoke with demonstrated a good understanding of people's characters and treated everyone as individuals. They were aware of people's likes and dislikes and how this would affect the care they provided. People's religious and cultural needs were identified and staff endeavoured to meet these through attendance at church services and visits from the services own chaplain and visiting chaplains.

Care records we reviewed included an opening statement indicating the care plan was produced in consultation with the person and their family. We saw that the provider had sent copies of new care plans to people's relatives for comment or amendment, One person's relative told us, "One of the staff told us we need to review the care plan but we haven't done it yet."

At the time of our visit none of the people at Woodleigh Christian Care Home used the advocacy service although the service employed a chaplain who could act as advocate if required.. People were offered the use of advocacy when they first arrived at the service. None of the people had chosen to use an advocate. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People told us they were generally treated with dignity and respect and their privacy was protected. This was confirmed by our observations during our visit. We observed that staff were polite and respectful when speaking with people and always called them by their preferred name. Staff told us they always tried to ensure people's privacy and dignity were protected when delivering personal care. For example, one staff member said, "I always explain to them [people] what I'm doing just so they know what I am doing, even if they can't understand." However, we noted a number of occasions when people's dignity was not protected. For example we saw two people at different meal times were left with food spilt down their clothing for a

number of hours. At lunch time another person was asked loudly by staff if they needed the toilet, when they replied they had gone first thing in the morning, the carer said, "Oh good, then you can wait until after lunch." Not only did this not protect the person's dignity it did not offer the support with basic daily activities. A family member told us, "My main concern is it's a dignity and care issue with going to the toilet. [My relative] shouldn't have to rely on their friend to ask for help."

People's confidentiality was not always protected. The manager told us they used a system called 'light bulb' whereby if a member of staff was discussing people's personal details in public another person would say, 'Does that light bulb need changing' to let them know to be more discreet. However, before and after informing us of this system we observed the manager and other staff discussing people's care needs in communal areas.

People had the opportunity to have undisturbed private time in their bedrooms. We saw that staff respected their privacy by always knocking on doors and waiting for a response before entering. Visitors were able to come to the home at any time.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. Care staff had an understanding of people's care needs but could not always ensure that the care was provided at the right time, for example when providing assistance with personal care or responding to requests for help.

Care plans we viewed were not person centred and used generic language and assessments that did not always reflect the present care and support needs of the person. However, staff told us the new care plan system was an improvement on what had been used previously and felt it gave them an understanding of the person, their needs and personality. A staff member told us, "The new care plans are ok." A second staff member said, "When they are updated they are good."

We looked at the care plans for four of the 37 people using the service and found they did not always contain sufficiently detailed information to allow staff to respond to people's needs. For example, the care plan for a person with a degenerative eye problem did not contain information about how this would affect the way care should be provided. The care plan for a person who had had a hip replacement did not contain any information about how this would affect their mobility or how to manage their pain. This was despite staff caring for this person informing us how they had experienced pain when receiving care from them. Guidance was not available for staff on how to support a person with a plaster of Paris splint to get dressed. This resulted in a staff member forcing the pot into the sleeve of a cardigan causing pain and discomfort. Detail on how to manage urinary tract infections, catheters and PEG feeds was either missing or inadequate in care plans we looked at.

We saw that where a person required regular positional changes to help manage and reduce the risk of pressure ulcers, charts were not updated to reflect guidance. We saw examples where a person's turn chart indicated that on one day they had not been moved for over nine hours and on a second day staff had not recorded any position changes at all after 7am.

Some care plans were reviewed and updated but not with sufficient detail to enable staff to adequately and safely meet people's needs. There was a system in place to ensure that staff were informed of changes to people's planned care; this included a handover of information between shifts and regular team meetings. A staff member told us, "Usually handover lets you know what's going on."

We found that where people required adjustments to be made to help maintain their independence and involvement, these were not always available. For example, people who required them had their hearing aids and glasses, whereas people who required adaptive cutlery did not have these provided.

The provider had instigated a system of support to enable people to take part in additional activities known as 'ambitions'. We saw that designated staff including the chaplain were allocated to the role of 'ambitions' for each shift and had supported people to take part in swimming, trips out, holidays and seeing their families. Photographs and other records showed that people who had taken part in this had greatly enjoyed it and felt it had given them a new lease of life and purpose.

However, beyond the 'ambitions' support, people told us they did not feel they had the opportunity to take part in meaningful, enjoyable activities. We observed the atmosphere in 'chapel lounge' to be very flat and quiet. People were sat in chairs with no interaction with each other and very little interaction with staff beyond receiving support. People told us, "We do things like colouring and bingo and quizzes. They are quite boring." A second person said, "I need more things to do. There's nothing to do at evenings or weekends." A third person told us, "I don't have enough to do. Some activities are things I can't physically do. Activities go up on the board but I can't read it so I have to go and ask someone." However one person's relative told us, "There's always something going on, they find you something to do."

People told us they would be happy to raise an issue or complaint at the service although some told us they did not always feel they were listened to. One person said, "If I was concerned, I'd just speak to the chaplain, I trust her." A second person said, "I made a complaint and felt it was acted on." A relative told us, "They [provider/manager] were very open when we complained. They took on board what we said. I have to admit it has been better since then." However, one person told us, "I complained to the chaplain about the behaviour of a member of staff and they told me just to ignore it." A person's relative said, "When I mentioned to [the provider] about low staffing he just said we have more staff per resident than other homes."

The complaints procedure was displayed in the entrance hall and main communal area of the building. Staff were aware of the complaints procedure and knew how to advise complainants. We asked to see the provider's complaints record since our last inspection which showed that 11 complaints had been received. Complaints concerned a lack of staff, quality of care, information not communicated and recording of daily activities. We saw that not all complaints had been responded to within the timescales indicated in the provider's complaints policy or showed evidence of investigation. Those that had been investigated and replied to showed that a thorough investigation and apology had been shared with the complainant and in the majority of instances they were satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

Staff we spoke with felt there was an open culture at the service and would feel comfortable in raising issues with or asking for support from the manager. One staff member said, "Usually we are able to sort things out straight away, if not we can always go to the manager." A second staff member said, "We can always give and get feedback. Feedback is good, things can always be improved on."

Staff told us they attended regular meetings as a group and were able to raise concerns there. One staff member told us, "We have away days, we talk about what's not so good and what's good. It's a good way of discussing concerns." A second staff member said, "We have away days, it's good because we have to be truthful. They [manager/senior staff] are truthful with us and things get acted on."

Systems were in place to allow people, their relatives and health care professionals the opportunity to give feedback about the quality of the service they received. However, these were not used regularly. The provider had a number of ways of gathering feedback including an annual satisfaction survey as well as staff and resident and relative meetings. We saw that the previous satisfaction survey was carried out in 2014 but unfortunately had a low response rate although the feedback was generally positive. Two resident and relative meetings had been held in the 12 months preceding our inspection. We saw that suggestions from these had been acted on. Feedback from the meetings showed that people were happy with the service they received. Comments included; (about the food) "The portions are a good size, it always tastes nice", and (about the manager) "She is really nice and approachable, her door is always open."

We saw that where people made comments or suggestions these were generally acted on. For example, at the residents and relatives meeting of March 2016, a request was made for 'proper chip shop chips'. We saw that these were provided twice per week following this.

The service had a manager in place who was not yet registered with the Care Quality Commission, although an application to do so was in progress. The majority of people we spoke with knew who the manager was and felt she was always visible and available. One person said, "The manager has recently changed, I know who it is." A staff member said, "The manager cares about the people and she cares about the staff as well." A second staff member said, "She [the manager] is a manager foremost but she is also our friend. [The provider] is approachable too." However, a number of people told us they did not know who the manager was. One person's relative told us, "As a rule you don't see them [manager]. They are out [visible in the care home] today more than normal. They aren't leading from the front it's from behind a desk."

Systems were in place to monitor the quality of service people received through regular auditing of areas such as medication and care planning. However, these were not always completed and were not always effective in identifying areas for improvement. For example, a system was available to analyse trends in complaints but this had not yet been completed. The medication audits carried out by the clinical lead had not identified the concern with recording of controlled drugs or the discrepancy with stock levels of standard medicines. A system was in place to audit falls and incidents but this had only been completed for June 2016 and did not evidence a reduction in the number of falls at the service.

Mental capacity assessments had not been carried out and the care record was amended to indicate they had been. Records of falls and injuries had not been completed in line with the providers policies and protocols and then amended to indicate they had been. This shows the service was not well led and management provided was reactive rather than decisive and proactive in its approach to the quality of care provided.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17. Systems were in place to provide effective governance of the service but they were not always used.

A new role of care quality manager had been created to help raise the standards, monitor the quality of care, identify training for staff and speaking to relatives and residents. They told us, "The main audit I do is the 'lived experience audit' this monitors mealtimes, communication and atmosphere. I speak to at least three residents for this." However, the feedback from people, their relatives and staff during our inspection, indicated that the audit had not yet had an effect in improving the experience of care and support for people living at Woodleigh Christian Care Home.

Regular safety and maintenance checks were carried out including, gas and electrical safety, water safety and checks of portable electrical equipment. Where these identified concerns action was taken immediately and a record kept. The service had achieved quality band 5 (the highest level) and the dementia quality mark from Nottinghamshire County Council. They had also achieved and retained investors in people awards, ISO9001 international quality standard (an internationally recognised quality monitoring mark) for the last 9 years and had been placed in the top four of the National 'Care Home Idol' talent contest for three years.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of service users as the provider had not acted in accordance with the Mental Capacity Act (2005) Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment as not always delivered in a safe way for service users as assessments of risk were not always identified, recorded or mitigated. Regulation 12 (1)(2) (a) (b)

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 Deprivation of Liberty Authorisations were not requested for people who required them. Regulation 13 (5) (7) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for good governance were established but they were not always utilised.

Regulation 17 (1) (2) (a) (b) (c)