Bupa Care Homes (CFHCare) Limited

Woodlands View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 11 January 2017 and was unannounced. We asked for further information and assurances to also be provided to us on 17 January 2017 due to the nature of the concerns identified. We returned to Woodlands View on 27 January 2017 to meet the Registered Manager to further discuss the inspection findings.

We carried out this inspection due to concerns received about the service. These concerns related to poor management of pressure care, insufficient staffing levels and unsafe care practises. At their last inspection on 23 April 2015 the service was found to be meeting all the standards we inspected and was given a rating of good. At this inspection we found that they were not meeting all of the standards. This was in relation to people's safety and welfare, staffing, cleanliness, person centred care and management systems. You can see what action we took at the back of our report.

Woodlands View provides accommodation and personal care for up to 120 people. At the time of this inspection 114 people were living at the service.

The service had a manager in post who had recently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

People did not always receive care that met their needs and kept them safe. People had not been supported by sufficient numbers of staff, however action had recently been taken to address this. Risks to people's health and wellbeing had not been consistently identified and responded to. Staff were knowledgeable about how to keep people safe from harm.

People were not consistently supported to have a varied diet. People at risk of poor nutrition did not always have their needs responded to and people were not consistently able to access specialist healthcare professionals, particularly the dietician. People's consent was sought prior to care being delivered, however the requirements of the Mental Capacity Act 2005 had not always been followed. People were supported by staff that had been sufficiently trained to carry out their role effectively.

People's dignity and privacy was not consistently met across the home, particularly for people who were cared for in bed. People felt staff were caring and kind in their interactions; however also felt that staff did not have time to meet their personal preferences that were important to them.

People were not provided with sufficient opportunities to engage in activities, hobbies or interests. People living with dementia did not live in an environment that promoted their independence or engaged them with meaningful activity. People felt confident in raising a complaint, however, opportunities to do so, such as meetings were not consistently held and people did not all know who the appropriate manager was to

raise them with.

People gave mixed views about the management of the service, and some people felt the registered manager was not visible. Audits and systems in place to monitor and improve the quality of care people received had not been effectively managed. People's records were not consistently accurate. The views of people living in the home had been previously sought; however the Registered Manager was awaiting the results of the recent survey. Notifications that were required to be submitted to CQC had been made without delay.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not supported by sufficient numbers of care or domestic staff.

Risks to people's health and wellbeing were not consistently well managed.

People did not live in a clean environment.

People told us they felt safe living at the home, and staff were aware of how to report their concerns about a person's safety.

People were supported to take their medicines when they required them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported to eat a varied diet and have sufficient choice of food. People were not able to access specialist healthcare professionals consistently across the home when their needs changed.

People's consent was sought prior to care being delivered, however the requirements of the Mental Capacity Act 2005 had not always been followed.

People told us that staff were proficient at providing care, and staff told us they felt the training provided to them enabled them to carry out their role effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they didn't feel listened to regarding their care needs in all units.

People told us they felt their dignity was met, however curtains

were left open when people were in bed who were visible from communal areas.

People who were cared for in bed did not feel staff consistently met their individual needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not provided with sufficient opportunities to engage in activities, hobbies or interests. People living with dementia did not live in an environment that promoted their independence or engaged them with meaningful activity.

People's care records documented people's preferences and choices, however staff were not consistently able to provide care this was due to pressures on their time.

People told us they felt they could raise a complaint, however meetings were poorly attended.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People told us they had mixed views about the management of the service.

People were not clear about who the Registered Manager was, or how to raise issues directly with them.

Quality audits designed to monitor and improve the quality of care people received were ineffectively operated at times.

Peoples care records were not accurately maintained.

Woodlands View Care Home

Detailed findings

Background to this inspection

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

This inspection was carried out by three inspectors, two specialist advisors and an expert by experience. The specialist advisors were a tissue viability nurse and a nurse with expertise in supporting people with dementia related nursing needs. An expert by experience is someone with personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We spoke with the local authorities commissioning and safeguarding adult's teams, and reviewed the outcome of recent visits by these teams.

During the inspection we spoke with 22 people who used the services, 15 staff members, five relatives, the registered manager, deputy manager and the regional manager. We also received feedback from professionals involved in supporting people who used the service and reviewed the recent reports from service commissioners. We viewed information relating to 13 people's care and support. We also reviewed records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People were not supported by staff when they requested assistance. One person told us, "I have waited max 15 – 20 minutes for staff to answer the call point. They generally come to me quite quickly as they know how disabled I am." A second person said, "It's up and down, some days they have enough and things get done but other days we have to wait, sometimes for quite a while."

Staff gave mixed views about the staffing levels in the home. Some staff felt that on the day of inspection, there were sufficient staff on their unit, whilst others did not. However, all staff spoken with told us this changed daily due to staff sickness and absence. They told us that this meant they were unable to consistently meet people's needs. One staff member told us, "The one thing that needs to improve here is staffing. We simply cannot manage to get everyone up by lunchtime and that's not fair on us or the people who live here." Staff told us that the weekends were the most difficult time as some staff felt they also needed to clean the units in the absence of cleaning staff. One staff member said, "It's ridiculous that as well as having to look after people, some who are really poorly, we then have to find the time to clean and tidy, it just can't happen."

We observed throughout that staff were constantly busy responding to people who required assistance, or getting people ready for the day. Call bells were within reach for people who were in bed, and when people pressed their bell, staff responded to them. However, we looked at the call records for the home for the previous two days, and saw that where three of the units responded swiftly to people's requests for assistance, Newton unit consistently answered calls with a delay of ten to fifteen minutes.

We spoke with the Registered Manager about the staffing levels. They told us that they, along with the Regional Director had identified at the end of the summer that an increase in staff was required. They told us that they had temporarily increased staffing on two of the units prior to Christmas, and then two days prior to our inspection, had increased staffing permanently on three of the units. They told us they were aware that pressure ulcers had developed in the home and that people's needs were not consistently met in a safe manner. Although it was premature to assess the impact of the staffing increase, staff were ambivalent about the improvement. One senior staff member told us, "It is very stressful working here. The workload is too much, despite the increase in staffing. We still need more nurses. We used to have two nurses working each shift, now there is only one on each shift. Often we have to cover other houses."

However, people's needs had not been safely met and responded to by sufficient numbers of staff deployed. This is was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from risks and avoidable harm. People had the appropriate assessment tools in place to identify and manage the risks to their health and wellbeing, and these were regularly reviewed by the nursing teams and unit managers. People had assessments in place that related to falls prevention, pressure care, moving and handling, personal care and medicines for example. However, these did not always identify where a person's needs had changed. For example, we saw one person's oral care

assessment was reviewed nine days prior to our inspection. This stated that there was no problem with oral care. However, during the inspection we observed the person was unable to eat their lunch because their tongue was sore. This person had also lost 19 kilograms since June 2016, however there did not appear to be a dietician assessment, and staff had not monitored their food intake.

People who were at risk of developing pressure ulcers, or who had developed them in the home, were not provided with equipment that was correctly maintained. We found that people who were cared for in bed, had their pressure relieving mattress settings incorrect. For example, we found one person who weighed 37 kilograms, had their mattress set to zero. This meant that the person was not benefiting from any form of pressure relief, and was at high risk of further tissue breakdown. We found that for other people, the pressure setting was not set in line with their weight, when either laying down or sitting up in the bed. People who required repositioning in bed, did not receive this when required, and we identified for one person where they had not been repositioned four hourly, twice in the previous twenty four hours. This was highlighted with the nurse for them to action. For a second person who required two hourly turning, we saw during the previous night they were positioned on their left side from 02.00 to 05.00, then on their back from 05:00. We observed this person four and a half hours later who was still positioned on their back. We looked at pressure relieving cushions for one unit and saw that of 11 cushions, five had the foam seat padding worn through indicating the cushions were not fit for purpose as they would not support the person's weight evenly.

One person's relative told us that their relative had been admitted to hospital with a chest infection, dehydration and a high sugar level. They told us they had asked for staff to send the person to hospital on Christmas Eve. They said, "[Person] had a chest infection 10 days before going into hospital, they were losing weight, and were unwell. I asked the nurse why they didn't give a drip because [Person] was dehydrated, they said they were not allowed. On Christmas Eve I asked if the staff could admit to hospital when [Person] was admitted and their blood sugar was 31, [Person] is type two diabetic." When we asked staff how they monitored people's blood sugar levels they told us they did not carry this out. This person remained in hospital at the time of our inspection and the concerns raised by the relative had been passed to the local authority safeguarding team.

When we reviewed the care plans for people who had developed a pressure ulcer, we found discrepancies within the categorisation of these wounds. We spoke with one nurse and showed them a photograph kept in the notes of one person which detailed three separate pressure ulcers. They stated the pressure ulcers were at least a grade three pressure ulcer however they had previously stated it was a grade two pressure ulcer care plans referred to the wound as a grade two. This meant that wounds were being inaccurately graded and suggested a lack of knowledge of the nurses in the appropriate identification of pressure ulcer grading. We asked the nurse what classification system they use to grade pressure ulcers, however they told us they did not know, and showed us a chart in the clinical room that differentiated moisture lesions and pressure ulcers but this did not classify the grade of pressure ulcers.

However, we also found when looking in the medicines rooms these were not all clean and well ordered. We found that each required a thorough clean, and there were people's emollient creams and one person's suction machine placed on the floor.

As a result, some of the people who lived at Woodlands View had suffered harm due to poor care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not cared for in a clean environment. People gave mixed views about the cleanliness of Woodlands View. One person told us, "I don't have much to say, my room and the lounges are kept clean

and tidy so I think it's good." However a second person told us, "There are times when it is not clean." We found that the standard of cleanliness was not of a satisfactory standard across the different units. For example, within Wellfield unit, we found the kitchen was dirty with foodstuff under units, staining to walls and tiles some of which were chipped, and one side of the kitchen had stored dirty bibs and tins of paint. In Lucas unit we saw that there was one house keeper Monday to Friday, with no weekend cover. The toilet when washed retained an unpleasant odour, toilet brush holders had brown staining to them as did one person's pressure seat pad. The kitchen was dirty, with foodstuff under units, splashes and staining to walls and where people had spilled food on the carpet this was not cleaned for some time. On Newton unit, bathrooms had heavily stained floors and the walls were scuffed and chipped. We found a curtain pole hanging off the wall in the dining room. Toilet areas across all units were accompanied by an offensive odour throughout the day, and staff were seen to clean the floors with filthy water. We saw that where bedrooms had been ticked as cleaned that morning, they remained in need of further attention. We found that in the communal toilets and shower rooms the vinyl floor was stained and in some places the seals were not intact. This meant that these areas could not be cleaned properly to prevent infection.

Staff wore appropriate personal protective equipment such as aprons and gloves when assisting people and arrangements were in place to dispose of clinical waste safely. Cleaning equipment was available to domestic staff, however as previously demonstrated, not effectively utilised.

Where people were at risk of developing infections, the registered manager was quick to escalate their concerns. For example, they had identified a number of people had developed a chest infection across the home. They had subsequently contacted Public Health England to report a possible respiratory infection, and were taking steps to address this, including a temporary suspension of admissions to the home. However, when we returned to the home on 27 January 2017 to meet with the registered manager, we toured the units and saw that little had been undertaken to address the cleanliness concerns. A senior manager for the provider told us they were organising for a cleaning team to carry out a thorough clean of the home the following week.

This meant however, that poor cleanliness and maintenance of the home resulted in people living in an environment that was not well maintained or cleaned. This was a further breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at Woodlands View. One person said, "Yes, very safe. The happiest I have been for a long time." A second person said, "I think we are well looked after overall, the staff do their best in trying circumstances." This person was referring to the pressures placed upon staff by poor deployment within the home.

Staff were knowledgeable about safeguarding procedures, and were able to describe to us what constitutes abuse. Staff were clear that they would immediately report any concerns to the unit manager or nurse in charge. Staff were aware of external organisations they could report their concerns to such as the local authority and CQC. One staff member told us that, "All residents are individuals and we are aware of their abilities and care needs." They also said, "If I had concerns I would flag these straight away I would speak to the nurse and the manager." Another staff member told us, "I would raise concerns with the unit manager or person in charge, if I felt nothing was being done I would talk to the [(Registered] Manager or CQC." Incidents were logged by staff and sent to unit manager or Registered Manager where they investigated possible causes, and looked for any possible themes or trends that may emerge.

However, the Registered Manager and Regional Director told us they experienced difficulty with the GP practise that supported the home. They raised concerns regarding unnecessary prescribing of antibiotics

and not considering underlying causes and also with regards to pressure care and nutrition. When asked whether they had escalated these concerns, that placed people at risk of harm, they told us they had not. We found they had not reported the issues to the local clinical commissioning group for investigation, or to the local authority safeguarding team. This issue was raised by CQC with the local authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines as the prescriber intended and were safely managed. Staff who administered medicines had been trained to do so, and regular checks and audits were carried out to ensure medication administration records (MAR) were completed and stocks were correct. Each MAR clearly displayed a current picture of the person for identification purposes, and indicated whether a person had allergies by coloured stickers.

We checked the stocks of medicines against the MAR's and found there were no errors or anomalies. Records were maintained when medicines were received and returned to the pharmacy and were booked in by two staff to minimise the risk of error. Where people were prescribed 'As required' medicine, staff had completed a medication protocol which was attached to every MAR sheet which recorded why the medicine is administered, and possible side effects that staff should observe the person for.

Where people were prescribed medicines that controlled their mood, the nursing team ensured people were regularly monitored for side effects, and that the prescriber continually reviewed the medicine to ensure people were not controlled by the use of sedative medicines. Since Christmas the Registered Manager had been able to safely reduce the number of people using these medicines from 14 to eight.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood the importance of offering people choice and respecting their decisions when seeking their consent. Staff were able to verbally demonstrate how they offer people choice and we subsequently observed numerous occasions where staff respected people's decisions when seeking their consent. People confirmed that when discussing various options, such as use of bed rails, or reviewing their health needs, staff explained the options and sought their consent.

However, where people lacked the capacity to understand the choices they were making for their own safety and welfare, we found staff had not followed the correct process for obtaining their consent. Staff were aware of how to obtain consent from a person who lacked capacity. One staff member told us, "I assume everyone has capacity or you are taking away their human rights. We don't talk for them we involve them in everything they do, choice is important." However, when we reviewed decisions made for people who lacked capacity we found the process for obtaining and recording consent did not follow the requirements of the Mental Capacity Act 2005. For example, where people were in bed and using bed rails, we found capacity assessments and best interest decisions had not been undertaken for some people, and the least restrictive method had not been considered.

Where staff had completed the best interest assessment and submitted a DoLS application to the local authority, they had not then assessed and documented how they would manage the deprivation of the person's liberty in the interim period whilst awaiting the local authority to review. For example, one person on Wellfield unit would attempt to leave the building. Staff had submitted the DoLS; however the care plan did not record how to distract the person, or when the person could be escorted outside with a staff member. Although there was a garden attached to the unit, this had been seldom used. We spoke with the registered manager and regional manager about ensuring the least restrictive methods are used, which they agreed required further development.

As consent for people who lacked capacity to make their own decisions had not been obtained within the requirements of the Mental Capacity Act 2005 this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt staff were well supported and competent at providing them with the care they needed. One person told us, "The training must be very good because I never need to complain about the help they give me, they are very professional."

Staff told us that they were provided with a comprehensive induction when they started working at the home. One staff member said. "I had a week's induction; I learnt about safeguarding, the training is face to face and we covered deprivation of liberties. (DOL's), hoisting and I received shadowing shifts until I felt ready to be on my own." Another staff member said, "I received good training, I felt supported, we have regular training and if we want training we get it." All staff we spoke with confirmed they had received an induction and received regular training. Staff confirmed that they had regular supervisions and meetings. One staff member said, "I asked the [registered] manager if I could do my national vocational qualification (NVQ) and they have put me forward for this."

People told us the quality of food provided was variable. One person said, "I think it depends on who is in the kitchen, some days it's good, others it's like slop." A second person said, "You never know what you're going to be getting when it comes to the taste."

We observed lunch across all the units and found that staff were under pressure to prepare people's plates and then assist people who required this. People experienced a variable lunchtime experience depending on what unit they lived on. For example, on Newton unit we saw that people were offered choice of what to eat, with one person who changed their mind about the meal they wanted being offered a third choice. However, on Wellfield unit where people lived with dementia, we found people did not receive the same experience. For example, people had chosen which meal they were having prior to lunch being delivered. Many people had forgotten what they had chosen, and needed reminding by staff, however were not offered an alternative. Those people who required a pureed meal due to swallowing difficulties were not provided with a choice or similar variety to others. For example, the meal on the first day was pureed meat and vegetables following by pureed fruit, and was the same on our final visit to the home. When we asked a staff member on Wellfield if people may appreciate a choice they told us, "Oh no, I don't think so, they have dementia so will forget anyway." When we discussed this with the Regional Director, and they were shocked at this response, particularly as this staff member had recently undergone dementia training provided by the Regional Director.

When dessert was served, all people were given the same option, some people appeared content with this however others did not seem so happy and picked at their food. People were offered only orange juice, with no other alternative, and where people were given a pureed diet, this appeared unpalatable and visually unappetising as all the meat and vegetables had been pureed to one pulp.

People were seen at times to be agitated or restless and leave the table before finishing their meal. Staff were busy assisting other people, meaning one person got up and walked away having eaten only two spoonful's of their dessert. Finger foods were not available in the unit for people who were restless and who preferred to eat whilst on the move.

We spoke with the cook who told us they were kept aware of any specific dietary requirements, such as allergies, or whether people required a soft or pureed diet. They told us they tried to accommodate people's specific wishes where possible. For example they told us one person had requested steak recently which they had ordered and cooked especially for them. They told us they would where possible accommodate any person's preferences and order from their suppliers to meet people's choices. However, we also found that there were examples where the kitchen had not been informed where people were type two diabetic, meaning they did not receive a special diet.

Not all people were enabled to have sufficient choice or support with their nutritional needs, and where people had specific dietary requirements the kitchen staff were not consistently informed to ensure their dietary needs were met.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives gave mixed feedback about the responsiveness or availability of healthcare professionals such as the GP or dietician. We saw that where people required the tissue viability nurse to assess and review a wound, this was requested. During the inspection we saw and spoke with one of the visiting GP's. They told us they found the home was welcoming and felt people were well cared for. They told us they visited on a Wednesday and worked in conjunction with the winter pressure doctor, who was also working with the home to identify and manage people's conditions that may result in further pressures placed on local hospital through admissions.

During our inspection we observed on Wellfield Unit a visiting health professional carrying out a consultation with a person in the communal area. They were seen to be abrupt and rushed, not particularly waiting for a response from the person or their opinion. This observation was passed to the management team. The Registered Manager told us they felt at times some health professionals who visited the home did not spend sufficient time with people. They said that they had experienced difficulties with some GP's and with the GP accessing support from dieticians in a timely manner. They told us this had caused them delay in accessing the appropriate healthcare professional when required. We found examples where people's nutritional needs had not been supported according to best practise. For example one person's family provided them with supplementary milkshakes themselves as they were unable to receive this from the GP. The Registered Manager had become aware of the potential concerns and had undertaken a review. However they had failed to act effectively or robustly to ensure the referrals to healthcare professionals were made in a timely manner and reviewed. This meant people were not always able to see a healthcare professional when they needed to, leaving people at risk of further health complications. We have referred our findings to the local authority.

Requires Improvement

Is the service caring?

Our findings

People felt that staff cared for them in a dignified manner, respecting their views and opinions. One person told us, "I chose my own clothes etc." A second person said, "When I am got ready I look exactly the way I want, they [Care staff] check every day what I want to wear and always help me behind closed doors and even remember to close the curtains." We saw that throughout the inspection staff were attentive to people. Where people had spilled food at lunchtime staff were quick to identify and assist them to change their clothes promptly. When staff entered people's rooms, they knocked, called out as they entered and closed the door behind them. We observed one person in their room knock their drink over themselves and the bed. The person pressed their call bell to summon assistance and within a couple of minutes staff were ensuring this person was comfortable.

However, people also told us that the staff did not always have sufficient time to be as attentive to them as they would like. One person told us at 11 o'clock in the morning, "I just lay here, I have been like this since 8am, I wanted to get up then but they have passed me by. I get so frustrated that I can't dress myself anymore, but when they don't come along it compounds my feelings of helplessness."

During both visits to Woodlands View, people's bedrooms were visible from the car park and other communal areas. We saw numerous people through the bedroom windows and doors where staff had left curtains open while people were in bed. Some of these people were in bed, comfortable and asleep, however they had moved position which placed them in an undignified and compromising position which could be seen from these communal areas. Prior to the inspection we were informed that people were seen in their bedrooms in an undignified state, and during the inspection one person's relative advised us that they had shown the Registered Manager their relative's feet which were visibly dirty, however the care staff told them they had been bathed that morning. One person's relative told us they had visited the home prior to our inspection and seen their relative sat for long periods in an environment that gave off an unpleasant malodour, and had not had their pad changed for long periods, even though they had requested this.

People gave mixed views about how involved and supported they were in planning and making decisions about their care. One person told us, "Yes I do get involved and they [Staff] do listen to what I want." However a second person said, "No, I have no named care worker that I can recall. They all work with me, but I have never been to a care planning meeting." When asked if they had a care plan in place that addressed their needs they told us they did not know but thought there would be one somewhere. Once again we found the views across the home were mixed, dependent upon the unit that people lived on. We found that Lucas unit prompted the most negative responses to people feeling involved or empowered. We observed that throughout the home staff interacted with people in a kind and sensitive manner, however, for people in bed generally those people who were considered to be end of life, staff did not have the time to spend. People who were end of life told us that generally staff were very caring in their approach; however people did not feel that they mattered, and that staff did not always have the time needed to listen to their worries or concerns. People who were anxious, or felt isolated in their rooms were not given the time or contact they required to feel comfortable and reassured.

The knowledge of staff across the home was variable about people's current needs. For example, on Astonbury, a senior staff member was able to tell us when asked detailed current information about a person's personal care needs, bathing, and moving and handling needs. They were able to consider the person's character and knowledge of them to respond to their particular needs. However, on Lucas, a senior member of staff was unaware that two people had passed away and one person left, and proceeded to tell us about their care. The agency staff member eventually informed us these people had passed away.

People's care needs were not met in a way that met their needs or that involved them in the development and decision making around their personal preferences. Staff were not all aware of how to care and support people with dignity who were end of life in a way that met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People were not provided with sufficient opportunities to engage in activities, hobbies or interests that met their needs in a person centred way, particularly in Wellfield, the unit that provided care for people living with dementia. People experienced a vast difference in the way they engaged with staff and the community depending on their level of independence. People who were mobile and able to join in with group activity had a choice of activity such as Christmas parties, fund raising and movies, games and discussions. However, whilst we were on one unit, no activity had taken place for any person sitting in communal areas. The 'Experience Manager' came on to the unit and left some board games out on the table, however it was a further two hours before staff led the activity to engage people who were living with dementia.

The environment on Wellfield did not support people living with dementia to occupy their time and stimulate memories from their past. There were a limited number of items of reminiscence available; however these were shut away in a side room. The corridors were dull, dark and had no items of reference to orientate people. Memory boxes were not used that could indicate to people which was their own room. On several occasions we found ourselves unsure of which hall to go down to find a particular room, so felt for a person with dementia this would be exceptionally difficult. We spoke with the Registered Manager about the need to improve the environment for people, and they agreed along with the Regional Director that much needed to be improved in respect of people with dementia and their environment.

We observed on numerous occasions that people who were considered to be end of life were cared for in bed, rarely left their bedrooms. Staff were unable to spend quality time with this group of people, having to attend to other people in the unit. One staff member told us, "It would be nice to have the luxury of just sitting and chatting with the person after providing their personal care but we are under a lot of pressure to get everyone up and dressed by lunchtime." One person who was in bed told us, "It can be very lonely, and when you are facing the things I am facing, that is not a nice thing to have to face alone, the staff should make more effort to spend time with me, just to take my mind off things, nothing special." We met one person who was in bed who although was unable to communicate with us verbally, their care records indicated and staff confirmed they would like to get up during the day to be around people. However, staff were unable to bring this person into communal areas as they would have liked because specialist equipment to mobilise them had not been sought. This meant that this person among other people in the home were unable to join in with the wider community in Woodlands View, because either equipment shortages or staff shortages meant they could not receive the longer care they needed to meet their personal preferences. Where people in Woodlands View were considered end of life, this meant that they then spent their remaining days isolated from the community they lived in.

People told us that when activities took place they were good fun, engaging and entertaining. Each separate unit had their own itinerary of daily activities, however people told us that these frequently changed or did not occur. One person said, "It used to be great, so much was going on and then nothing. [Activity staff] does their best but there is 30 of us, the soul has gone from here at the minute." A second person said, "This is not good, but the weekend is much worse." Staff told us that at the weekend there were no activity staff in the home. They told us that they set up an activity such as a movie or game, however staff did not ensure it was

carried out due to being busy with other duties.

Care plans we looked at were person centred and most staff we spoke with were able to verbally demonstrate they knew the people they supported. People had an assessment of their likes, dislikes and preferences about how they wished to receive their care undertaken when they moved in the home, however this did not translate consistently to the care they received. Although these plans were person centred, the pressures that staff had been under meant people did not receive their personalised care. For example, on one unit three people were waiting to get up at 11:30. On a second unit some people were not ready until after they had eaten their lunch, even though these people's preferences were to be up earlier than this. We spoke with one person who said, "I have asked about getting up, but today it's not possible, maybe tomorrow."

People were not supported to consistently engage with meaningful activity. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt they could approach the management team to raise any concerns or complaints they may have. People said they felt their complaints they had raised in the past were managed well, and they had the outcome of the complaint explained to them. We saw there were notices on how to complain and people we spoke with knew how to report any concerns they might have. One person said, "If you have any worries or complaints, I would see the nurse in charge. They have told me if there are any problems see the nurse." A second person said, "We made one complaint about the food and cobwebs in the window. They handled it very well and matters were resolved." However, people were clear on how to complain to their individual unit manager, but most people spoken with did not know who the Registered Manager was to escalate their concern if needed, or if their concern was related to the unit manager.

Meetings were held for people and relatives to attend, however these were very poorly attended by both residents and relatives. For example, in the 30 bedded unit in Lucas, one person and their two daughters attended. It was noted in the minutes that, "No resident wanted to attend this meeting," held in January 2017. When we reviewed the minutes of the meetings held on Lucas and Newton, the issues raised and actions were identical. People told us they would like to be involved in the meetings more, but that previously have felt their opinions have not been taken up by previous management. This was an area that required improvement.

Requires Improvement

Is the service well-led?

Our findings

The views of people were mixed regarding their views of the management of the home. Some people told us their individual units were well led, for example one person said, "I know [House manager] but I do not know the manager of the whole care home." People were not clear about either who the Registered Manager was, or who was in the home's management team. One person said, "Who is the manager, I don't know, I thought we spoke to the nurse." When people were asked about how they felt the home was managed, once again their responses focused on their individual units. For example one person when asked told us, "I think [House Manager] is excellent and makes sure we are well looked after." However a second person told us, "No, not really 5 out of 10." when asked their views about how the home was managed.

The previous Registered Manager was transferred to another of the provider's homes, and the deputy manager was promoted to the position of manager. This was during the summer period of 2016, and notably where a number of the concerns identified at this inspection occurred during this period. The Regional Director told us they had taken their eye off the ball during this period, and it was clear that the newly promoted manager at the time required additional support to identify the issues developing in the home. We were able to see from the audits, action plans, and improvements in areas such as pressure ulcers developing, and identifying chest and urinary tract infections and reducing these, that once the management team identified the issues they took steps to address these. However, the short period of time where the home was without an experienced Registered Manager, and sufficient governance from the provider, had an impact on people's health and wellbeing.

The registered manager and other senior staff members carried out regular checks and audits in a range of key areas in order to identify monitor and reduce potential risks to the service and the people who used it. This included in areas such as medicines, infection control, care planning and staffing. Senior representatives of the provider also carried out unannounced visits and spot checks to make sure that risks were managed effectively. However, the registered manager acknowledged that some of the systems used to monitor and check the delivery of care and support had not as effective as they could have been in some cases. We asked the Registered Manager and the Regional Director why the home had been understaffed. They told us, "In about September time we took our eye off the ball, people's needs increased and there were changes in staffing that we didn't respond to quickly enough. We listened to the staff; we increased the staffing levels and have now made that a permanent change on three units." Senior manager audits identified throughout this period that additional staffing was required, and did eventually address this, however, had the monitoring of the service been more robust, then people would have experienced a consistent quality of care unaffected by fluctuating staffing levels.

The management team had reviewed patterns and trends for some incidents. For example, they had identified that a number of chest infections had developed in Newton and Wellfield units. They contacted the appropriate organisations and took the necessary advice to manage these. They further noticed that with urinary tract infections (UTI's) there had been unnecessary prescribing of antibiotics. They told us they thought there may be other underlying courses.

However people living in the home had also acquired 32 pressure wounds between July 2016 and the date of our first inspection. The Registered Manager identified that tissue viability nurse support for the last year had been sparse due to the demands on their service, however they told us this had greatly improved and now have a dedicated TVN who will come to site to review and advise on phone when needed for dressing choices. The Registered Manager told us that the deputy manager carried out weekly reviews of those people either at risk of developing a pressure ulcer, or those who had. However, audits of equipment used or how equipment was set, for example bed mattresses set to zero did not highlight issues with the manner in which equipment was used. The Registered Manager was in the process of ordering Quattro pressure relieving mattresses for the whole home, but at the time of inspection did not know for certain that all people were on appropriate equipment. We had to ask each of the unit managers to conduct a review of their units to ensure people had the appropriate mattress. Despite staff informing the management team of the needs to increase staffing levels in the home between July and December 2016, temporary increases to staffing occurred only from December 2016. Of those, 28 had developed before December 2016. Had auditing, reviewing and monitoring been used effectively, staffing could have been increased sooner, and less pressure ulcers acquired within the home.

People's care records were not always accurately maintained. We observed one staff member completing the daily notes about what the person had for lunch and the fluid they had drunk. However we observed that this had been completed before the person was given there meal and fluids. This meant that the written record was not correct as the person may not have completed their lunch. One person's relative told us, "Record keeping is a bit of hit miss, food and fluid charts not completed properly." We saw examples of this where fluid charts recorded the optimal amount for a person to drink but did not record the actual amounts. We found examples where repositioning records were completed either inaccurately, or not completed at all when a person was repositioned to assist with the pressure care.

Staff morale had been affected by the shortage of staff and the increased pressures placed upon their workload, including an expectation they would clean their units at weekends. One staff member said, "We are short staffed but we make it work by doing overtime to cover the shortage." A second staff member said, "Working the extra hours are good, what with it being Christmas, but I didn't enjoy my holiday, I was too tired. I feel that the managers can only rely on us carers goodwill for so long and then we will say no more, one [more] staff member is better, it shows they listen, but it's still not enough with the needs of the people we have. If it doesn't improve, then I and a number of my friends will go to [local care home] who are recruiting."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications of significant events that had occurred within the home had been notified to the Care Quality Commission as required and without delay.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 Person Centred Care (1) (a) (b) (c) Care provided to people did not meet their individual needs and preferences, designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Regulation 11 Need for consent (1) (2) (3) People who lacked the capacity to consent to care or treatment did not have an assessment of their needs carried out in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (b) (h) Risks to people's safety and welfare were not managed effectively to mitigate the risks of poor care being delivered. People were not protected from the risk of infection because the home was not clean.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) (6) (a) Systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse and take appropriate actions to report concerns to the appropriate bodies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (1) The nutritional and hydration needs of people were not consistently met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 Good Governance (1) (2) (a) (b) (c) Systems were not effectively operated to assess, monitor and improve the quality and safety of the services provided. Accurate records relating to peoples care needs were not always maintained.