# Larchwood Care Homes (North) Limited

# Withy Grove House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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| 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 comprehensive inspection took place on 24 and 27 July 2018. The first day of the inspection was unannounced and the second was announced. At our last inspection of the service in November 2017 we rated it as Good overall.

Withy Grove House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Withy Grove House is registered with CQC to accommodate up to 54 people in two units, each of which have separate adapted facilities. One of the units specialises in providing nursing care to people living with dementia.

There was a registered manager in post at the time of our visit. The registered manager was new in post and had just received confirmation of registration with CQC. 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.

At this inspection we found that Withy Grove House was in breach six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing deployment, the need for consent, person centred care and good governance.

We spoke with the registered manager, the regional manager and the operations manager about the shortfalls we had identified in the running of the service. They were aware of the seriousness of the concerns and took immediate action to begin to mitigate the risks we had identified on the first day of our inspection. This indicated an understanding of what needed to be done and a willingness to engage with us to make the service safer for the people living there. We wrote to the registered provider and registered manager notifying them of the seriousness of our concerns. We requested that they draft an urgent action plan setting out, how they intended to address the concerns in the letter. They should respond to each concern, with a specific time frame for implementing the action, who would be carrying the action out and the action taken to mitigate the risks during the time taken to complete. They did this as requested.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This may lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We spent time in the communal areas of the home and spoke to staff, people living in the home and their relatives. We were told by one relative that they were "Quite satisfied." A person who lived there told us "It's alright." Some relatives told us that they felt they were made welcome when they visited. The service had a programme of activities and supported people to follow their own beliefs. We looked at how medicines were administered and managed within the home. We noted that whilst overall management was satisfactory there were some medicines that had been missed.

Care staff were not always being deployed in the right way and there were occasions when there were not enough care staff available to provide people with the individual assistance they needed in a timely way. There were shortfalls in the support people received to maintain their personal hygiene and to eat and drink and maintain good hydration. People were not always well supported at mealtimes to maintain their independence. Whilst some staff took time to try to engage with people not all took up opportunities for interaction with people.

We found that risks to people were not always being well managed, such as risks within the environment, checking equipment, some care practices, recognising safeguarding issues and in record keeping. The provider's lack of effective quality assurance systems meant that issues were not being consistently found and acted on quickly to resolve risk and quality issues.

Providers of health and social care services are required to inform us of significant events that happen such as serious injuries and allegations of abuse. Whilst the provider had dealt with such events appropriately they had not always notified CQC. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process

We found that the service was not acting within the principles of the Mental Capacity Act (MCA) as they were using the most restrictive means available to them to limit a person's liberty rather than the least. It was not always clear that decisions had been made with the involvement of relevant others with the legal authority to speak for someone else.

The care provided was not always person centred in planning care and supporting individuals living with dementia. The service did not have a dementia care strategy setting out how they care for people living with dementia. We made a recommendation that the registered provider finds out more about best practice in dementia care and communicating with people living with dementia and the importance of engaging with people whilst supporting them.

The service had a complaints process and procedure available in the home. We were told by relatives that they did not always feel the complaints process was effective. We have made a recommendation that the registered provider seeks information and guidance on the management of and learning from complaints.

We looked at the staff training records which showed what training had been done and what was required. We could see that the registered manager was trying to make sure that staff received required training and had sourced some additional training to help staff in their roles. Not all staff had received all the up to date training they needed. We found that despite training on areas of practice staff had not always applied them

in practice. We have made a recommendation that the management team look at guidance and best practice on implementing a dementia strategy that supported staff training and evaluates staff training, assesses staff learning needs and the correct application of training given in practice.

Work was underway to improve the environment in the home, this included putting in new windows, getting new furniture and work was due to begin on redecoration in the home the week following the inspection. This should improve the environment for people who lived there and make it more homely and attractive.

The provider had put resources into a staff recruitment programme since the start of the year and taken on new staff. We found that recruitment procedures covered all the appropriate security checks on staff. However, there were still times when sufficient staff were not available to support people with all their needs.

You can see what action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

This service was not safe.

There were serious shortfalls in the arrangements that were intended to ensure that people received safe care and treatment.

There were concerns about the safety of the environment that placed people at risk of harm. Some equipment in use was not being checked to see that it was working properly.

People could not always be sure that there were sufficient staff being deployed with the right information to meet their needs and support them to eat and drink safely.

Overall medicine management was satisfactory but there were some medicines that had been missed.

There were suitable recruitment procedures in place that helped to make sure suitable people were employed.

### Is the service effective?

**Requires Improvement**

The service was not always being effective.

The service was not always acting within the principles of the MCA.

There was a programme of training for staff but the registered provider needed to check training was being put into practice by staff.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Care staff had not been fully supported to provide care in a way that always promoted people's independence and dignity.

We saw some staff interacting with people in a kind and caring manner but some staff did not communicate well with people whilst supporting them.

Relatives told us that they felt they were made welcome when they visited.

## Is the service responsive?

**Requires Improvement**

This service was not consistently responsive.

Assessments of people's needs had been conducted before people moved into the home. However, assessed needs were not always reflected and
guidance was not always followed in day to day practice.

People's care and treatment was not being specifically personalised for them and responsive to their needs.

The service had an accessible complaints procedure but some relatives had not found the procedure effective in addressing their complaints.

People had the opportunity to express their preferences for their end of life care.

## Is the service well-led?

**Inadequate**

The service was not well led.

There were serious shortfalls in the systems and processes used by the registered provider to assess, monitor and improve the quality and safety of the service.

Statutory notifications for some incidents had not been always submitted as required by regulation.

Feedback from families and people living in the home was not being actively sought to get their views on the service.

Staff and management communication needed to be strengthened.

# Withy Grove House

**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.

The inspection team consisted of three adult social care inspectors and a pharmacy specialist advisor.

This inspection was prompted by information sent to us as by receiving five 'share your experience' forms where people shared their concerns about aspects of the service via a link on our website. We were also contacted by members of the public to tell us of their concerns. We were also made aware of safeguarding enquiries being carried out by the local authority and of an incident that was the subject of a police investigation. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks. Information shared with us by the public and other agencies indicated potential concerns about the standards of care, the management of risk, safeguarding people, especially regarding nutrition and hydration, the levels of staff and management oversight and quality monitoring

We checked all the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with five people using the service and six visitors. We spent time observing people's care and how staff interacted with them. Some people had communication difficulties or dementia and were not able to communicate with us easily. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with six members of staff, we spoke with senior care staff and two registered nurses, the registered manager, the regional manager, a quality manager and the operations manager.

We looked at the care records for ten people who used the service and 12 medication records. We also examined other records relating to the management and running of the service. These included five staff recruitment files for new staff, training records, and supervisions. We looked at the staff rotas, complaints,

incidents and accident reports and quality monitoring audits.

We also used a planning tool to collate all this evidence and information prior to visiting the home.

Inadequate

# Is the service safe?

## Our findings

We spoke to staff, people living in the home and their relatives. We were told by one relative that they were "Quite satisfied" with the home and felt that their relative was safe living there. Relatives also told us that, "There seems to be enough staff but there been the odd time we've come in in the evening and there is less staff about then." We were told, "The bedroom doors are locked because of people wandering in and there aren't enough staff to keep an eye out." One relative told us, "There does always seem to be more staff upstairs [residential]."

We made a tour of the premises to look at the areas of environment and looked at maintenance and safety records. We saw that there were obvious environmental risks to people that had not been noted on checks or reported by staff and consequently had not been attended to. There were open wiring panels on the ground and first floor units, there were radiator covers on both units that were not fixed to the walls and a bare wire in one of the communal rooms. This put people at risk of injury and we asked that this be addressed immediately to prevent harm to anyone. The registered manager took steps to address this straight away.

There was a plug protruding from the wall on the first floor that could catch people's feet and therefore created a potential tripping hazard. We noted that window restrictors were in use but that one window in the first-floor dining room had no restriction on its opening. It opened more than the recommended distance of 100mm and this increased the risk to people of falling. Internal maintenance records indicated that all windows had been checked and satisfactory, which was inaccurate information.

Contractors were in the home fitting some new windows to improve people's bedrooms. However, there was no assessment of the risks to people living in the home and how to manage them whilst contractors were on site and within bedrooms as the windows were being removed and replaced. We saw tools, such as hammers and screwdrivers were being used and left out in rooms where contractors were working. We asked the registered manager to take steps to assess and reduce the risks to people immediately whilst the work was going on. The registered manager addressed this as asked.

Some equipment in use was not being checked to see that it was working properly. For example, we saw that mattresses on beds designed to relieve pressure were not always at optimum working pressures. On one bed the battery light was flashing to indicate a low battery but the equipment was still in use. We saw that some daily records had not been completed consistently to record position changes and mattress settings. We stood on one sensor mat in a person's room but the alarm did not activate to alert staff to movement. This put people at risk of skin damage and at greater risk of falling because of poorly performing equipment and unreliable records. One person had a preadmission assessment that stated they needed to be watched as at risk of choking and needed referring to the speech and language team (SALT) but we could not see where this had been done.

Risk assessments for people who lived in the home were not being well managed. We found that appropriate risk assessments had been completed in some cases but not in all circumstances to keep

people safe. For example, people routinely had their bedroom doors locked to prevent other people going into their rooms but there was no risk assessment had been done around this practice to make sure people were kept safe whilst in their bedrooms. There was no assessment of their understanding of the door locks or on their dexterity and ability to open the doors themselves should they need to. This approach to risk management placed unreasonable restrictions on people and did not protect them from harm.

On the first day of the inspection we asked staff to unlock a person's door to speak with them. The person was awake and in bed but had no bell or other means of calling for staff assistance. We returned for the second day of the inspection and were told that overnight a person had fallen in their room whilst the bedroom door was locked and had injured themselves. People were at risk of harm and one person had suffered harm. We made sure the registered manager put new procedures in place regarding keeping people safe in their rooms straight away.

We saw that some care plans did not contain appropriate and necessary risk assessments. For example, we looked at one person whose care plan contained no risk assessment or care plan for skin integrity. This was despite a body map that had identified six areas on the body where there had been some skin damage. We saw an accident record for a person where they had fallen but their falls risk assessment had not been updated following the fall to reflect this. We also noted that the person's sensor mat was not plugged in, as were three others. These mats alert staff to when people move around so they can check their movements and offer support with mobility. Not having these devices plugged in put people at risk from falls and injury. We could not find evidence of an accident report for one person who had suffered a fracture nor evidence of analysis of accidents to help the service learn lessons from things that had gone wrong.

We saw that people were not being adequately risk assessed and safely supported to have the correct diet to meet their needs safely and have sufficient fluids to stay hydrated. This put people at risk of receiving an inappropriate diet, becoming dehydrated and at an increased risk of choking. We looked at fluid charts for people living in the home and on one chart the recorded fluid intake for that person was 400 mls of fluid in 24 hours. One person had been admitted to hospital for dehydration and the records of their fluid intake for the previous three weeks showed that insufficient fluid had been given and was not in line with the target amount stated in their care plan. On the second day of the inspection a system had been started to improve the oversight of fluid monitoring and dietary information to help make the system safer. However, a person was readmitted to hospital for dehydration between the first day of the inspection and the second day. CQC raised this as a safeguarding alert with the local authority the day before our second visit.

We saw that people were being given inappropriate diets at meal times and that staff were not clear about what type of diet people should have. This put people at risk, for example, one person who was recorded as needing a 'soft diet' was given beef casserole for lunch. We pointed out to staff that this was not appropriate and they took it away. Staff returned with chicken pie which was not a suitable alternative. We were told by a carer supporting one person that the person had a pureed diet but their care plan did not state that. We saw one person given sandwiches at lunch, although their care plan stated that the person should have a "mashable" diet and thickened drinks. Improvement was required with the communication within the home to ensure people's current dietary and nutritional needs are known to all staff.

We looked at how medicines were administered and managed within the home. We noted that whilst overall management was satisfactory there were some medicines that had been missed. For example, a medicine used in the treatment of dementia had not been given for a period of 13 days and the drug might have to be re titrated to recommence [to measure and adjust the balance of the drug dosage]. This meant the person had not had the treatment prescribed by their doctor and placed their health at risk. We could see that daily notes showed that care staff had contacted the Mental Health Team and GP surgery to follow

this up twice but no escalation had been done to management for urgent action on this treatment.

There were no controlled drugs [medicines liable to misuse] being held at the time of the inspection. The controlled drugs register had been completed although the form of some medication, for example a liquid, a tablet or an injection, was not included for clarity. The register did not have space for the name of the person prescribed a specific medicine and this could lead to confusion if staff were not already familiar with that person's medicines.

Our findings above constituted a breach of Regulation 12 [safe care and treatment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not making sure that the systems, processes and practices within the home provided in a safe way for people living in the home.

Whilst walking around the home we observed that doors to the sluice rooms on both floors had been left unlocked and these rooms contained cleaning and disinfecting liquids. Staff were not in the rooms or in the vicinity and therefore people were at risk of harm. Before we visited we had received concerns raised with about staffing levels in the home from people using our CQC website. We were told that "staffing levels are always low" and that on one occasion there was only one trained nurse and had two carers on duty on the nursing unit where people were living with dementia. We looked at the staff rotas and saw some inconsistencies in staffing levels between nine and twelve staff across the home with most noticeable drops at weekends and with staff sickness.

The service had a dependency tool that it used to assess how may staff were needed to meet the needs of people who used the service. Using this they had increased the number of staff on night duty from five to six. However, we noted on the rotas that there had been an occasion when there were four staff on night duty and another when there were five. On one occasion there were seven staff on night duty. We saw no changes in the dependency of people for the day and night shifts but there were times when the staff levels were altered. This was on different days without any identified changes in the dependency of the people being cared for. This indicated that staffing was being managed according to how many staff were available at any one time rather than because adjustments were needed due to changes in people's needs.

The home was using agency staff to cover gaps in the rota and on night duty but tried to use the same staff for consistency. An agency nurse was in charge on the first day of the inspection and this was the fourth shift they had worked in the home since June. We noted that the morning medication round had started at 8.20am but by 11.40am the nurse still had five people who were still in bedrooms to see to complete the medicine round. This task occupied the entire morning and meant that other nursing interventions people might require would be delayed.

At the time of the inspection we found that care staff were not always being deployed in the right way. This was because there were times when there were not enough care staff available to provide people living there with the assistance they needed in a timely way. There were shortfalls in the support people received to maintain their personal hygiene and to eat and drink and maintain good hydration. We found it hard to find staff on the ground floor unit at times in the morning to assist people to the toilet and found people in the two lounges unsupervised at times throughout the two days of the inspection.

Staff told us, "When we have a bad day, someone has gone off sick or we are down, I don't feel I've done everything I need to do." We were also told, "We need more experienced staff and more products, that would make life better for everyone." We were aware that there had been a high level of staff turnover since the start of the year and that the registered manager was continuing to recruit new staff, some of whom were inexperienced in social care. We were told that more nursing staff were due to start work in the coming

weeks. Agency staff were being used to maintain the minimum nursing levels in the short term.

This was a breach of Regulation 18 [staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the registered provider had not always deployed sufficient experienced staff to make sure that they could meet people's personal care and treatment needs.

We looked at how people were protected from abuse and avoidable harm. According to training records staff had received training on safeguarding vulnerable adults and recognising the signs of abuse and the actions required. We spoke with a staff member who described an occasion when this had been needed and done. However, we found staff had not always recognised incidents that required a safeguarding alert being raised to adult social care. We asked the registered manager to make three referrals under safeguarding procedures to the local authority during the inspection and we raised an alert ourselves. The registered manager told us that they used a triage tool initiated by the local authority safeguarding team to assess if an issue was a safeguarding matter. We were told that this tool was used in the home in relation to incidents that were potential abuse. However, we were shown no evidence of this tool having been used in regard to the safeguarding alerts that should have been made.

This was a breach of Regulation 13 [safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems in place had not operated effectively to prevent people from being at risk of abuse.

The home was in a poor state of decoration and some communal areas looked shabby and uncared for. Some bedroom doors and wood work were significantly scratched and marked. The registered manager provided evidence that a refurbishment plan was in place and work was due to begin on redecoration the following week and new more appropriate furniture was being bought. This should improve the environment for people who lived there and make it more homely and attractive.

We saw that there were plans in place that outlined when to administer extra, or 'as required', medication (PRN) and were in sufficient detail for staff to be able to administer correctly. We did random stock checks for different medication on both floors. All items were found to be correct according to the expected or recorded stock count. Homely remedies stock was suitable and recorded. [ A homely remedy is another name for a non-prescription medicine available over the counter for the short-term management of minor, self-limiting conditions].

We found staff checked temperatures for the medicines refrigerator and storage room, usually daily, and that these were within the acceptable range. We observed medicines being administered safely and that the staff took time to support people. Medicines were stored securely and stock levels were reasonable for the needs of those who lived in the home with only some excess supplement drinks. However, we did find thickening agents for drinks left out in dining areas where they could pose a risk for people loving with dementia if they ingested them.

We looked at the latest fire risk assessment and fire safety policy that had been undertaken by an independent company in February 2018. This new risk assessment had made several recommendations to the registered provider and these had all been carried out to improve fire safety

We reviewed recruitment procedures in the service. We saw application forms had been completed, references had been taken up and a formal interview arranged. The files evidenced that a Disclosure and Barring Service (DBS) check had been completed before the staff started working in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to

work with children and vulnerable adults. This helped to make sure suitable people were employed.

Requires Improvement

# Is the service effective?

## Our findings

People we spoke with told us that the meals were "Okay" and a relative told us "As far as I can see there is always food available, [relative] certainly does not go without." A relative told us. "I don't like [relative] being locked in, no one has ever asked me if they can lock the door." We spoke with relatives who confirmed that bedroom doors were locked and some told us that they had not been involved in any best interest discussions about this.

As we went around the home we observed that people's bedroom doors on both units were kept locked. Staff had a master key to let people in and to let visitors go in to the rooms see them. Staff told us that it was company policy to keep doors locked but that the doors could be opened from inside by people if they wanted to come out. We asked the registered manager why it was necessary to restrict people's freedom in this way. We were told this was to stop other people who lived in the home from going into other people's rooms. We were told that people's relatives had given consent if they could not or that best interests meetings had been held.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was not acting within the principles of the MCA as they were using the most restrictive means available to them to limit a person's liberty rather than the least. These restrictions were also not referenced in people's DoLs. One person who could have their medicines given 'covertly' or hidden did not have this referenced in their DoL's application nor had it been consulted on with a pharmacist.

It was not always clear the decision to lock the door had been made with the involvement of relevant others with the legal authority to speak for someone else. For example, we spoke with a family who told us that they had not been consulted about or asked for their views or permission for the door to their relative's room to be locked with the relative inside. They also said they had not been involved in any meetings to discuss if such action was in their relative's best interests. The care record stated that relatives had been consulted and had a power of attorney. The record was not correct and therefore valid consent had not been obtained.

We noted that some consents had been signed by staff. For example, the consent for photographs to be taken. We also noted that some family members had been asked to give consent when the person themselves could do this. Consent and best interest decisions had not been subject to a review process or audit monitoring of their appropriateness.

We raised these matters with the registered manager and asked them to start to address this straight away.

This was a breach of Regulation 11 [need for consent] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the actions being taken in the home were not in line with legislation and current guidance.

We looked at the staff training records which showed what training had been done and what was still required or being planned. We could see that the registered manager was trying to make sure that staff received all the training required by the registered. Training was being organised and the registered manager was looking at how they could develop the training programme for staff. The ongoing recruitment meant that there were significant numbers of new and inexperienced staff. From speaking with the registered manager and looking at training records we could see that making sure that new staff had completed induction training for their roles had been prioritised. The registered manage had sourced some additional training to help staff in their roles. For example, they had organised for the speech and language team to come to do some training with staff.

However, not all staff had received up to date training in how to manage people who could be verbally and physically challenging.  As the service was accepting people with complex mental health needs staff needed to skills to meet their needs. The service and the unit for people living with dementia did not have a strategy on how to support those people living with dementia. A dementia strategy is usually based on nationally recognised best practice, including the philosophy of care and approach to people living with dementia, adaptation to the environment, activities and staff training and skills needed. Staff working in the unit for people living mostly with the effects of dementia did not have any additional specialist knowledge or skills than the rest of the staff team to support people living with dementia.

Training records indicated that staff had been given training on 'Fluids and Nutrition' although we did not see evidence that this was being put into practice as record keeping was poor and we saw staff gave drinks to people but did not assist them to drink. Relatives we spoke with told us this was something they had experienced and that when they visited their relatives during the hot weather they would often drink large amounts of fluids when they assisted them to take them.

Staff told us that they felt they were "up to date" with training, knew that they had to complete on line training and had recently done moving and handling training, fire and first aid training. We recommend that the management team look at guidance and best practice on implementing a dementia strategy that supported staff training and evaluated staff training to assess learning needs and the correct application of the training given in practice.

Requires Improvement

# Is the service caring?

## Our findings

Some relatives told us that they felt they were made welcome when they visited. Some people and their relatives were complimentary about the staff team and told us they [staff] were "really nice" and "very friendly" while others had a less positive view. We were told that, "They [staff aren't interested" and "don't want to take the time they need." We asked people living there and relatives if they felt there was anything they would like to change about the service to make it better for them. One relative told us, "If I could change anything it would be that [relative] gets loads of clothes that aren't theirs to wear, once [relative] has someone else's watch on and glasses."

Some people found it hard to talk with us about their views on the service so we observed how people in the home were being supported by staff and how they were spending their time during the day. We sat in the dining area at lunch time and in lounge areas, throughout the day with people who were living with dementia. We looked at how staff were supporting and interacting with people who lived in the home.

Some of the arrangements for the lunchtime meal we observed taking place in the dining room did not support people to fully enjoy a relaxed and dignified experience. During our observations at lunchtime we noted some staff did not give people individual attention to help them enjoy their meal. Some people living with dementia stood from the table and walked around and we saw their meals removed without making sure they did not want to return and continue eating. One person asked us to help them as staff had put a cake down in front of them but did not assist them to eat it. on.

Some people clearly struggled to eat independently and 'chased' their food around their plates and on the table with a fork. Such people would have benefitted from the use of aids such as plate guards and adapted cutlery to help them be more independent and be able enjoy their food. We asked a staff member to help one person who was clearly struggling to eat their meal. Staff put protective aprons over people for lunch but did not always ask or explain why they were putting them on and we saw people still wearing these long after lunch was over. These things did not promote people's individuality and dignity.

We observed that some staff were not always taking up the opportunity to chat and interact with people but went from one task to another. In the lounges we sat with people living with dementia, some of whom were asleep. There were no staff present but the television was on. The people just sat there with nothing to do, although a staff member did come in and ask if everything was okay or if anyone wanted to go into another room.

We recommend that the registered provider finds out more about additional training for staff on best practice in communicating with people living with dementia and around the importance of talking and engaging with people whilst supporting them.

During the inspection we also observed some examples of good practice with some staff interacting with people and including people in conversations. We saw occasions when staff displayed empathy and kindness as they comforted people when they became distressed or as they helped them around the home.

We looked at the arrangements in place to ensure equality and diversity and that support was provided for people in maintaining important relationships. People had been supported to maintain relationships that were important to them with their family and friends.

We saw that people had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items and photographs around them. People could spend time in private if they wished to. Relatives told us they had to ask staff to unlock doors for them to go into their relative's rooms.

Requires Improvement

# Is the service responsive?

## Our findings

Family members we spoke with felt they were not being fully involved in planning the care and support of their loved ones and they had not been asked to be involved at care plan reviews. One person told us, "I have never been invited to any meetings at all." Relatives told us about activities in the home and that it was not always easy to get people to be involved. One relative told us, "They [relative] have lost interest really. I know they do stuff like play dominoes but don't know what they have been doing today."

We looked at how the service provided person centred care. We did not see that the home was making use of current best practice best in dementia care such as that from NICE (National Institute for health and care excellence) 'Guidelines on Dementia' and environment to ensure the home was 'dementia friendly' and would meet the needs of people living with dementia. The service did not have a formal dementia care strategy setting out the philosophy of how they provide person centred care for people living with dementia and how this was to be met through staff training, adaptation of the environment and suitable activities.

Pre-admission assessments had been carried out and were of a variable quality and information had not always been transferred into the care plans. For example, a need to refer a person to a speech and language therapist noted on the preadmission assessment. Was not carried forward to the care plan. Some assessment records were not dated and body maps were not always completed when people were admitted.

Daily records were in place to demonstrate the care provided to people but these had not always been completed. We observed that people's care plans did not always cover all their needs. For example, one person had a fractured wrist with a back slab on but they had no care plan in place to show how it was to be managed or the injury monitored.

People's care plans had been reviewed and changes had been recorded, although improvements were required in providing handover records to better reflect people's current clinical needs. On day two of the inspection the registered manager had made changes to the handover sheet and implemented a system with improved clinical information. This would need time to embed with staff using it. The registered manager had started to review care plans and this was intended to help make sure that care plans had clearer instructions for staff to follow. Some care plans had been rewritten but had not included all important information such as on skin integrity, life stories and social and leisure activities.

We noted that there were mental health strategies in care plans to guide staff on supporting people and on how to manage distress but we did not see staff always following these in practice. For example, one person had a plan to help staff support them with a behaviour but we did not see the actions advised being carried out by staff. From speaking to staff and observing how they supported individuals we saw that the staff did not always have a detailed level of knowledge about the needs of people who were living at the home to always give the support they needed. For example, contradictory information on their dietary needs and support at meals.

These indicated there was a breach of regulation 9 [person-centred care] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care and treatment was not being specifically personalised for them and responsive to their needs.

The home had an activities coordinator in post and staff were taking people, who could, out into the garden on the first day of the inspection so they could enjoy the fine weather. We saw photographs of activities that had taken place and that people had participated in. Relatives told us about celebrations for the 'royal wedding' and the summer garden party that everyone had enjoyed. There was a planned activities schedule, that included themed musical events for different types of music and the hairdresser visited twice a week. People could follow their own faiths and beliefs. We spent time in the lounges during the two days and noted that less physically able people and people who were living with dementia might have benefitted from more one to one activities to engage them.

The service had a policy and procedure regarding how to make a complaint policy that was displayed within the home. This outlined the procedure people needed to follow, should they wish to make a complaint. Systems were in place for recording any complaints received. Some people who used the service and relatives knew how to make a complaint or raise issues others were less sure. Some relatives told us they would not be comfortable making a complaint. We were told by some relatives that they did not have confidence in the way complaints were dealt with and did not feel their complaints made any difference. Other relatives we spoke with told us that they had no complaints to make. We recommend that the registered provider seeks information and guidance on from a reputable source on the management of and learning from complaints.

Some people living in the home had expressed their preferences for end of life care. Information regarding resuscitation was indicated in their care plans and the staff were aware of these. The registered manager told us that people and families were often reluctant to talk about advance care planning [discussions between people and their families about their future wishes and priorities for care]. Training records did not have evidence of staff receiving formal training in end of life care. The registered manager said they realised the importance of this area of care and support and had already started to look at how to approach this sensitive subject and to record in detail people's advanced wishes at the end of life.

Inadequate

# Is the service well-led?

## Our findings

Relatives told us that the new registered manager was "Very nice" and that she had made appoint of introducing herself to people and relatives. Staff told us "The new manager gets out and about on the floor" and also "Sometimes I feel supported and at other times feel like I am talking to a brick wall."

There were systems in place to monitor the quality of the service at Withy Grove House however these systems had failed to identify or to address in a timely way the areas of concern identified at this inspection. These included concerns with risk management, obtaining consent, the environmental risks, staffing deployment, and with the individual support being provided to people who were vulnerable. Whilst the home had a registered manager they were new into post and taking stock of the situation within the home. However, we noted that regional management had been visiting and overseeing quality and safety matters during the period when there was no registered manager in post. They had not noted the shortfalls found at this inspection when they were carrying out their visits and monitoring checks. Any delay in the registered provider picking these issues up and taking remedial action affected the people who lived in the home. This meant that people living in the service had been at risk of unsafe care and treatment.

Accidents and incidents were not being consistently reviewed by the registered manager to identify any patterns or themes that needed to be addressed or lessons that needed to be learned. Providers of health and social care services are required to inform us of significant events that happen such as serious injuries and allegations of abuse. Although we had been sent some notifications about these when they had occurred, during the inspection, we found six incidents that we had not been notified about. This meant that CQC could not check that appropriate actions had been taken. The failure to notify us of matters of concern as outlined in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 and this is a breach of the provider's condition of registration. This will be dealt with outside of this inspection process.

We noted that staff and management communication needed to be strengthened as we found that staff were not always escalating issues up to management level for action. For example, staff had not brought to management attention for urgent action the situation when a person did not have their medication for 13 days, also the environmental dangers they should have seen daily as they went about their work.

We found staff also lacked formal support and guidance on how to support people living with dementia. We observed a meal time where some staff exhibited little understanding of the complex needs of people living with dementia. Monitoring of staff understanding of training received and their ability to apply knowledge competently in practice was absent especially in was regard to fluids and nutrition. This was important given the number of new and inexperienced staff working in the home.

This is in breach of Regulation 17 [good governance] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Governance management was not always reliable and effective.

Staff we spoke with told us their morale was low and there had been many changes within the service. We asked if they felt the provider acted on staff concerns and were told "Sometimes I feel supported here and

at other times feel like I am talking to a brick wall. " We were told by staff that a lot of staff had left and some often called in sick. We were told "We have been under pressure but the new manager has told us things will improve." We looked at the minutes of the last three staff meetings and could see that the registered manager had been persistently raising issues with staff about where improvement was needed. Staff sickness was being addressed formally by the registered manager and training was being monitored to make sure staff were doing this on line. It was clear from the issues the registered manager kept returning to at staff meetings about documentation, record keeping, not giving care as planned and not working as a team that they were trying to tackle these things with staff. It was evident that the registered manager was trying to develop a better working culture in the home and raise the standards amongst staff. This was presenting a challenge but the registered manager had started this difficult process and required support and resources to continue it.

We did not see any records of meetings for the people who lived in the home and their relatives and friends or any recent surveys about care and service provision in the home. Relatives we spoke with told us they had not been invited to any meetings with their family members in the home. They told us this would be good as they had ideas about what needed to improve.

We spoke with the registered manager, the regional manager and the operations manager about the shortfalls we had identified in the running of the service. They were aware of the seriousness of the concerns and took immediate action to mitigate the risks we had identified on the first day of our inspection.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered provider was not doing everything reasonably practicable to make sure that people who lived in the home always received person centred care and treatment and were not working collaboratively with families and relevant others. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider had not made sure that the practices within the home to underpinned valid consent and were always in line with the requirements of the Mental Capacity Act 2005, associated codes of practice and the Deprivation of Liberty Safeguards. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider was not making sure that the systems, processes and practices in use in the home were being effective in preventing people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. This was because -<br><br>The registered provider had not ensured that systems and processes within the home made sure that the premises and all equipment used by the service were safe for their intended |

purpose.

The registered provider had not ensured that there were systems and processes being consistently used to assess the risk of harm to the health and safety of all the people living in the home.

The registered provider had not put systems in place for making sure relevant fluid and dietary risks were assessed so people could be safely supported to have the correct diet to meet their needs and have sufficient fluids to stay hydrated.

The registered provider had not made sure there were effective systems in place to endure that there were always sufficient quantities of medicines people needed to meet their needs.

The registered provider was not ensuring that staff were being deployed within the home to meet the diverse needs of people living in the home.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered provider had not made sure that systems and processes were operating effectively to make sure that people who used the service were always protected from improper treatment and abuse. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not ensured that effective systems were in operation to assess, monitor, mitigate risks and improve the quality and safety of services being provided. |

| Regulated activity | Regulation |
| --- | --- |

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had not always deployed sufficient experienced staff to make sure that they could meet people's personal care and treatment needs.