Tulip Care Limited

Woolston Mead

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and took place on the 24 and 25 February 2015.

Woolston Mead was inspected on 21 August 2014 and found to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Satisfactory improvements had not been made and we found a continued breach of Regulation 9. The Care Quality Commission (CQC) did not receive an action plan from the provider to outline how improvements would be made.

Woolston Mead care home is situated in a quiet residential area and is registered to provide accommodation and personal care for 28 people.

Accommodation is provided on four floors with two lounges on the ground floor and a dining room in the basement. A passenger lift and stair lift provide access to all areas of the home. The home is located close to local amenities and transport links.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was in the process of deregistering and a new manager had recently started at the home and planned to apply to register.

Summary of findings

People told us they felt safe living at the home. Staff were aware of what to do if they were concerned that a person living there may have been abused. Over half the staff team had not received training in adult safeguarding. The safeguarding policy was not reflective of local safeguarding procedures. You can see what action we told the provider to take at the back of the full version of this report.

Both staff and people living at the home said there was sufficient staff on duty at all times to meet their needs. Staffing levels had been increased at night recently. The manager was in the process of recruiting a housekeeper and activities coordinator.

Effective staff recruitment processes were in place. All the relevant recruitment checks had been undertaken to ensure new staff were suitable to work with vulnerable adults.

Controlled drugs were not always stored securely and second signatures were missing from the records when controlled drugs had been administered. You can see what action we told the provider to take at the back of the full version of this report.

People's risk assessment and care plans did not always reflect their current needs. Assessments and care plans had been regularly reviewed but people's changing needs or increased risk had not being taken into account as part of the review. You can see what action we told the provider to take at the back of the full version of this report.

There were gaps in staff training but the manager had organised training to take place over three days in March 2015. The approach to staff supervision and appraisal had been made more robust since our last inspection and staff confirmed they had received supervision from the manager.

Changes had been made to the menus recently and overall people were happy with the meals. We observed staff supporting people in an engaging and warm way with their meal if they needed it. Drinks were available throughout the day.

Staff sought consent from people before providing personal care. However, staff had not received awareness training regarding consent and mental capacity. They had a limited understanding of how it applied in practice. Mental capacity assessments were completed in a generic way and were not specific to the decision the person needed to make. Restrictions were in place for a person to minimise their risk of falling but this had not been agreed in accordance with the principles of Mental Capacity Act (2005). You can see what action we told the provider to take at the back of the full version of this report.

People had access to a range of health care practitioners when they needed it.

We observed staff supported people in a kind, caring and unhurried way. Personal care activities were carried out in private. A keyworker system had recently been introduced.

The manager was promoting a person-centred culture and this was starting to have a positive impact for staff and people living at the home. We made a recommendation about this.

A complaints process was in place and an easy-read leaflet was displayed in the foyer advising people what to do if they were concerned about anything.

Regular meetings with people living at the home and their relatives had started in December 2014. Suggestions people made and any feedback about the service had been actioned by the manager.

Structures to monitor the quality and safety of the service had been made more robust since our last inspection. An overarching quality monitoring tool was being used each month to monitor the service. Medication audits were established and medicines were checked weekly and monthly. Staff meetings had started and they were being held each month.

A health and safety policy had been developed for the home and environmental risk assessments had been undertaken. Policies and procedures were in place but a number of those we looked at were not reflective of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People told us they felt safe living at the home.

Although staff were aware of what to do if they were concerned that a person living there may have been abused, most of the staff team had not received training in adult safeguarding. The safeguarding policy was not reflective of local safeguarding procedures.

There were enough staff on duty at all times to meet people's needs. Effective recruitment processes were in place.

Safeguards regarding the management of controlled drugs were not being adhered to. The medication policy was not reflective of how medicines were managed at the home.

People's risk assessment and care plans did not always reflect their current needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People had access to health care when they needed it, including their GP, district nurse, optician and chiropodist.

Staff supervision and appraisal was up-to-date. There were gaps in the staff training but the manager was addressing this.

People living at the home were satisfied with the meals. Adequate support was provided for people at lunch time to ensure they had sufficient to eat and drink.

Staff had limited knowledge about the Mental Capacity Act (2005) and how it applied in practice.

Is the service caring?

Good

The service was caring.

Staff were caring and kind in the way they supported people. They treated people with dignity and respect. They ensured people's privacy when providing support with personal care activities.

People could have visitors when they wished.

Although not well recorded, people were involved in discussions about their care.

A keyworker system had recently been introduced by the manager.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

People living at the home had choice about how they spent their day but we found people had passively 'fitted into' the routine of the home. The manager was promoting a person-centred culture and this was starting to have a positive impact on the service.

People told us they knew how to raise any concerns or complaints about the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

A new manager had started at the home and intended to apply to be the registered manager once the current registered manager had applied to deregister.

Staff spoke positively about the changes the manager was making.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Quality monitoring processes for routinely monitoring the quality of the service had been strengthened but it was too early to determine the impact this was having.

A number of operational policies we looked at were not reflective of the service provided at the home.

Woolston Mead

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 unannounced inspection was undertaken on 24 and 25 February 2015. The inspection team consisted of an adult social care inspector and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We usually ask the provider to submit a Provider Information Return (PIR) prior to the inspection but we had not asked for a PIR prior to this inspection. A PIR 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.

We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service and environmental health to see if they had any updates about the service.

Over the two inspection days we spoke with five people who lived at the home and two friends of a person who were visiting at the time of our inspection. We spoke with the registered manager, a new home manager who had recently started working there, three senior care staff, five care staff, and the chef.

We looked at the care records for four people living at the home, four staff recruitment files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, dining rooms and lounge areas. We carried out a Short Observational Framework for Inspection (SOFI) as some people were unable to verbally share their views about the home with us. SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication needs.

Inadequate

Is the service safe?

Our findings

The people we spoke with consistently told us they felt safe living at the home and that staff treated them in a respectful way. A person said to us, "I feel safe here; you can't get better than this." Another person told us, "I'm happy I decided to come here. I feel safe." Throughout the inspection we observed staff supporting people in a discrete and safe way. Staff spoke to people in a kind way whilst supporting them.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential was reported. They said they would inform the manager of any concerns. We could see from the training records that over half the staff team required training or refresher training in adult safeguarding.

An adult safeguarding policy was available and accessible to staff. However, the policy made reference to Central Bedfordshire and Liverpool Safeguarding Adults Board but made no reference to the local safeguarding procedure for Sefton. This meant the policy was not reflective of the local arrangements for adult safeguarding.

By not making suitable arrangements to ensure people were safeguarded against the risk of abuse was a breach of Regulation 11(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who lived at the home told us there were enough staff on duty at all times. They also said staff responded in a timely way if they rang the call bell. A person said, "I think there are enough staff to look after the people here." Another person told us, "The staff are very good and manage to do everything that needs to be done for me." Both relatives and staff we spoke with said the number of staff on duty was adequate to meet the current needs of the people living there.

We looked at the personnel files for two recently recruited members of staff. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff. We spoke with a member of staff who was recently recruited. They confirmed that they did not start working at the home until all the required recruitment checks had been completed.

Staff told us they were up-to-date with their medication training and that other staff who administered medication had received training also. The manager provided information to show that further training had been arranged for the staff who were responsible for managing the medication.

A member of staff provided us with an overview of how medicines were managed within the home. The medication was held in a locked trolley in a dedicated lockable room. The medication was administered from the trolley to people on the ground floor. Staff told us the trolley could not be supported in the passenger lift so medication was transferred to a hand-held for box for staff to administer to people on the other floors. We looked at the medication administration records (MAR) and noted a small number of missing signatures where staff had failed to sign to say they had administered medication to people. The missing signatures were being addressed by the manager as she had identified this deficit in a recent medication audit. Body maps were used to show where topical creams should be applied. The MARs or care records contained no information to show that people who lacked mental capacity had consented to their medication being managed and administered by staff.

Medication requiring cold storage was kept in a dedicated medication fridge. Although the fridge temperatures were monitored daily, we were not confident about the accuracy of the fridge thermometer. The manager agreed to replace the thermometer.

We found controlled drugs on top of the fridge. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. They are required to be stored safely in a dedicated cupboard fixed to a wall. We checked the controlled drug administration record book and noted occasions when a required second staff signature was missing even though the controlled drugs had been administered. This meant the safeguards in relation to the management of controlled drugs had not been followed.

The nationally recognised medication reference book (referred to as the British National Formula or BNF) available for staff was dated 2011. This would not provide up-to-date information as the BNF is produced twice a year

Is the service safe?

to ensure the information about medicines is current. Although this reference book can be accessed electronically, not all staff who worked at the home had access to the computer.

We looked at the home's medication policy. It was last reviewed in September 2013. The policy was not reflective of the nature of care provided at the home as it made reference to terms, such as the 'Kardex', and referred to registered nurses administering medication. Registered nurses were not employed at the home. We also noted the policy did not capture all the guidance outlined in the NICE guidance for managing medicines in care homes. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care.

Not ensuring safeguards were in place for the safe management of medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We arrived at the home at 6.59am and the door was not answered by a member staff until 7.12am. We could see through the glass door that staff were not available on the ground floor for the 12 minutes we were waiting even though some people who lived at the home were up. We looked at the care records for one of the people who was up. The person was at risk to falls and an incident report showed the person had fallen in the lounge on 16 December 2014 at 7.35am. The person's care plan titled 'Safe environments' stated, '[person] to be supervised at all times to reduce risk of falls'. This meant staff were not following the care plan and the person was at risk of receiving care that was unsafe. The manager confirmed that a member of staff should monitor the two lounges on the ground floor when people are up.

Although individual risk assessments and associated care plans were regularly reviewed, we identified a number of examples whereby they were either inaccurate or not effectively revised in response to people's changing needs. For example, a person was assessed by a speech and language therapist (SaLT) in June 2014 and advised to have thickened fluids because of a risk of aspiration when eating and drinking. A 'Kitchen notification' form from June 2014 stated the person refused to have their drinks thickened. The person's nutritional care plan was reviewed in January 2015. The care plan stated 'Due to signs of aspiration [person] will require syrups to thicken any drinks'. Given the conflicting information, we discussed the matter with of the staff who confirmed the person had not had thickened drinks since June 2014. Despite being reviewed recently, this meant the care plan was inaccurate.

As a further example, we saw that a person's risk assessment and care plan, which was reviewed in February 2015, highlighted that the person displayed challenging behaviour towards staff in the form of verbal aggression. An incident form had been completed on 22 January 2015 detailing how the person had physically assaulted a member of staff. The member of staff confirmed this incident took place. Although the care plan was reviewed after the incident, it remained unchanged and this meant the review did not take into account the incident and the changing nature of how the person displayed behaviour that challenges towards staff.

Not having effective arrangements in place to ensure people were protected from unsafe care and were appropriately assessed in response to increased risk or changes in their needs was a breach of Regulation 9(1)(a)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The environment was assessed by the local Council in December 2014 and a number of legal requirements were identified in relation to current health and safety legislation. The manager confirmed that the requirements had either been completed or were in the process of being addressed. We had a look around the building and the manager showed us some of the work that had been completed. An internal stairwell was located near to bedrooms and was not secure. It could present a risk to falls. We were concerned about this as the stairs were steep with turns. The manager arranged that day for the stairwell to be made safer. The manager provided us with information to confirm that a health and safety policy had been developed and risk assessments had been undertaken for various areas of the premises.

A range of checks related to the environment and equipment were routinely carried out. These included water safety checks, portable appliance testing, gas safety and bedrail checks.

Whilst looking around the building we noted that staff had not followed the colour coded mop system. Specific coloured mops and buckets were in place for various areas of the building in order to reduce the spread of infection.

Inadequate

Is the service safe?

We found the blue kitchen mop in the lounge and the green mop bucket for general areas in the kitchen. We raised this with the manager who addressed it with the staff immediately. The manager told us staff undertook the cleaning at night. This was due to change as the manager was in the process of recruiting a dedicated housekeeper for the home.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home told us they had access to medical care when they needed it. A person said, "I've been healthy enough whilst I've been here but I have seen the doctor from time to time." Another person told us, "I've seen the doctor from time to time, when I've not been well. I just ask them and they ring for him to come." Whilst talking with a person they told us, "I have seen the doctor two or three times since I came in here. I had a chest infection and he gave me antibiotics. I've also seen the chiropodist. When I came in I was on a course of physiotherapy. I go to the hospital to the audiology unit. I had my eyes tested recently for new spectacles".

We could see from the care records we looked at that local health care professionals, such as the person's GP, district nurse, chiropodist or dietician were involved with people if they needed it. The care records informed us that staff requested health professional involvement in a timely way. District nurses visited people at the home during the inspection. We also heard staff reporting to the manager if people had any health care needs and we then heard the manager arranging appointments for people by telephone.

We asked people their views of the meals served at the home. One person said, "The food is alright. I suppose they give me a choice and I can eat whatever they give me. I'm not fussy over food." Another person told us, "The food is very good now, I couldn't say if they have a menu, but the quantity of food is enough for me and I get enough to drink during the day". People told us a meeting had been arranged and the food and menus were discussed and they had requested more cooked meals. As a result the menus were altered and people advised us that the meals had improved. A person said, "They [staff] come round in the morning and take my food order for the day. The menu varies now. We had a meeting which resulted in much more resident involvement. I've been to two of the meetings and we talked about the food there". The meeting minutes confirmed that menus had been discussed and changes made based on people's requests and views. Menus were displayed on the notice board in the foyer and the menu for lunch each day was displayed on a chalk board in the dining room and foyer.

At lunchtime some people ate their meal in the dining room, others ate their meal in one of the lounges and some people had their meal in their bedroom. Most of the people who ate in the back lounge needed assistance or prompting and we observed staff providing this support in a caring and unhurried way. They took time to talk and engage with people over lunch. In the dining room most people were able to eat independently. We observed staff promptly offering two people assistance when it was noticed they were having difficulty cutting up their food. Drinks were served at lunch time and throughout the day.

We spoke with the chef during the inspection and were advised that the menus had been changed every few months. New choices had been added to menu, including pizza, spaghetti, garlic bread, jacket potatoes, prawn salad and poached eggs. Meals were cooked from fresh ingredients, although some food was prepared from frozen. Records were kept in the kitchen about people's individual preferences and information about people's special dietary needs was also available.

We could see from the care records that people's weight was checked each week to check for any fluctuation. Any weight loss was monitored and a referral made to an appropriate health professional if required.

All the staff we spoke with said they were up-to-date with the training the home required them to undertake. They also said the new manager had put individual supervision in place. The manager told us the service aimed to facilitate individual staff supervision every month and for each member of staff to have an annual appraisal. The manager confirmed that all staff had received supervision since the manager started in November 2014.

We looked at the training monitoring record. We could see there were gaps in training. The manager advised us that the training record was not up-to-date as a number of staff had left and new staff had started. The manager provided us with email evidence to show that training had been booked over three days in March 2015 for staff in the following topics: first aid; food hygiene; lifting and handling; infection control; dementia care; risk management; fire awareness; equality and diversity; behaviour that challenges; medication and safeguarding adults.

We spoke with a member of staff who was recently recruited. They described a good induction that prepared them for the job. They told us they shadowed a more experienced member of staff for three shifts before they were included in the staffing numbers.

Requires Improvement

Is the service effective?

Throughout the inspection we heard staff seek people's consent before providing care. For example, we heard staff ask people if they wished to use the bathroom or asking people if they would like to join in with an activity. We noted from the care records that a form was in place to seek the consent from either the person or a family member to take photographs of the person and for the sharing of information related to their care. However, these consent forms were inconsistently completed and signed by the person or their representative.

Some people we spoke with clearly had capacity to make decisions about their care needs. We could see that other people most likely lacked mental capacity to make significant decisions. We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) for the people who lacked capacity. This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

Mental capacity assessments were in each of the care records we looked at but these were generic in nature and did not clarify the decision that was being assessed. Generic mental capacity assessments had also been completed for the people who staff told us had capacity to make their own decisions. We observed a person's care plan that began with "Under no circumstances to be allowed to…." The person clearly would have lacked capacity to make this decision yet a mental capacity assessment specific to the issue had not been undertaken and no best interest meeting had been held regarding the decision. This showed that staff had limited understanding about how the Mental Capacity Act (2005) applied to the people living at the home.

We asked staff what they understood about the Mental Capacity Act. Staff said they had not received training in this area and their understanding was limited. The manager advised us that training in the Mental Capacity Act had been organised for March 2015.

A DoLS screening form was in each care record we looked at but the majority were blank. One form had been completed but under the 'best interest assessment' section the following had been recorded, "To help me with choices of food." This misinterpretation suggested staff had limited understanding of what DoLS meant. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

A care plan (reviewed in December 2014) for a person stated, 'To be supervised at all times to reduce the risk of falls.' This implied the person was receiving constant supervision. We asked staff about this and were told the person was a high risk to falls and had a significant visual impairment. Staff said the person does not try get out of the chair much anymore because staff position a table in front of the person, which has helped to prevent the person getting out of the chair. This would be considered restrictive practice under the Mental Capacity Act (2005). We discussed it with the manager who agreed to prioritise applying for a Deprivation of Liberty Safeguard (DoLS) for the person. The manager also agreed to review the risk assessment and care plan to check and clarify whether the person required constant supervision.

Not adhering to the principles of the Mental Capacity Act (2005) was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Good

Is the service caring?

Our findings

People living at the home were satisfied with the way staff interacted with them and said staff treated them with dignity, and respected their privacy. A person told us, “The staff are very attentive. They always knock before they come in and they check on us at night. I’m quite happy with the staff.” Another person said, “They always knock before they come in to help me. I have enough privacy if I want to be on my own.”

Throughout the inspection we observed staff calling people by their preferred name and supporting people in a caring, respectful and dignified way. We observed a member of staff bend down to get eye contact when speaking to a person. The person responded with a smile when the member of staff warmly said, “Good morning lovely. How are your legs today?” We heard another member of staff say to a person, “Is there anything I can do for you.” Staff spoke in an encouraging way to people who needed support with their breakfast and lunch time meal. We heard staff explaining to people what was happening prior to providing care or support.

People told us they could have visitors at any time. A person said, “My daughter-in-law lives close so she comes to see me. She can come whenever she likes and does so.” Another person told us, “My daughter visits twice a week and she brings my grandson. She can come any time she likes.”

There was a calm atmosphere in the home. Throughout the inspection we observed staff supporting people in an easy going and unhurried way. The staff we spoke with demonstrated a warm and genuine regard for the people living there. We observed a positive and on-going interaction between people and staff. We heard staff explaining things clearly to people in a way they understood. Personal care activities were carried out in private. People did not have to wait long if they needed support.

There was limited evidence in the care records to suggest that people or their relatives were involved in discussions about their care. Some care plans were signed by the person to say their care plan had been discussed with them but many care plans gave no indication whether the person had been involved. However, we did observe people who lived at the home and relatives casually calling into the office to discuss things with the manager. People told us the manager and staff were approachable and communicated well with them.

A key worker system had recently been introduced by the new manager. A key worker is a member of staff responsible for one or more persons. The role involves ensuring the person’s support and care meets their needs. Often this role involves discussing and reviewing the person’s care with them.

Throughout both days of the inspection we noticed the display boards in the dining room, back lounge and foyer contained information that was either out of date or inaccurate. For example, the staff listed as on duty both days of the inspection was incorrect. The day and date displayed was inaccurate. A clock on the first floor was showing 3.50pm when it was 11.25am. This lack of attention to orientation cues could be confusing for people. Staff said displaying the day, date and staff on duty had been introduced by the new manager and the staff needed to get into the habit of changing the display boards daily. We discussed this with the manager who agreed to check the display boards daily.

The manager confirmed that nobody living at the home needed an advocate to represent them.. The manager was aware of the local advocacy service should any of the people living at home need to use it in the future.

Requires Improvement

Is the service responsive?

Our findings

We arrived at the home just before 7.00am on the first day of the inspection. We started the inspection early as the Care Quality Commission had received anonymous information to suggest that staff were getting people up at an unreasonably early time. Four people were up when we arrived. Staff told us three people were up by choice. One person who was at risk of falling had woken up early and staff had assisted the person to the lounge where the person could be supervised. The other three people told us they liked to get up early and they had the capacity to make that choice. Staff told us they had been advised by the new manager that people should not be prompted to get up unless they wished to do so.

We asked people throughout the inspection whether the home accommodated their preferred daily routine and we received mixed responses. Some feedback from people suggested they were passive and compliant in how they described their experience of life at the home. In addition, we observed that their general demeanour was one of fitting into a routine that was more communal than person-centred. One person said, "I can decide when I go to bed, but in the morning I have no choice. The staff help me to get washed and dressed and then most days I come into this lounge." Another person told us, "I can decide when I get up in the morning but they usually start getting us ready for bed about 9.00pm. They allocate two staff to help you to bed and they do it in turns. I spend my time reading mainly. You have to fall in with the rest of them when things happen." By this the person meant that they had to "fall in" with the routine of the home. We discussed this with the manager who acknowledged that people had likely adapted to the routine of the home. As an example, the manager told us how one of the people living there was unhappy because they thought another person was getting preferential treatment because they had been given a cup of tea outside of the regular tea break time. The manager advised the person they could have a cup of tea whenever they wanted and said the person seem surprised by this.

We looked at a selection of care records to see if they contained information about people's background and preferred routines. There was an inconsistency in how this information was recorded. Various documents were in place to record people's background and preferred routines. For some people, there was good background information and a good record of the person's preferred routines. For others, this information was either too scant or not in place. The manager acknowledged that changes needed to happen and said she was working towards developing a genuine person-centred culture within the home. Staff had recognised this too and said they welcomed a more person-centred approach in the way they supported people. The term 'person centred' means that people's individual needs, wishes and preferences are at the centre of how the service is delivered. There was limited evidence in the care records to suggest that people or their relatives contributed to the assessment and planning of their care.

We asked people about the recreational activities they like to participate in. People told us they spend most of their time in the lounges, watching television or reading. A person said, "I spend most of my day sleeping or watching television. I used to read but my eyes aren't good any more. There are no regular activities that I want to take part in." Another person said, "I spend my time in the lounge watching TV; I can change the channel if I want. There are no activities in the home for me." We joined in with a chair exercise session that was taking place during the inspection and observed that people joined in enthusiastically and appeared to enjoy the session.

The meetings that had taken place with people living at the home and relatives showed that people had raised concern at the first meeting in December 2014 about the lack of activities. Minutes of the January 2015 meeting showed that the manager was addressing this and an activity programme had been introduced. We saw this was displayed on the notice board in the foyer. The manager advised us they were in the process of recruiting an activity co-ordinator for the home.

We asked people if they had any opportunities to go out. Some people said they went out with family. One person told us, "It's alright here but I can get out quite a lot. I'm able to walk about and my daughter comes and takes me out." Another person said, "I used to play darts and snooker, but I can't do that in here now. I can still walk with my stick and I get out with my son."

People living at the home told us they had few complaints. Some people had raised issues about the food, the lift not working and the lack of activities at the meetings started by the new manager. We could see from the meeting minutes

Requires Improvement

Is the service responsive?

that these issues had been addressed by the manager and that people were satisfied with the outcome. Meeting minutes were displayed for people living at the home and visitors on a notice board in the foyer.

We asked people how they would make an individual complaint or raise any concerns outside of the meetings. A person said, "If I was concerned about anything I would talk to my son, I know the manager by sight, but I don't know her name. I have not been to the meetings; my daughter-in-law goes and she takes a full part in the meetings but I don't know what they talk about.". Another person told us, "If I had any complaints I would see the manager. When I first came in here she reassured me about things. I never thought I could be happy here but I am now. I have no complaints and if I did I can always raise them at the meetings.". We noted that an easy-read leaflet was displayed on the notice board in the foyer advising people what to do if they were unhappy about something.

The manager advised us that there had been no formal complaints received except for one in December 2014 which had been resolved. There was an open door policy and the manager said that people or relatives called to the office and raised issues promptly. They were resolved quickly before they became a bigger concern. One person had on-going concerns about the food and the manager maintained a log of all discussions with the person and action taken to resolve each complaint.

We looked at questionnaires that people living at the home had completed as part of a feedback survey. Our brief review of the questionnaires highlighted general positive feedback from people about their experience of the home However, the questionnaires were in different formats. Some required boxes to be ticked whilst others required a more narrative response. Some asked different questions, some were signed and some were anonymous. A number of the questionnaires were undated so it was unclear what timeframe they related to. Some of the questionnaires referred to another residential care home rather than Woolston Mead.

The questionnaires had not been analysed and, given the variation, it was difficult to identify how the responses could be effectively analysed.

We recommend that the service considers current best practice guidance about person centred planning and care for older people, including planning for recreational activities.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post but they had recently applied to cancel their registration. Correspondence had been sent to the registered manager on 4 February 2015 by the Care Quality Commission's (CQC) registration team advising that the application had not been accepted because it was incomplete. A new manager had been appointed in November 2014 in anticipation of the registered manager leaving. The registered manager had remained in employment as an advisor/mentor to the new manager.

People living at the home were pleased that the manager had started regular meetings for people to share their views about the home. Meetings had been held in December 2014 and two meetings took place in January 2015. We could see from the meeting minutes that requests and issues raised by people living at the home or relatives were actioned and an update provided at the next meeting. Updates were provided on other issues, such as the recruitment of staff, the introduction of a keyworker system and upgrades to the environment. This showed that the manager had provided people living at the home and their relatives with a forum to share information about developments within the home. Further meetings were arranged for 2015 and a list of meeting dates was displayed on the notice board in the foyer.

We asked staff about the key achievements and key challenges of the service. Staff were pleased that the manager had made positive change. A member of staff said, "She is a good manager and is getting things done. Staff were particularly pleased that the number of staff on nights had been increased from two to three as they said they had found it difficult to manage on nights with just two staff. Senior care staff were pleased that they had been given more responsibility. Staff said there was more structure in that regular supervision had been set up for 2015. They said the supervision was more structured and detailed.

Staff told us communication had improved and they had opportunities to share their views about how the service developed. A member of staff said, "Staff feel more energised and the team work is good." Meetings were taking place each month and these included a full staff meeting and a senior staff meeting. A kitchen meeting had also taken place in January 2015. We noted from the meeting minutes that planned changes and expectations of staff were discussed. A communication book was also used as a means of communication and we could see that feedback from the outcome of audits and checks was recorded in the book. Staff were required to sign to say they had read the entries in the book.

Staff suggested that the key challenges for the service included a refurbishment of the environment and better access to training. The manager advised us that training had been organised for March 2015 and one of the senior care staff was booked on to a leadership and management course. The manager also told us a refurbishment of the building was due to start in the spring.

A member of staff said to us, "It [home] is less institutionalised. We are more connected with residents and doing a lot more activities." We had discussed with the manager that we found people living at the home were orientated to the routine of the home so it was positive to hear that staff were supportive of a more person-centred approach to the way the home was run.

We asked some staff about whistle blowing. They were aware of what whistle blowing meant and said a policy was in place at the home. Staff said they would have no hesitation in raising any concerns with the manager.

We looked at a range of policies within the policy folder. The manager had requested that staff sign to say they had read each policy. We had some concerns about this as all the policies we looked at were not bespoke to the service. For example, these included the medication policy, risk management policy and adult safeguarding policy. We also noted policies in place that were not appropriate to the service, such as a policy regarding the use of an isolation room. Policies provide a framework which outlines how the service operates therefore the policies at Woolston Mead should reflect the operation of home.

The manager had introduced a 'quality assurance monitoring' audit and we could see this had been completed for January and February 2015. The audit structure was aligned with the five questions the CQC focus on during inspection. It took account of health and safety matters, complaints, safeguarding, medication and incidents. A structured approach to auditing the medication was in place, including a weekly and monthly

Requires Improvement

Is the service well-led?

audit of the medication. Arrangements were not in place to audit the care records which could explain why the inaccuracies with the risk assessments and care plans we found had not been identified.

Although it was clear the new manager was making changes, it was too early to fully see the positive impact these changes were having in developing the service in a person-centred way.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had not made suitable arrangements to ensure people were safeguarded against the risk of abuse. Regulation 11(1) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Safeguards were not in place for the safe management of medicines. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider was not adhering to the principles of the Mental Capacity Act (2005). Regulation 18.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider did not have effective arrangements in place to ensure people were protected from unsafe care and were appropriately assessed in response to increased risk or changes in their needs. Regulation 9(1)(a)(b)(ii).

The enforcement action we took:
The provider was served with a warning notice under Section 29 of the Health and Social Care Act 2008. The provider is required to comply with this notice by 17 April 2015.