Woodleigh Christian Care Home Limited

Woodleigh Christian Care Home

Inspection report

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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

This inspection took place over four days on the 27 and 28 November 2018, 10 and 18 December 2018. The service was last inspected in November 2017 when it was rated 'requires improvement' for the fourth time; with an ongoing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 - Safe care and treatment. At this inspection we found further breaches in relation to staffing levels and governance.

The service is a care home with nursing and is registered to care for 44 older people. On the first day of inspection there were 29 people living at the 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. Woodleigh Christian Care Home is based in an old convent and has been extended to provide additional accommodation. The two halves of the building are joined by a long corridor on the ground floor, there are multiple lounges and communal areas for people and families to sit and chat. There is access to a communal garden from the older building and a lift at either end of the building.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were not managed safely. We found examples of errors in medicine administration records. People did not always receive their medicines as prescribed and we found some people had missed their medicines, with gaps in-between doses or incorrect doses. We also found occasions when the provider had run out of medicines for people.

Incidents were not always identified or investigated. Inadequate recording meant improvements were not made to people's care and similar incidents were often repeated. Risks to people from known health conditions were not always managed safely and risk assessments and care plans were not consistently reviewed after incidents.

Staff did not always follow advice or recommendations from specialist healthcare practitioners, or senior staff. Communication across teams was not always effective and staff were not always informed of changes to people's needs in a timely way. There were inadequate staffing levels at night and a lack of permanent nursing staff to ensure consistent care. This impacted on the quality and consistency of care people received and increased the risk of errors and poor communication about people's changing needs.

Staff did not effectively monitor people's food and fluids when they were identified as at risk of weight loss, poor skin integrity and diabetes. People who were dependent on others to provide food and drink were not always offered drinks or snacks in-between meals. Record keeping was inconsistent and could not always

be relied upon when people's care was being reviewed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The principles of the Mental Capacity Act (2005) were not consistently applied. Mental capacity assessments were not always decision specific and best interest decisions were made without full consultation of relevant people. Appropriate steps were not always made to keep people safe.

Staff had access to relevant training that supported them to meet the individual needs of people. Staff used evidence based guidance and tools to assess people's needs.

We observed occasions when staff did not always promote people's dignity. The service was not always adequately staffed to meet people's needs and this was impacted by the design and layout of the building. The chaplain provided a pastoral and spiritual service which staff and relatives said they found comforting and reassuring. Where possible staff promoted people's independence and decision making. People and families were involved in care plan reviews and said staff were respectful and considerate.

We found concerns and complaints did not always lead to improvements in people's care and people's needs were not always met. There was a variety of activities and events for people to join and people's spiritual needs were met.

Senior management were not always clear about incidents and changes that occurred which impacted on the quality of care people received. Quality assurance and monitoring of the service had not supported managers to identify where improvements were required. A lack of provider oversight, management and leadership of the service had led to continued concerns regarding people's care.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

Medicines were not managed safely and people were at risk of not receiving their medicines as prescribed. Stock control was not effective and they ran out of stock of some people's medicines.

Incidents and risks to people were not managed and lessons were not learnt from incidents. This left people at continued risk of harm from repeat incidents. The service was inadequately staffed at night and this led to people waiting for assistance and increased risk of falls.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow advice or guidance from specialists. They did not adequately monitor food and fluids for people at risk of weight loss, poor skin integrity or with unstable health conditions.

Communication was not always good and information was not always shared with relevant people. The design and layout of the building impacted on staff ability to provide consistent, responsive care, at all times.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and compassionate. They developed positive relationships with people and promoted their independence and decision making.

However, care was not always provided in ways that promoted people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff understood people's personalities and preferences. They used people's preferred names and supported their interests. The chaplain supported people's spiritual needs and provided pastoral care for staff and families.

Managers and staff did not always follow advice and recommendations which would improve people's care. Complaints were not always well managed and some relatives remained dissatisfied with the care of their loved ones.

Is the service well-led?

Inadequate

Management and leadership of the service was inadequate.

Senior managers did not always have the skills to address the concerns we had identified. Quality assurance systems were inadequate and did not support the managers to identify areas for development or check progress where changes had been made. Information was not always shred with relevant services, which meant people continued to receive poor quality care. The management team was reactive and did not plan for change; and staff did not always feel consulted about changes taking place.

Woodleigh Christian Care Home

Detailed findings

Background to this inspection

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

The inspection took place over four days on the 27 and 28 November 2018, 10 and 18 December 2018. The inspection was prompted in part by concerns that had been raised with us about poor management of the service, the management of risks to people and poor quality care. These included poor staffing at night time, concerns about the care of named individuals and an increase in safeguarding referrals associated with choking, falls, medicines, equipment, infection control and continence. The local authority also had concerns and conducted an unannounced night time inspection when they found insufficient staff on duty to assist people to bed. They subsequently, suspended their contract with them.

After two days of inspection, the inspectors remained concerned about the quality of care for people and requested further information from the provider and registered manager. We returned a third day to follow up this information and look at specific aspects of care and the management of medicines. We were still not satisfied with the quality of care and felt risks were not being identified or managed consistently. Although night time staffing arrangements had been improved we were not assured that these met the needs of people at night. We considered the likelihood of any current risks occurring was high, which would have a detrimental impact on the health and wellbeing of people living at the home.

The inspection team consisted of three inspectors and a specialist professional advisor (SPA), who was a nurse with experience of caring for older people.

Before the inspection we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the

provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development.

We reviewed any notifications the provider had sent us. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred. We also contacted other agencies for feedback on their experiences of working with Woodleigh Christian Care Home and for their views on the quality of care people receive.

To assess the quality of the service, we looked at a variety of records and spoke to people. We also spoke to ten people who used the service or their families; as well as the provider, registered manager, chaplain and 11 staff. We also reviewed six care records which included needs assessments, risk assessments and daily care logs; 20 medicine administration records; and management records which included staff records, policies, development plans and evidence of training.

Inadequate

Is the service safe?

Our findings

People were not safe at Woodleigh Christian Care Home. At the previous inspection in 2017, the service was found to be in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – Safe care and treatment. At this inspection we found ongoing concerns around people's safety.

Medicines were not managed safely. We found examples of poor administration and recording of medicines. For example, people who required insulin to manage their diabetes did not consistently receive the required dose, at the required time, to manage their blood glucose levels. This put people at risk of hyperglycaemia or hypoglycaemia which are serious conditions that require hospital treatment if left unmanaged. We were not assured that people received their medicines as prescribed. One person's medicine administration records (MAR) did not clearly identify the dose and time when insulin was administered and frequently referred to 'insulin given as prescribed'. As this person received different forms of insulin and variable doses depending on how they presented at the time, we were not assured they always received the correct dose. This person had experienced multiple incidents associated with poor blood glucose monitoring which led to them being hospitalised six times in two weeks.

Medicine was not always administered in accordance with the timescales in the prescription. One person was prescribed medicine to be administered weekly, every Monday. However, this had not been given consistently and MAR showed gaps of more than seven days between administrations. For example, records showed it had been administered on Monday 26 November, Wednesday 5 December and Thursday 13 December 2018. There was no investigation or explanation for the delayed administrations. This person was at risk of poor health management, as they did not receive their medicines as prescribed.

There were four occasions when medicines had been out-of-stock in the previous three months. These medicines related to the management of people's health conditions, including Parkinson's Disease, digestive disorders, mental health and pain management. For example, there had been a delay in obtaining a morphine patch which is used for pain management. This is prescribed weekly and on 28 November 2018 it was noted that only one morphine patch remained in stock. This was administered on 3 December 2018 and on 10 December 2018 it was recorded as out of stock on the MAR. It was reordered and delivered on 11 December 2018 but the missed dose was not administered until 15 December 2018. This meant this person was without appropriate pain relief for five days.

Medicine administration records were not completed accurately and contained errors, crossings out and gaps. Action taken when a person was consistently refusing their medicines was not recorded. There were two types of MAR in use; and codes across both forms were inconsistently used which provided opportunity for error. Not all staff who were administering medicines were named on the list of people authorised to give medicines, so it was difficult to identify who had made errors. The registered manager could not account for the errors in administration or recording and did not know that medicines had been out of stock on four occasions. We were not assured people received their medicines as prescribed which could have an adverse impact on their general health and management of their health conditions.

Risks to people associated with their health conditions were not well managed and action was not always taken to reduce the risk of further incidents. For example, one person assessed at high risk of falls had a sensor installed in their bedroom to alert staff if they got out of bed and were moving around. However, family visitors reported this was frequently turned off when they visited and it was turned off on the day of our inspections on 28 November 2018 and 10 December 2018. This placed the person at increased risk of harm from falls, as staff were not alerted when they got out of bed. A second person who was assessed as high risk of falls and used a walking frame to support them when walking around was found twice outside their room and staff had not been alerted by the sensor mat in place. On one occasion they had left the building after midnight and were found in the garden at 1.30am. Incident reports had not been completed and there had been no analysis of the incidents which could have led to better management of risks for this person.

We reviewed the incident records for the previous three months and identified that there were 40 falls and other incidents during the night shift, when there were less staff on duty and 23 incidents during the day. This information had not been analysed by the management team prior to our inspection and had not led to a review of people's risk assessments or identification of themes or areas for improvement. This put people at risk of repeated incidents.

There was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Prior to inspection we received concerns raised in relation to inadequate staffing at night. We were advised that sometimes there were only two or three staff after 7pm at night, to care for 29 people; and many people were left downstairs in the lounge areas until the early hours, as there were not enough staff to assist them to bed. This information was confirmed by the local authority who had conducted a night inspection and found 11 people in the lounges when they arrived at 10.30pm and six people on a further night inspection. The registered manager said this was people's choice to stay up late but we saw records that indicated people's preferred bedtimes were much earlier.

Staff gave us different accounts of how people needs were met at night and the number of staff on duty. All agreed staffing at night was insufficient. The rotas we saw were not accurate and included staff who no longer worked for the service and staff who were off sick or on annual leave. They did not assure us that there was sufficient staffing to meet people's needs.

During our inspection visits we noted many examples of how poor staffing arrangements impacted on people. We saw two people waiting and shouting for help in their bedrooms at 9.30am. One person said they wanted their breakfast, their bell was already ringing when we saw them and they waited a further 10 minutes for a staff member to respond. On the same afternoon there were no staff available in one lounge to attend to a person's request for assistance. Another person appeared to be anxious and was trying to get up from their chair and climb over the chair next to them. This person was high risk of falls and there were no staff available to assist them. People told us they often had to wait for staff to answer their call bells. One person said, "I don't bother unless I really need help, I just wait for one to walk passed (their room)". Another person said, "There's hardly anyone here at night, never see a soul." A relative told us they visited at night or mealtimes to ensure their family member was supported to eat and assisted to bed at a reasonable time. They told us, "Lots of people are up till very late at night – too late for an older person, they look cold and uncomfortable and no staff around."

Staff told us they did not have enough time or staff available at night to meet people's needs in a timely manner. One staff member said, "We have to do two hourly checks on everyone, assist people with personal

care or turns, support people in the lounges and eventually assist them to bed, sometimes there are only three staff – it's not possible." Another said, "Some people have to wait to go to the toilet, we can't help them if we are already helping someone else, many people need two staff so there's not always enough staff to look after everyone. We have to wait until another staff member becomes available, it's not fair on people."

The registered manager said they had reviewed the rota and developed a new 'twilight role and night manager' to support the night shift. However, the night manager only worked five nights each week and they had not yet recruited to both twilight roles. On the first evening of inspection there was no staff members doing the twilight shift but they were present on the second visit. We concluded there were not enough staff available to care for people and people were at risk of harm, from increased falls, poor response times to requests for assistance and loss of dignity. The impact on people and staff of changes to the rota, had not been fully explored; and new roles were not recruited to, before the changes were implemented. This meant the changes had not led to the desired improvements to people's care.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We found that lessons were not always learnt from incidents, accidents or feedback from external agencies, who had a shared responsibility to ensure people were safe and well cared for. We had been notified of 10 safeguarding incidents in the previous 12 months and only one came from the provider. This meant they had not learnt when it was necessary to inform other agencies, when people were potentially at risk of harm. The registered manager had not identified themes or done any analysis of safeguarding reports or incidents. They had not always followed recommendations made from safeguarding investigations conducted by external authorities which meant people remained at risk of harm and poor care.

Staff told us they knew how to identify signs of abuse and there were policies in place to support them to report any concerns. Staff knew how to escalate concerns within the service and knew how to use the whistleblowing policy if they felt their concerns were not addressed. People told us they felt safe living at the home.

We found the home was generally clean and fresh. Staff wore protective clothing during personal care and when preparing food. Hand wash facilities and hand gel were available throughout the home and we saw these in use by staff and visitors.

However, we observed unpleasant smells in some rooms when we walked around the building and in one room found an uncovered commode which had been used. The room was empty and there were no staff around to attend to this. Many of the rooms did not have hand towels in the ensuite toilets and some did not have soap.

Staff told us one of the macerators, which is a piece of equipment used to dispose of continence products, was frequently blocked and caused a backlog of disposal which was unhygienic and increased the risk of contamination. The registered manager confirmed they sometimes had problems with this, but said it had recently been repaired and was now 'running Okay'.

The local authority environmental health inspector had made an unannounced visit in August 2018 to follow-up on concerns that had been raised with them. They found issues with food storage and preparation areas and a risk of cross contamination. Staff told us this had been addressed and they had not identified any further concerns during their recent infection control audits.

We observed improvements in pressure care that had been recently introduced by one of the new nurses. For example, we viewed the care plan for a person at high risk of developing pressure sores. It contained clear instruction for staff to follow; a body map of high risk areas and mattress settings for pressure reliving equipment. Nursing staff had reviewed all people who were at risk of pressure areas and developed care plans to manage this risk.

We saw a positive impact on one person's care following a review of the incidents when they had fallen. This person had been at high risk of falling due to low blood pressure and an unsteady gait and had experienced 12 falls in August 2018. Following a review of their risk assessment which included installing a PIR sensor to alert staff when they were out of bed, provision of suitable footwear and a medication review, the number of falls reduced to nil in September and one in October.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. Records did not always demonstrate that wound care advice was followed. We spoke to staff and checked care records to assess staff knowledge and skills in meeting individual people's health needs. Nurses told us how they cared for a person with feeding tube directly into their stomach and said they recorded this in the daily records of care. However, we found this was not consistently recorded. As this person frequently refused care this posed a risk to them. Also, staff were at risk if the area breaks down and their records do not demonstrate that care has been provided, or offered and refused.

Although records had been reviewed and gave clear instructions for skin care we were told by staff that this was not always followed. We saw this impacted on the length of time people were treated for existing pressure sores; and for one person, inconsistent care had led to a deterioration of an area that had previously improved. Pressure relieving mattresses were not always set according to the weight of the person using them. This reduced their efficacy and potentially increased the risk of pressure ulcer development. Records also indicated that people who required two hourly turns to reduce the risk of developing pressure sores, were not always turned at the required intervals.

We found a pressure relieving mattress for one person was set on soft when it should have been set on firm according to their weight. A second person who was underweight had their mattress set on firm when it should have been set on the soft end of the scale. When we spoke to staff they said this person was at high risk of developing pressure ulcers and required regular re-positioning. However, the daily records showed there were extended intervals between re-positioning for two consecutive nights in December. A combination of incorrect mattress settings and long intervals between turns increased this person's risk of developing pressure ulcers. We discussed this with the registered manager who advised us that they would ensure all mattress settings were reviewed and correctly labelled, with names, weight, setting and date. However, when we checked on the fourth day of inspection, we found labels on the mattress's but they did not include the person's weight, mattress setting or date. This demonstrated that staff did not always follow advice or instruction which could have a detrimental impact on people's health.

Food and fluid charts were not consistently completed for people who were at risk nutritionally. They did not always record the amount of drinks or food a person had eaten. For example, one person had a grade three pressure ulcer, which was linked to their weight and nutrition. It is essential that they receive adequate food and fluid to improve their skin integrity and repair the damaged area. However, the care records from 17 to 26 November 2018 documented the food they had eaten at meal times but did not indicate if snacks had been offered between meals and did not always indicate the amounts eaten. This meant the records were not an accurate representation of what this person had eaten and could not be relied upon if this person's weight continued to drop or the pressure area was not healing. Similar issues were found with the recording of fluids. People were at significant risk of harm and discomfort due to poor management of food and fluid intake.

One family told us their relative had been admitted to hospital from the home and was found to be severely

dehydrated on admission. We observed jugs of water in people's rooms that had been labelled four days prior to the inspection, other rooms had cups but no jugs and vice versa. We were not assured that people had regular access to drinks to keep them hydrated.

The local authority had also raised this as a concern prior to our inspection. They had made recommendations to the registered manager, about how to record this information and reminded them how important it was to have accurate records to identify people of concern, to ensure safe administration of medicines, and to maintain people's health. They recommended these records were kept in people's bedrooms so they could be updated when people had a drink or their meals. However, during our inspection visits we found the provider and registered manager had not always followed this advice. For example, when we inspected on the third day of inspection there were no food and fluid charts in people's rooms, even if they were at risk. We were not assured that staff were monitoring people's food and fluid levels which would help maintain their health and support safe administration of medicines.

This was further evidence of a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Communication across the organisation was not always effective. We were told different versions of events and incidents; and a variety of reasons were offered for the concerns we had raised. Staff felt they had not been adequately informed about the concerns raised previously and said they received little feedback following the initial inspection visits. Some staff told us their own concerns had not been acted upon and they had little feedback. A new quality manager had been employed but their role was not adequately explained to staff and staff told us they received conflicting advice as to how to care for people and maintain records. New forms had been introduced prior to and during the inspection and involved changes to the recording of daily notes, handovers and medicine administration. Some staff were still using the old forms, others the new and recording in both was inconsistent. A new rota was implemented the day before our first inspection visit, but some staff told us they had not been adequately consulted about this. They felt it had a negative impact on people during the evenings and night times, when there was less staff available to care for them.

The building had two distinct areas separated by a long ground floor corridor. The old building accommodated the kitchen, clinic room, two communal lounges, dining room/kitchenette and the kitchen. It also had two bedrooms downstairs and six upstairs, many of which were vacant during our inspection. The remaining rooms were located on both floors of the 'new' part of the building. There was a distinct separation between the two sides of the building and although some people did spend time in both lounges, this was less easy for those with limited mobility due to the long corridor in-between.

Staff told us the layout of the building made it difficult to care for people at night. On the first floor there was no access from the 'old building' to the 'new building' which made it difficult to hear if people needed assistance or attend to call bells quickly in different parts of the building. This was especially difficult when some people were in both lounges, others were in bed and there were only three or four staff on duty.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found DoLS were in place for people who required some form of restrictive care to keep them safe, for example the use of bed rails to reduce the risk of falls. However, we found mental capacity assessments were not always decision specific, were inconsistently applied and best interest decisions were not always made in consultation with all relevant people. This showed that the provider did not always follow the principles of the MCA and were at risk of placing unlawful restrictions on people.

For example, we found inconsistencies in the records and staff understanding of one person's capacity to make decisions about what they ate and drank. This person had dementia and was at high risk of choking and received most of their nutrition through a feeding tube. There was a DoLS in place which stated they did not have capacity to make safe decisions about eating. However, we found conflicting information in different areas of the care plan and associated risk assessments. Some areas of the care plan stated this person had capacity for decisions about eating and understood the risk of choking, whilst other areas stated they did not. Many aspects of the care plan had a section referring to the person's capacity to make decisions in that aspect of their care; where we repeatedly saw the comment "No problems". The mental health and speech and language teams (SALT) had been involved in this person's eating and drinking risk assessments. They had agreed they could have small taster portions of pureed food and thickened drinks under strict supervision. However, records were not consistent and there was no complete assessment of this person's capacity, that included advice from all the specialist practitioners that had been involved in their care. Staff were confused and we were not assured that decisions made in this person's best interest, always protected them from the risks of choking.

The registered manager said some staff had attended recent training on MCA and DoLS and would be cascading this to the rest of the team. We recommend this is done as a matter of priority and with advice from a recognised external source to ensure this is fully understood and embedded into practice.

Care plans were in place for people's individual care and support needs and we saw they were reviewed regularly with people and their families, as appropriate.

There had been four new nurses recruited just before our inspection and we were told by staff, families and external health care practitioners that this had led to improvements in people's care. The registered manager told us they had developed 'champion roles' and assigned different responsibilities to the nurses and to other key staff. Staff told us they preferred this way of working. One nurse was working solely on improving pressure care, other nurses had joint roles of medicine administration and specialist roles in continence, mental health or stock control. Care of non-nursing residents had improved following the arrival of the new nursing staff. For example, the continence needs of all residents had been reassessed; and nursing staff had worked with the district nurses to ensure consistency of care and appropriate information sharing. The housekeeper had taken on responsibility for oral hygiene along with their main role of infection prevention and control.

We found some improvements had been made to the management of people's skin care and pressure care. Wound assessment documentation had been implemented by one of the nursing staff. We saw evidence of good documentation of wound healing, photographs to illustrate progress of healing and we saw most wounds were improving. They had also obtained integral heel boots for people with ankle or heel pressure ulcers.

People had access to community health services and staff made referrals for specialist care and support where required. GP's visited on a regular basis and one visited during our inspection. They told us they had

good communication with the service and had no concerns regarding their patient. When we asked them about some of the concerns we had regarding managing people's health conditions they told us they were not aware of these and had 'only a few' patients at this home. People had access to other health care professionals such as dentists and opticians and we saw appointments in people's care records. One person told us they had just had some reading glasses. We saw people had glasses and hearing aids. Staff told us and records confirmed that referrals were made to the 'falls prevention team', the 'tissue viability nurse' and the 'continence nurse' when people needed specialist support to manage their health conditions.

During our inspection the service was being supported three days per week by a 'Home Care Team' nurse, who was supporting the staff to address concerns raised by commissioners and the local health authority. They told us they had seen many improvements in care and communication since they had been visiting the home and supported staff by providing knowledge and guidance on best practice in all aspects of care. They said they had seen a reduction in falls and improved skin and continence care. People looked well and were well groomed and dressed appropriately for the season.

Evidence based guidance and tools to monitor people's health were in use to identify those at most risk. For example, staff used tools to identify those at high risk of falls, of developing pressure sores and those at risk of malnutrition or dehydration. Policies referred to health and care regulations and best practice. However, tools were not always used effectively and did not always lead to improvements in people's care.

The provider had an induction programme for new staff which supported them to develop the skills necessary for their caring role. This induction was aligned to the Care Certificate. The Care Certificate identifies a set of care standards and introductory skills that non-regulated health and social care workers should consistently adhere to. This showed the provider recognised the need to ensure staff had the necessary training and skills to meet people's needs.

People were offered a choice of meals from a nutritionally balanced menu. Where people required a specialist diet or had preferences for particular foods, this was catered for. We saw people enjoying their meals and assistance offered to people. People's food and drink preferences were documented in their care plans. For example, one person's records showed they had lost weight over the last 3 months and needed a fortified diet and food supplements twice a day. Their care plan stated they should be offered additional snacks between meals and particularly liked chocolate and ice cream.

Requires Improvement

Is the service caring?

Our findings

Although we saw some lovely respectful interactions where staff promoted people's dignity; we found this was not consistent. We observed one person had been incontinent whilst sat in the communal lounge and for two hours staff did not notice or respond; despite one staff member sitting and chatting to them. They were only assisted when we brought it to the attention of staff. We observed a lady being transferred by a hoist and staff did not ensure she was appropriately covered to protect her dignity during the manoeuvre. A relative told us how they arrived to visit their loved one and found them in bed in urgent need of personal care. Staff had not maintained regular checks to ensure this person had the required assistance with personal care and they were in a very undignified state when their visitors arrived. This was very upsetting for the person and their family. A relative told us this was not the first time this had happened. They were disappointed it was still happening; especially after they had discussed previous incidents with the registered manager, who assured them it would not happen again.

We were talking with a person where English was not their first language and asked staff for assistance to understand them. One staff member responded by saying, "They can speak English, they just choose not to", and another staff member said, "It usually means they are swearing at you, they can speak English if they want to". None of the staff offered to assist the person to communicate and were dismissive of them speaking their own language. This did not demonstrate respect for people's differences or respect for individuals, their rights and their dignity.

However, other people and their families told us staff were kind and caring and our observations supported this. One person told us, "I like it here, this is my home, I have everything I need." A relative told us, "The staff here are wonderful, they understand my family member and can't do enough for them." We saw staff interactions with people were kind and gentle. Staff used people's preferred names and bent down to speak to people at eye level. We saw staff took time to talk to people walking in the corridor and sat in the communal areas. Staff understood people's needs and spoke to them about day-to-day events and areas of interest. We saw people laughing and joking with staff and they clearly felt comfortable in their presence.

There was a chaplain at the home who provided pastoral care for people and staff. They told us they lived in the local community and knew some people and their families from outside of the home. They said it was a lovely community and people supported each other and looked out for each other's family members. They told us some people were related to each other or were former neighbours or school friends; and it was nice for them to keep in touch and maintain those relationships. The chaplain held regular religious services at the home and conducted memorial services to remember people. We saw they had a good rapport with people and were kind and gentle. Families told us the chaplain was a source of comfort at difficult times. People told us they had chosen the home based on the presence and reputation of the chaplain to meet their pastoral and spiritual needs.

Staff supported people's relationships with their family and friends. Visitors were encouraged to spend as much time as possible with their loved ones and join them for meals where possible. The home accommodated couples, and relatives told us their family members had chosen to go to this home when

they could no longer manage independently, based on how they had cared for their partner in the past. Relatives told us they could visit at any time and there was always somewhere private to sit and a friendly smile from the staff. We saw relatives help themselves to drinks and refreshments and they told us, they liked the home from home environment, which made them feel welcome.

Staff told us they enjoyed working at Woodleigh Christian Care Home. One staff member said, "This is such a lovely place to work, I wouldn't work anywhere else. Staff and managers are lovely and so kind, it's part of my family now." Another said, "Everyone is so supportive, I've had lots of praise and encouragement since working here. I feel valued and encouraged to do more."

At the time of our inspection there were dedicated staff responsible for reviewing care plans. We saw that people were invited to these reviews along with their families, if appropriate. Records demonstrated people and their families were involved in the initial assessment and in care plan reviews. We saw people contributed to their care planning and were given the options on how they wanted to be cared for. Relatives told us they were informed of incidents or changes in their loved one's health and felt they were involved in caring for their loved one.

We saw staff promoted people's independence. We saw them assisting people only where it was necessary and offering support from a discrete distance. People were asked discreetly if they required assistance with their personal care and we saw people returning in clean clothes if required, demonstrating that staff had promoted people's dignity on these occasions.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive personalised or sensitive care. Although we saw some lovely examples of personalised care and staff who understood people's personalities and care needs; we found other aspects of care were not personalised or responsive. For example, one person with complex needs required half hourly observations according to their care plan. Yet staff had not noticed they had been incontinent. One evening we witnessed one person repeatedly calling out, "I want to go to bed, take me to bed please", but staff walked passed them without comment. They were not taken to bed until 30 minutes later. On the same evening we observed many people asleep in their chairs in the lounges with hot drinks that had become cold by their chairs, this indicated there had not been enough staff to assist people to drink or to remove the cups once they were no longer required.

Staff told us the provider did not like the idea of a drinks trolley, as it felt 'institutionalised'. The provider said many people could independently access drinks and snacks which were always available in the kitchenettes; and staff were always available to offer drinks and snacks to people to people who needed more support. However, we saw that snacks were not always readily available in the lounges due to the need to remove them from the sight of a person who was at risk of choking and another who had complex diabetes, but still liked sugary snacks. There appeared to be no structure or timing to drinks and snacks and sometimes these were offered just before meal times which impacted on people's ability to eat their lunch. At lunch time we observed people sat at dining tables for over an hour, whilst more people were brought down to the dining room. During this time, they were not offered their meal or a drink. Staff were busy passing through the dining room and although they made an occasional remark to some people, they did not have time to sit and chat with people, whilst they waited. Lunch time was not very personalised and people had to wait for long periods without conversation or stimulation, which meant they became sleepy or restless.

People did not always go to bed when they preferred or when they needed to sleep. We observed many people asleep in the lounges during the evening when they would have been more comfortable in bed. We saw records that indicated it was not always people's choice to stay up late. We found records that indicated one person had been up all night in the lounge the night before our inspection. The registered manager said this was their choice as they did not want to go to bed. However, we were concerned to find this person had been incontinent during this time and staff had not attended to their personal care needs.

We had a mixed response from relatives regarding how the registered manager responded to complaints and feedback. Two relatives were very happy and said they always had a positive response and open discussion about any concerns they had. They said they knew there was a complaints policy in place, but had not felt the need to make a formal complaint as they were "very happy" with the care of their loved one.

However, the relatives of a second person were less happy with how their concerns had been responded to. They told us, "They promise the earth, but never deliver". They said they had repeatedly complained about the care of their loved one and although the registered manager said they would deal with it, things had not improved. For example, they complained about a lack of drinks in their family members room and had been

assured this would be addressed. However, they said they regularly visited and found nothing available for their relative to drink.

Another relative had contacted us before our visit and complained about the lack of response to their concerns about their family members care. They were concerned about dehydration, slow response to personal care and a lack of understanding of the additional needs associated with their failing sight. They said drinks were often left out of reach or in clear jugs even though they had advised staff that drinks needed to be in coloured cups and jugs and placed closer to them so they could see them. They said although assurances were given, improvements were not always made or maintained. This meant their family member continued to receive poor quality care.

People, families and staff told us there was a 'lovely atmosphere' in the home and they enjoyed spending time there. Bedrooms and communal areas were furnished with people's personal items of furniture, pictures and photographs. There was a display of artefacts from the coal mining industry which was part of the culture and history of many of the people who lived or worked at the home. Special items of furniture were donated to the home from people and families in appreciation of care given.

There were two 'ambitions coordinators' who focused on offering activities for people in groups or on a one-to-one basis, if this was more appropriate. We saw people enjoying a craft session, having manicures and planning their next trip. The newsletter contained photographs and information on recent and planned events, which were available to people and their families. The home had a very popular choir called the 'Woodleigh Warblers' and we saw people were very happy singing carols during the regular Tuesday choir session. There was a 'Blokes Club' which met each week; and focused on activities and interests of the men at the home. Staff said this was very popular and encouraged men to talk to each other, maintain their interests and keep more alert. 'Friends on Fridays' was a coffee morning where family and friends were invited to join people eat the home and take part in activities or just chat over coffee and cake. Care plans were reviewed monthly and we saw people and relatives were invited to these meetings. Relatives confirmed they attended these meetings and found them useful.

People and their families had recently completed a satisfaction survey and staff showed us the positive comments they had received. There were 'resident and family' meetings, where staff asked for feedback on the service and they planned future activities. Where people had made suggestions regarding meals, we saw this had been implemented and the menus changed to reflect the preferred options of the people living there.

Relatives told us they had lots of support from staff when their loved ones were approaching the end of their life. They said they were able to spend as long as possible with their loved ones, overnight if they wished and they would be made welcome and comfortable. They told us the chaplain was a particular source of comfort during this time and one family member said, they had asked the chaplain to deliver the service at their relative's funeral. We saw memorial services were advertised on the notice boards and both people ad staff were welcome to attend. Staff said they had lots of support at such times and one staff member said, "The managers are really good, they are not shy at talking about things; it makes it easier to cope with. Especially when it is someone you've become attached to, some of these people are like family."

We saw end of life care plans in place and these included people's preferences for after their death, funeral services and hymns. End of life care was also discussed and preferences for staying at home or declining any attempts at resuscitation, were recorded and shared with family where appropriate.

Inadequate

Is the service well-led?

Our findings

When we shared our concerns during the first two days of inspection, the registered manager and clinical lead were not aware that poor management of medicines had led to stock running out, missed medicines, inconsistent recording, delays in administration of medicines and inadequate assessments of people's changing conditions. The management of nursing care and safe management of medicines was not effective; and as the provider and registered manager had not provided consistent or robust oversight, they were not fully aware of the extent of our concerns.

For example, before the inspection we had received concerns about how people were cared for which we had discussed with the registered manager. They assured us that our concerns would be addressed and action taken to reduce the risk of repeat incidents and people were safe from harm. However, during inspection we found that these concerns were still evident and it became obvious they had not been fully addressed in the way we had been advised. For instance, we had been advised that concerns about the management of diabetes had been addressed and blood sugars, food and fluid intake were being monitored to ensure safe administration of medicines. However, we found records evidenced multiple inconsistencies with monitoring of blood sugars, food and fluid intake. The management audits had not identified these errors and people were at continued risk of harm from poor management of medicines; and a lack of effective control measures which would ensure recommendations were being followed.

A safeguarding referral had been made in relation to one person's care and a local authority social worker was investigating this. They made several recommendations regarding this person's care which were not consistently followed by the registered manager, for example to maintain accurate food and fluid charts throughout the day and night. We found these charts were not in this person's room overnight as requested and staff could not evidence how much they had drunk during the night. The registered manager said they had alternative ways of monitoring at night and used their preferred method. However, it was evident that this method was not effective in supporting people safely.

There was a lack of clarity about who was responsible for quality assurance within the service. The registered manager had delegated this to other senior staff but had not provided effective oversight. There were few processes in place to monitor and evaluate the quality of the service and those in place were not effective in identifying issues. For example, the auditing of medicines had not identified that stock had run out and that MAR were not completed correctly. This meant errors were repeated and we saw several examples of this in the previous three months records we viewed. For instance, one person's patch medication from the previous day was 'not found' on their body on three separate days in one week. We informed the registered manager who was not aware and said they would take action to ensure this was addressed. However, at the following inspection we found further dates when the patch was 'not found'. This demonstrated that audits were not effective as they had not identified the original concern and improvements were not always made when brought to the attention of staff.

Staff were not always consulted about changes that happened at the service. The problems identified with the new rota and a lack of recruitment for all new posts before the new rota started, demonstrated a lack of

foresight when making changes within the service. The rota did not give an accurate picture of the staffing arrangements in place, and we were not assured there were consistently enough staff available to meet people's needs. Given our concerns about inadequate staffing in the evenings and night time, we were concerned that this change had been made without fully considering the impact on people and staff.

People remained at risk of harm due to the lack of a clear action plan for improvements; and inadequate oversight and management of the service. Consequently, we formally requested an action plan which clearly set out how the provider was going to address our concerns. This was provided within the required timescale. On our fourth visit to the service, we found that some actions had not been completed, despite the provider assuring us that they were and we found further concerns with staffing, where some staff had left without notice leaving vacancies in key roles.

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

Since November 2018, the provider had secured support from a management advisor, to assist them to make the necessary improvements. This person was present on the first two days of our inspection. They planned to support the development of new quality assurance processes and improve overall record keeping. Staff were also supported by an external nurse advisor who visited three days per week, to support staff to improve care, refresh skills and learn from evidence based best practice. The nurse advisor told us they had seen significant improvements in the quality of care since they had been visiting the service and staff appeared happier and more confident. They said the registered manager was responsive to suggestions and appreciated the support.

However, healthcare professionals said staff did not always follow advice or recommendations and were not always prepared for their visits. For example, staff had not monitored food and fluid intake as requested, had not followed recommendations to care for people with diabetes and had not passed on information at handover regarding a person's test date. Other professionals said they were not always informed about incidents which put people at risk of harm and these were often reported by relatives or other healthcare practitioners. We found evidence of incidents which had not been notified to us; and found we had not been made aware of information about significant changes to staffing or incidents that had occurred, during our inspections.

The service had been rated 'requires improvement' at the previous four inspections, since 2015. After the last inspection in November 2017, the provider sent an action plan outlining how they intended to address our concerns about management of medicines. Whilst we are aware some of these actions did take place and some improvements were made; they were not sustained and were not effective. A lack of provider oversight, management and leadership of the service, has led to continued concerns regarding the management of medicines and people's care.

Despite our concerns about people's care and the governance of the service, there was a warm and friendly atmosphere in the home and visitors told us they were made to feel welcome. Staff told us they enjoyed working there and were supported by the managers of the service. The service was developed around Christian principles, however being a Christian was not a requirement for staff or people using the service. Staff were invited to attend a weekly prayer group led by the chaplain. One new staff member told us they found this was calming and reassuring. Another staff member said it was lovely to have their spiritual needs supported at work. The chaplain provided a pastoral service for all staff, people and their families; staff told us they welcomed this additional support, especially when a person had died or they had difficulties in their life.

The provider was keen to achieve recognition for the staff and the service and regularly participated in regional or national care awards. Staff had been nominated for awards in different categories and some staff had won awards over recent years. The provider also held internal award ceremonies 'The WOSCARS' which acknowledged the contribution of staff and shared any achievements or good practice. Staff told us they found this empowering and appreciated the recognition they got from their managers. One staff member said, "The owner is very good, he's always here and he gives me good feedback about my work. It makes me want to do more." Staff were supported and encouraged by the opportunities for recognition within and outside of the service. This boosted their confidence and inspired them to do well.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive care and treatment in a safe way. The provider had not always assessed the risks to people's health and safety, or taken action to reduce the likelihood of harm from known risks. Incidents were not always reported, investigated or analysed. Learning from these did not lead to improvements in people's care. Medicines were not managed safely.

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 Systems or processes were not effective at ensuring compliance with the regulations and did not ensure people received safe, effective and responsive care. The provider had not responded effectively to previous requests to improve and could not demonstrate how feedback was used to improve people's care experience. Senior managers did not demonstrate the skills or competence to evaluate and improve their practice and did not always follow advice or recommendations to safeguard people from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff available to meet people's needs.

Staff were not always deployed effectively to meet people's needs.