Care Quality Commission

Porthaven Care Homes No 2 Limited

Woodland Manor Care Home

Inspection report

Micholls Avenue
Chalfont St Peter
Gerrards Cross
Buckinghamshire
SL9 0EB

Tel: 01494917600
Website: www.porthaven.co.uk

Date of inspection visit:
06 November 2019
07 November 2019

Date of publication:
16 September 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodland Manor is a care home providing personal and nursing care to 52 people aged 65 and over at the time of the inspection. The service can support up to 64 people.

Woodland Manor accommodates 64 people across four units. Two of the units accommodate people with dementia, whilst the other two units are described as nursing units. The service is purpose built, with all bedrooms having an ensuite shower. The units have shared communal dining and sitting room facilities and a bathroom. There is a separate dining room for special occasions, a café bistro at the entrance to the service, a cinema, hairdresser and activity room.

People's experience of using this service and what we found
Sufficient staff were not consistently provided, and some staff were not suitably trained and supported.

Safe medicine practices were not consistently promoted and risks to people were not always identified and managed. Person centred care was not provided. There are also two specific incidents that we are currently reviewing in relation to people's care.

Some people were supported to make choices in relation to food, drinks and activities. However, people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Records were not accurate and up to date. Good governance was not established. Senior management visited the service but the auditing that had taken place had not identified the issues we found. The provider failed to learn from previous inspections and bring about the required improvements. They failed to review the service's progress in complying with previous breaches of regulations which has resulted in continuous breaches of regulations of the Health and Social Care Act 2008.

We received mixed feedback on people's experience of care. People were happy with the meals and activities were provided. Some people and relatives told us they felt safe and were generally happy with their care. They confirmed staff were kind and caring and we observed positive engagements with people during the inspection. Other people and relatives felt the high use of agency staff lead to inconsistent care and a delay in getting the support they required.

The service had a new manager in post. They had a proven track record for improving services. They had identified areas for improvement and had an action plan in place to support that.

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 December 2018) and there were

multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough, improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the relevant key question sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodland Manor on our website at www.cqc.org.uk.

Follow up
We served warning notices in respect of breaches of Regulation 9, 11 and 18 of the Health and Social Care Act 2008 with a timescale for compliance. The progress with meeting these regulations will be reviewed at the next inspection.

Special Measures:
This service has failed to achieve a good rating since being registered in 2015. It was previously in 'special measures' from March to June 2018.

The overall rating for this service at this inspection is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate** ●
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement** ●
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement** ●
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement** ●
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate** ●

Care Quality Commission

Woodland Manor Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors over two days. A pharmacist special advisor was present on day one and a nurse specialist advisor and an Expert by Experience were present on day two. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Woodland Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The previous registered manager had left in October 2019. A new manager had been appointed and had been in post three weeks at the time of this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection, including their updated action plan. We sought feedback from the local authority and reviewed a recent Healthwatch report. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
We spoke with eleven people who used the service and nine relatives about their experience of the care provided. We spoke with seventeen members of staff including the nominated individual who is responsible for supervising the management of the service on behalf of the provider, the manager, two agency nurses, two team leaders, five care workers, an activity coordinator, trainer, two administration staff, the maintenance staff member and chef. 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 reviewed a range of records. This included thirteen people's care records and multiple medication records. We looked at seven staff files in relation to recruitment and staff supervision and profiles for seven agency staff. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas, policies, meeting minutes and records relating to individuals care.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely and assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure safe medicine practices were promoted and failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements have not been made and the provider is still in breach of regulation of regulation 12.

- Safe medicine practices were not promoted, and the service did not work to best practice or their own policy in relation to medicine management. People on timed medicines for Parkinsons were not given their medicine as prescribed with delays of up to an hour for some people. This had the potential to cause loss of symptom control and take a long time for the person to recover. For another person two antidepressant medicines were being administered for a period of six days despite communication from the GP instructing one was stopped and the new one commenced. This was pointed out to the provider during the inspection, medical advice sought, and a safeguarding alert made.
- Body charts were not in use for the application of creams and emollients. Staff involved in medicine administration told us they relied on the instructions from the prescription labels to apply emollients. After the inspection the provider sent us evidence that the instructions on administration of creams and emollients are outlined on the electronic medicine record. Homely remedies such as dioralyte, senna and paracetamol were in use but there was no evidence these had been agreed and approved by the GP.
- Medicines were not always suitably stored. A person's eye drops were stored without the required opening date recorded on the bottle. We noted the eye drops had to be used within 28 days of opening. This meant people were at risk of receiving medicine that was ineffective and past its use by date. The medicine fridge and clinical room temperature records were maintained although minimum and maximum temperatures were not recorded.
- We found a container of thicken up powder which had been prescribed for an individual person was used for general use for others who required their fluids to be thickened. The person's name the powder had been prescribed for had been crossed out. This had the potential to put people at risk of taking an item that was not prescribed for them.
- Risks to people were not identified and managed. Risks around specific medicines such as anticoagulants and paraffin-based emollients were not identified and mitigated. The nurses and team leader on duty responsible for medicine administration were not aware of the risks associated with the use of these medicines, such as the fire risk associated with paraffin-based emollients and the risk of bleeding from anticoagulants.

● The service had a person with a specific medical condition. Their care plan indicated that a specialist consultant had advised their fluids were to be restricted to 1200 millilitres per day and they were to be weighed daily. There was no information for staff on what to do in the event of the person either losing or gaining weight. We spoke with the nurse in charge and a carer on the unit. The nurse told us "[Name of person] is on a normal diet including fluids". We asked to see fluid charts for the person and the nurse told us the person does not need to be on a fluid chart and does not have any. The nurse told us the person was "weighed daily "but was not sure why. They commented "I think we weigh [Name of person] because they have heart problems". Another staff member said, "We weigh [Name of person] daily because of their liver". We found fluid charts were partially completed for two dates in October only and their weight chart showed they were weighed on five occasions from the 11 August 2019 to the date of the inspection. This puts the person at significant risk in relation to their cardiac problems as the lack of monitoring of fluids and weight could lead to the person going into heart failure.
● The service had people who were at risk of malnutrition and pressure damage. Some people were required to have their food and fluid monitored, their mattresses were required to be set to their weight and the frequency of turns were outlined in their risk assessments. We found fluid charts were not routinely completed and fluid targets were not reached, according to what was recorded. Five people's records showed their mattress was not set at the right setting for those individuals' weight and people were not turned at the frequency outlined in their care records. The turning chart for one person on end of life care showed they had been positioned on their back at 08.15 am. We observed they were still positioned on their back at 11;00 and 12;20 pm. Another person had a sacral lesion but did not have a reposition chart in place. This puts the person at a higher risk of the lesion worsening if their position was not changed on a regular basis. In addition, the person may experience significant pain around the lesion and surrounding area due to remaining in the same position for any length of time.
● A person left in bed till 12.30 pm was deemed a high risk of falls. They had a sensor mat in place to mitigate the risk. We observed the sensor mat had been pushed under their bed and would be ineffective in mitigating the falls risk if the person had attempted to get out of bed.
● A person was discharged from hospital to the home on the 5 November 2019. There was no record of a discharge letter to outline the persons medical needs or treatment plan on discharge. The deputy manager had contacted the hospital to obtain the required information. We were told the person had a seizure. Their care file was not updated to reflect that and there was no risk assessment in place to outline how to identify and manage risks around seizures.

Preventing and controlling infection
● Infection control risks were not managed. The service had a person with an infection. Their care plan made reference to the infection but there was no risk assessment in place and the nurse in charge was not aware the person had an infection, to prevent the risk of cross infection.
● A relative told us their family member had loose stool on day one of our inspection. They informed us there was a delay in staff accessing gloves and despite the loose stool been reported to staff this was not handed over, recorded in the persons file and no infection control measures were put in place to mitigate any potential risks of cross infection.

These are continued breaches of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during and after the inspection to address the issues we had identified in relation to medicine practices and mitigating risks to enable them to promote safe care and treatment. The manager confirmed that personal protective equipment would be made more accessible to staff with a key code put on the storeroom door as opposed to a key.

● The service had an environmental risk assessment and people had personal emergency evacuation plans (PEEP's) in place. A grab bag for emergency use was available in the reception area. The service had a maintenance staff member who was responsible for carrying out health and safety checks as well as dealing with day to day repairs. There was a daily, weekly, monthly, quarterly, six monthly and annual schedules of health and safety checks in place. The records showed that these were up to date and completed. Fire safety was promoted with regular checks of equipment and fire drills taking place. Equipment such as fire, gas, electric, water, moving and handling equipment and lift were serviced.
● The service had housekeeping staff in place. They were responsible for the cleaning and laundry. The service was clean and hygienic People and their relatives told us the service was kept suitably clean and hygienic. A person commented "The cleaners, well they are always cleaning and constantly hoovering. The home is so clean".

Staffing and recruitment

At our last inspection the provider had failed to ensure the required staffing levels were maintained. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements have not been made and the provider is still in breach of regulation 18.

● The staffing levels deemed as required by the provider for the service was not consistently maintained. The provider confirmed after the inspection the required staff numbers and roles per unit. They confirmed there was two nurses on duty at night and two hosts were on duty each day on the ground floor units. We reviewed the rotas from the 14 October to 10 November 2019. The rota showed on 19 out of 28 shifts one nurse was on duty at night and there were 14 occasions where there was one host on duty and one occasion where there was none. On Balmoral unit there was two occasions where there were only two staff till 10 am and another two occasions where there were only 2 staff on shift. On Windsor unit there was one occasion where there were only two staff till 10am and no host that shift either and on Buckingham unit there was four occasions where the required staffing levels were not provided.
● The service had a high turnover of staff and had a number of staff vacancies, which they confirmed they were attempting to recruit into. They had no permanent registered nurses for day shifts and relied on agency staff to cover the vacancies. They tried to use the same agency staff to provide continuity of care. However, whilst people and their relatives acknowledged this they felt there was a lack of continuity of care and a delay in getting the support they needed. People commented "There are never enough staff here. I think we understand there are busy times for them (carers) in the morning and at meal times but you just have to learn patience living here". "There are so many agency staff working here, especially at the weekends". "Sometimes I am particularly happy to see someone I know". "I try very hard not to press my bell, particularly at night. the response time varies anything from ten minutes to 30 minutes I suppose". Relatives commented "There are lots of agency staff here", "I am equally concerned about the numbers of staff on duty sometimes". My [family members name] has advanced dementia and remains in their room most of the time. I came in one day and the food on the plate was uncut. They really cannot eat without that help."
● At lunchtime on day one of our inspection on a dementia care unit, there were two carers and a team leader on shift. Two additional carers provided one to one supervision to two individuals. The two carers on the unit told us the they were responsible for getting everyone up and dressed which meant there was a delay in getting people up. At 12.30pm a relative showed us their family member was still in bed with the curtains drawn, door closed, and their breakfast left to the side, uneaten. The same relative told us later that day they were unable to find any staff on the unit when their family member needed personal care. They eventually found an agency worker who assisted them. The person required two staff for moving and

handling but the relative had to support with the moving and handling manoeuvre as no other staff were available.
● The service did not have a shift planner in place therefore, tasks were not allocated and followed through, staff did not have breaks as they should and there was a lack of oversight and management of the unit. The provider told us they did not want allocation sheets in use as it had the potential for staff to only do what they were allocated to and the expectation was that senior staff on those units would manage the shift appropriately. There was no evidence this was being monitored and where shifts were not appropriately managed it was not addressed. On day two of the inspection the manager told us they had put an extra staff member on that unit. At lunchtime on day two we observed there was several staff available to assist, including members of the activity team. Staff and relatives told us this was for our benefit and the unit would revert to being short staffed again after the inspection.

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

The provider took action during and after the inspection to address the issues we had identified in relation to the deployment of staff. The manager told us that they were in the process of reviewing people's dependency levels to ensure these were accurate and to take account of changes in people's needs.

● Staff were suitably recruited. They completed an application form, attended for interview and pre-employment checks such as references from previous employers, medical questionnaire and disclosure and barring checks were carried out. The service had obtained confirmation from agencies that individual agency staff had the required pre-employment checks in place.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives confirmed that they felt safe living at Woodland Manor.
● The training records showed that 59 out of 89 staff were trained in safeguarding. Staff spoken with were clear of their responsibility to report poor practice and they felt able to raise concerns with management.

Learning lessons when things go wrong
● Systems were in place that when a complaint was dealt with the manager was to record learning from the complaint. This was not routinely completed for all complaints logged and there were two similar complaints dealt with by the previous registered manager which indicated lessons were not learnt.
● The service had a system in place which enabled them to monitor accident, incidents and pick up trends. There was no evidence of learning from accident and incidents. The new manager told us they had set up weekly clinical review meetings to enable them to have an overview of changes in people, discuss accident and incidents and be responsive to those, to promote learning.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection the provider had failed to ensure staff were working to the principles of the MCA Act 2005 and consent was not obtained in relation to their care and treatment. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements have not been made and the provider is still in breach of regulation 11.

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 had the appropriate legal authority and were being met.
● The service was not working to the principles of the MCA. The training matrix showed not all staff were trained in MCA and DoLS. During discussion with us some staff had an awareness of the MCA and DolS whilst other staff were less knowledgeable. We requested a mental capacity assessment for a person who had bed rails. The staff member told us "There will not be one as a DoLS application has been made for that".
● People's care plans were contradictory as to whether people had capacity to make certain decisions or not. In one person's care plan under the heading mental health and well-being it indicated the person had full mental capacity and no issues. Within the same section it was recorded the person was unable to make decisions and outlined the family members who had power of attorney for health and welfare. In the section my wishes for the future and end of life care it was recorded the person is assumed to have capacity to make decisions relating to their care. However, at the end of section it was recorded a best interest meeting to be done soon with family and GP. In another person's care plan it indicated they did not have capacity to make decisions in relation to their care. Mental capacity assessments were partially completed, and best interest decisions were not recorded.

This is a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during and after the inspection to address the issues we had identified.They provided further training for staff on completion of MCA assessments.

● Prior to the inspection the provider had identified staff required further training on the MCA and DoLS. The regional director had commenced workshops for small groups of staff. The plan was for all staff to attend the workshops.
● The manager told us when they started at the service there was no tracker for the DoLS applications and approvals. This had commenced and was in progress. However, the manager had identified some authorisations had expired, some had not been applied for and others had been approved but not recorded. They also told us they had identified that CQC had been informed when the DoLS applications had been made as opposed to when approved. The new manager was clear of their responsibility for reporting to us.

Staff support: induction, training, skills and experience

At our last inspection we recommended staff receive performance reviews and appraisals in line with the organisations policy. The provider had not made improvements.

● Staff were not supported in line with the providers policy. The providers policy on appraisals outlined that staff would have an annual appraisal and three performance reviews each year on a one to one basis. Staff spoken with told us they were not having one to one meetings, although some staff told us the new manager had recently met with them. Some staff told us despite having no one to one performance reviews they felt supported whilst other staff indicated they did not feel supported. A staff member commented, "The level of support varies and depends who is on duty with you and who is the team leader on shift." "I don't recall any supervisions or one to ones happening."
● The supervision and appraisal matrix provided showed staff were not supervised and appraised in line with the providers policy. A new staff member told us they had been confirmed in post without any review of their performance. Another staff member in post since November 2018 told us they had no performance review meetings. The staff files viewed confirmed regular one to one meetings were not taking place. Three staff had one supervision record on file which was not at the frequency outlined in the policy.
● Staff told us they had been inducted and trained when they started working at the service. The training matrix showed gaps in training which we were reassured was being addressed and was as a result of the turnover of staff within the service. There was a low percentage of training for fire safety, moving and handling, infection control, food safety, MCA's and the electronic care plan system. The training records viewed showed the two permanent registered nurses had completed some of the training considered mandatory by the provider. The bank nurse did not have training considered mandatory by the provider such as moving and handling, infection control, safeguarding and none of three nurses who worked at night had up to date fire safety training. This was fed back to the manager to take immediate action on. They also confirmed the bank nurse was not working until their training had been updated.
● The medicine management policy stated, 'all medication is administered by a registered nurse who have received appropriate training and subsequently been assessed as competent for this role'. The training matrix did not include medicine management training and there was no evidence the registered nurses were trained in medicine management or had been assessed as competent to administer medicine. The training records for agency staff nurses viewed at the inspection and whom we observed administering medicines did not indicate they had received any medicines training with their agency or the service. After the inspection the provider sent us updated training records for the agency registered nurses which

indicated they had been trained in medicine management and had completed medicine competency assessments. The provider told us one of the agency nurses had used the electronic medicine system in a previous role and was familiar with it. There was no evidence this had been established or recorded in the agency nurse's induction prior to them administering medicines at the service.
● Team leaders were administering medicines. We were told they were trained and assessed as competent in this role. However, at the inspection the service was only able to provide us with up to date medicine competency assessments for three out of the eight medicine technician/team leaders listed on the rota. After the inspection the provider sent us evidence that two other team leaders had undertaken medicine training which included medicine administration competency assessments and another team leader was reassessed the day after the inspection. They confirmed five team leaders had attended medicine refresher training in October 2019 and they were awaiting the certificates of that training.
● Agency carers and agency registered nurses were regularly used to cover the rota. The agency nurses staff profile showed the agency provided their staff with a one-day training on various topics such as health and safety, basic life support; safeguarding vulnerable adults, infection control, manual handling and fire safety. Agency staff had an induction into the home which included an orientation to layout of the home, fire procedures and information including key risks on people. However, we found the agency nurse was unaware of risks to people in relation to restricted fluids and Methicillin-resistant Staphylococcus aureus (MRSA). An agency nurse we spoke with told us, "The first day I was here there was no one to do my induction because of issues within the service." They went on to tell us… "The induction was not great." An agency carer told us "I had an induction on the other unit but on here I have had no induction and as I am on one to one all the time I do not know the support others need. Therefore, I did not know how to support the relative with their family member yesterday when requested."

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

The provider took action during and after the inspection to address the issues we had identified. They commenced medicine competency assessments and identified training that needed to be actioned as a priority.

● Staff new to care had completed the Care Certificate training. The Care Certificate is a set of standards that health and social care workers should adhere to. We viewed three completed staff care certificate training and saw this had been signed off as completed by the in-house trainer. The nurses and some of the team leaders had additional training in diabetes, syringe driver and management of behaviours that challenged.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported with their nutrition and fluids.
● The chef confirmed there was a four-week menu with a second option available to people. There was a board in the kitchen with people's dietary requirements. The chef told us, "When someone first comes to live here I personally go and ask them what food they like and discuss their options." The chef told us they had a five-star rating and all food is fresh and locally sourced.
● During the inspection people were supported with their meals. One person was reluctant to eat and drink and three staff members briefly prompted them as they walked past. However, no one staff member had an overview of what the person had eaten and drank and as a result the food and fluid recorded was not reflective of what we had seen they had consumed. The manager agreed to address this with staff as part of the improvements they had planned for the service.
● We received mainly positive feedback on the meals provided. People commented "By and large I find that the food is quite good". "The chef is good, and they often come around to see us". "The food is not too bad

on the whole, it is usually meat and veg and a vegetarian option, but you can have anything off the light menu instead and you could always ask for something else". "The food here is better now".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were assessed prior to them being admitted to the service. We found issues identified on the assessment were not always cross referenced to people's care plans and aspects of the assessments were incomplete such as mental health and well-being. This had been picked up by the provider as part of their care plan auditing.
● People's cultural, religious and preferences were identified, and staff were trained in equality and diversity to enable them to support people appropriately.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support.
● People had access to a GP, dentists and chiropodists. One person's care plan indicated they did not require dental appointments. There was no indication as to why.
● People were referred to other health professionals when required for example speech and language therapist and physiotherapists. They were supported by staff at the service or family to attend hospital appointments.

Adapting service, design, decoration to meet people's needs
● The service was purpose built and was suitably maintained. The service had a maintenance staff member who dealt with day to day maintenance issues and they had access to contractors as and when required for more complex maintenance issues.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● Throughout the inspection we observed staff offered people a choice of food and drinks. They were made aware of activities that were scheduled and could choose to go to them or not.
● People told us they could get up and go to bed when it suited. One person told us it depended on staff availability as to when they could get up and go to bed. They commented "I get up when the carer's come, it was quite reasonable today about 8.30 but it can be 9.30 before they come." Another person commented "It is a case of when they want me to go to bed. I like to go to bed about ten o' clock."
● On one unit at 16;15 we heard the team leader tell the carer that they needed to start getting people to bed. It was not specific to one individual or clear if it was individual's choice. After the inspection the provider told us that staff acknowledged the comment was made but that it did not reflect as general practice within the unit or service.

It is recommended the provider works to best practice in providing a person-centred service which promotes people's involvement in their care.

Ensuring people are well treated and supported; respecting equality and diversity
● People and their relatives told us staff were kind and caring. People commented "There have been a few new faces, but I think it is the same level of care." "I much prefer the day staff, on the whole they are mostly kind, and you can have a laugh with most of them." "Some of the agency are lovely but they do not know us, and we struggle to get to know them." A number of people and relatives referred to particular staff members whom they trusted and had confidence in. They described them as "of a high standard, fabulous, genuinely caring."
● We observed positive engagement between staff and people. Staff were respectful and attentive when they were supporting people. They walked with people, at their own pace, and often with gentle words of encouragement or of conversation. Many staff held hands with people whilst walking with them or offered a friendly arm around someone's shoulder. There was good use of eye contact and appropriate touch when supporting and engaging with people.

Respecting and promoting people's privacy, dignity and independence
● People's care plans made reference to promoting their independence in relation to aspects of their care.
● Staff addressed people clearly when speaking to them and always used people's first or preferred names. Most of the carers spoke clearly and with good tone when speaking with people.
● People had their own bedrooms with an en-suite shower. These were personalised and reflected

individuals' choices and interests. We observed staff knocked on people's door before they went in and staff were respectful in their engagement with people.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure person centred care was provided. This was a breach of regulation 9 (Person –centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements have not been made and the provider is still in breach of regulation 9.

- Person centred care was not consistently provided. The service used electronic care plans. We noted some of the profiles on individuals had improved and was much more detailed and specific. However, the care plans viewed lacked specific detail to enable the staff to provide consistent care to people.
- People's care plans outlined people's nutritional needs, support and risks. However, these were not routinely followed as fluid and food charts were not always completed and there was no oversight of people's food and fluid intake to ensure they were getting the target fluid and food outlined in their care plan.
- Care plans lacked detail on the management of medical conditions such as epilepsy and diabetes. They did not provide specific detail for staff on how they would recognise and respond to a person having hypo glycaemic (blood glucose drops too low) or hyper glycaemic (blood glucose rises too high.) symptoms relating to their diabetes. Another person went for regular dialysis. There was no care plan in place in relation to this to outline food and fluid restrictions and to alert staff to actions to take if there were any complications as a result of the procedure.
- Prior to the inspection we had been notified of an incident where a person had hit out at another person. The person's care plan indicated they displayed behaviours that challenged and had become increasingly more aggressive. It outlined staff were to be aware of the triggers for the behaviours and whilst some triggers were outlined such as food on the floor and other people living on the unit, there was limited information as to how staff could prevent the person being exposed to those triggers. The interventions were not specific either and outlined staff were to keep the person away from other people and ensure they were not left alone with other people. There was no guidance what to do when behaviours that challenged were displayed other than stating that staff were to use gentle prompting and encouragement and to offer support and understanding to the behaviours.
- One person's care plan indicated they were to have their meal placed in front of them due to their impaired vision. We observed at 12.30 pm their breakfast and cup of tea (which was untouched) was on a table to the right of them and out of their sight. We discussed this with the team leader on the unit who told us it was difficult to put the meal in front of someone when in bed". This was not indicated on the person's

care plan.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At our last inspection we recommended the provider works to best practice in meeting the Accessible Information Standard. The provider had not made improvements.

● People's care plans made reference to communication needs but they were not specific as to how staff should communicate with people who had difficulty expressing themselves. A person's care plan indicated staff were to ensure that the level of communication is appropriate to the persons needs at the time. It went on to say to ensure conversations were held at the best time of day for the person to maximise their understanding however, the care plan did not indicate what was the best time of the day for the person.
● Written information such as complaints and information regarding staff on duty were not provided in a format suitable and understood by people who had difficulty reading and understanding small print.

End of life care and support
● There were five people receiving end of life care at the time of our inspection. Anticipatory medication was in place for when this was required.
● Care plans lacked details on people's wishes and choices in relation to their end of life care. A care plan outlined the person had a "Do Not Attempt Resuscitation" (DNAR) in place and their relative did not want them to go to hospital. There was no indication if their needs and wishes on their end of life care had been explored.
● The in-house trainer told us staff had received end of life training. The carers we spoke with could not recall end of life training and the training matrix did not evidence this was provided or recorded. The provider confirmed end of life training was included in their standard training. Updated training records provided after the inspection showed only seven of the current staff team had end of life training in 2017.

These were continued breaches of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during and after the inspection to address the issues we had identified. They commenced training of staff on the care plan system as well developing person-centred care plans as examples for staff to work from. The manager showed us they were in the process of developing more pictorial information for people to meet the AIS standard.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People had access to activities. The service had four activity staff who worked across the service in providing activities to people. They also assisted people on the units with their meals. The activity programme provided showed a range of activities were provided which included art, pat a dog service, trips out, music, massage and exercises. During the inspection we saw a group of people went on a trip out and an external entertainer and a music therapy session took place.
● We received mixed feedback on the activities. Some people were happy with the variety and frequency whilst other people told us there was limited activities at weekends. Some relatives felt the activities had

increased whilst other relatives felt it was always the same people who were enabled to be involved in the activities. They commented "Very little activities provided or available to the less able people." The manager told us they intended to review the activities as part of their improvements within the service.

Improving care quality in response to complaints or concerns

● The service had a system in place to record complaints, however not all complaints were logged or showed learning to demonstrate complaints were managed effectively. The complaints log showed four complaints were recorded since October 2018. We had been copied into a complaint in July 2019 which the previous registered manager had investigated and responded to. However, this was not recorded on the complaints log. The provider acknowledged the complaint was not logged but they confirmed it had been dealt with in line with their complaint's procedures.

● People and relatives told us they know how to raise concerns, although some did not feel reassured that their concerns or complaints were always listened to.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure records were suitably maintained and good governance was established and operated effectively. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements have not been made and the provider is still in breach of regulation 17.

● Records were not suitably maintained and accurate. People's records were contradictory throughout. A person's file indicated for all moving and handling transfers they should be assisted by one carer. In the same section it indicated the person is able to transfer themselves with minimal assistance and they are able to walk short distances with a zimmer frame and assistance of one carer. In another person's file it indicated they were on a low diet and in another section, it indicated they require a low salt, high protein and homemade milkshakes. A third person had two daily entries in their care file for the same shift. They both contradicted each other and did not provide an accurate picture of the concerns from the morning shift. There was gaps in the recording of people's records. For example, some food and fluid charts were incomplete or not in place where required. One person's fluid record was not an accurate reflection of what they had drank.
● The staff allocation sheets were not always clear due to amendments. They did not outline clearly people who required one to one support therefore, it was difficult to assess the staffing levels per shift. The rota and allocation sheets did not always include the name of the agency staff per shift and the rota outlined how many hours agency staff worked as opposed to whether they worked the early or late shift.
● Auditing was not effective in highlighting shortfalls in the service and managing risks. The audits completed by the previous registered manager suggested the service was compliant and no actions were required. The findings of our inspection showed the service was not compliant. Therefore, their auditing was ineffective.
● The electronic care plan and medicines were audited by the providers group clinical auditor. Those audits were detailed and comprehensive. Follow up visits took place which showed actions from the audits remained outstanding. There was no evidence this had been addressed. Monthly medicine audits took place but they failed to identify the shortfalls we found with medicine management. As a result, the service had not identified that a person's MARR record indicated that on one occasion their Parkinson's medicine was administered four times a day instead of three. During the inspection this was pointed out to the provider

who investigated it and concluded it was an error on the system as opposed to a medicine administration error. It was also not identified a person was having two antidepressants administered instead of one and controlled medicines had not been crushed prior to being disposed.
● The provider had no oversight of the rota, shifts, staff support and training. This resulted in shifts not been managed, and the staffing levels and staff mix the provider told us the service required was not consistently maintained. The provider had not satisfied themselves staff supervision and performance reviews were taking place in line with their policies and staff had the required training and competency for tasks they were responsible for.
● The updated action plan sent to us in September 2019 had not identified the continued breach of regulations. The nominated individual told us they had concerns about the previous registered manager and had identified they were not performing in aspects of their role such as auditing the service. They confirmed regular and constant supervision was provided. A total of 125 senior manager visits had taken place to the service since January 2019 but there was no record to demonstrate what intervention and support was provided at each of those visits.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The service has had three registered managers and two interim managers since it was registered in December 2015. The previous registered manager had left in October 2019 and had been deregistered by us.

● We received mixed feedback on the previous registered manager. Some staff and relatives described them as "Approachable, personable, hardworking and committed", although they felt they did not get the support they needed to manage the service. A person commented [previous registered managers name] we all liked very much, and we were sad to see her leave." However other people and their relatives described the previous registered manager "Guarded, defensive, non-engaging and rarely had time to talk to you." Two staff told us "they had started to dread coming to work as they were blamed for things and they did not know what they would find".

This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action after the inspection and put an action plan in place to start to bring about improvements.

● A new manager had been appointed and had applied to be registered. They had been in post three weeks at the time of the inspection. They had previous experience of management and a proven track record for turning services around. Since their appointment to the home they had audited aspects of the service and had an action plan in place to address their findings. They had commenced one to one meetings with staff and had introduced weekly clinical review meetings to enable the service to be responsive to changes in people. They were clear of their vision and values for the service and was confident they would improve the service.
● People and relatives were positive about the new manager. Relatives commented "[Managers name] seems pretty good." "I do believe "[Managers name] can put it right. They seem to have the experience and skill to manage."
● Staff were positive about the new manager. The manager had met with some staff and staff felt positive about that. They described the manager and newly appointed deputy manager as "Accessible, approachable, supportive and they provided guidance." A staff member commented "I get the impression the "[Managers name] is firm, fair and takes no nonsense. They have already made their expectations clear

to us which can only be a good thing."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, staff and relatives felt communication varied and could be improved. Relatives told us that key working had ceased, and they were rarely invited or enabled to contribute to their family members care when they were "resident of the day". The new manager had identified "resident of the day" was not working as intended and they had started to address that.

● The service had people and staff survey results recorded from December 2018 to present. These showed people and staff were happy with the service. Where issues were raised there was no evidence these were followed through and addressed.

● People, relatives and staff meetings took place, although the frequency and scheduling of staff meetings were not regular. People told us resident meetings took place although the same issues about meals and staffing were discussed and no action was taken. The new manager had put a schedule in place for meetings and those had commenced.

Continuous learning and improving care and working in partnership with others

● The service has had a history of non-compliance since its first inspection. There has been repeated breaches of regulations and the provider has failed to learn and put effective measures in place to monitor the service and ensure compliance with regulations.

● The new manager was experienced and committed to improving the service. They had a good knowledge of up to date practices and had identified immediate improvements required. They had commenced engagement with other health professionals to promote partnership working to improve the quality of care for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The new manager was aware of the duty of candour regulation and to be open and transparent when things went wrong.

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 RA Regulations 2014 Person-centred care Person centred care was not provided.

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not working to the principles of the MCA 2005.

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not provided.

The enforcement action we took:

The provider already have a positive condition imposed on them since March 2018. They have not applied to have it removed. Therefore the positive condition already in place for regulation 12 will be enforced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not suitably maintained and good governance was not established and effective in addressing issues within the service.

The enforcement action we took:

The provider already have a positive condition imposed on them since March 2018. They have not applied to have it removed. Therefore the positive condition already in place for regulation 17 will be enforced.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Sufficient staff were not provided and staff were not suitably trained and supported.

The enforcement action we took:

We served a warning notice against the provider.