Kodali Enterprise Limited

Woodside Care Home

Inspection report

Woodside Care Home
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Woodside Care Home on 21 July 2016. This was an unannounced inspection. The service provides care and support for up to 42 people. Some people required more assistance than others either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks and loss of memory. When we undertook our inspection there were 26 people living at the home.

People living at the home were older people. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks and loss of memory.

There was no registered manager in post. However, an interview date was set by CQC for the following week for the current manager. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. At the time of our inspection there was no one subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered through the use of a care plan. However, people were not always involved in the planning of their care and had not always had sight of their care plan. The information and guidance provided to staff in the care plans was however clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe. Care plans were currently under review to ensure all people's needs were being met.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence, choices and control over their lives. Staff had used family and friends as guides to obtain information.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had not been consulted about the development of the home. A new audit process had been put in place and checks on the quality of the services being provided had recently commenced. Therefore the provider had limited information to judge whether the services provided met people's needs. No systems were in place to monitor the upkeep of the building that adequate fire precautions were being maintained and there was no refurbishment plan in place. Due to building work in progress within the grounds the infection control procedures were being compromised.

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.

Checks were not made to ensure the home was a safe place to live.

Building work meant that infection control procedures were being compromised.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely. Record keeping and stock control of medicines were good.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not planned and reviewed on a regular basis with them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were only beginning to be undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were not sought on the services provided.

Woodside 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.

This inspection took place on 21 July 2016 and was unannounced.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service.

During our inspection, we spoke with six people who lived at the service, three relatives, five members of the care staff, an activities organiser, a cook, two housekeeping staff and the manager. We also observed how care and support was provided to people.

We looked at seven people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and staffing rotas

Requires Improvement

Is the service safe?

Our findings

When we looked around the home we found that woodwork in all areas was badly scuffed, making it difficult to keep clean. Some of the woodwork was dirty. Paintwork and wall paper generally looked worn. Carpets were stained especially in the sitting room areas and corridors. Staff told us they were difficult to clean as they were worn in places. We saw the staff vacuuming carpets in hallways where there was an odour. This disappeared after vacuuming, but the smell returned an hour later. We saw floor covering in some of the bathrooms and toilet areas were lifting from the floor surface. This could present a trip hazard for people walking in those areas. We informed the manager who took remedial action during the inspection. Some items of furniture in communal areas and bedrooms were chipped and scuffed in places.

Emergency pull cords in all communal areas and in some toilets and bathrooms did not have wipe clean sleeves. We saw this could be an infection control risk. There were currently no staff members to look at whether the infection control procedures were being adhered to in the home. A process was in place to identify and disinfect soiled mattresses. We checked the mattresses in four rooms and they were clean, but in one there was a split in the waterproof cover. This was removed by staff. However, some bed linen had stains on and staff told us stain removers no longer had any impact on the stains. Those items of bed linen were removed. There were gloves and aprons stationed at various points along corridors, all contained adequate supplies. We saw staff using gloves and aprons during the day when they helped with certain tasks such as helping someone in a toilet.

The provider had appointed a person to oversee the maintenance work within the home. However, the provider had not undertaken any safety checks with the Disclosure and Barring Service (DBS) for that person. Therefore, the work they could do was of an advisory nature only as they could only have limited access to the home. There was no maintenance or refurbishment plan in place so we did not know how the provider was going to improve the living conditions for people.

Prior to our visit we were sent a report from the fire and rescue service about items of safety which required to be completed. The finish date for this was four days after our visit, but work had not commenced. The manager told us they would liaise with the fire and rescue service and the provider to ensure work was commenced. However, there were personal emergency evacuation plans in place for each person in the event the building had to be evacuated. This included details of how people would react to an emergency situation and what staff should do and how people's mobility problems might compromise a swift exit. A business continuity plan was in place, which told staff how to respond when utilities failed. Staff knew how to access the file.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section 1a to f and section 2.

People gave us mixed views about the cleanliness of their environment and the laundry service. People told us domestic staff were on duty each day. Two relatives told us that the cleanliness of the home could be better and sometimes there was an odour in the home. However, three other people told us they were

happy with the standards of cleanliness. One person said, "It's very clean." Another person said, "It could be better in the lounges, it can smell." A relative told us, "It's improved but there is sometimes a smell. [Named relative] clothes go astray; I've seen them elsewhere even though they're named." Another relative told us, "I'm happy with the place generally and my [named relative] is kept clean."

The traffic of people through the main reception area from the building work in progress, in the grounds had made the reception area dusty and the carpet was full of dust and debris. This was not a welcoming sight for people entering the building or to live in and was compromising the cleaning programme. One relative told us, "It's shocking. I pity the housekeeping staff. It has been like this for months." The manager told us they would have a discussion with the builders and resolve the traffic of people to the care home from the building site.

Staff told us that new checklists had been put in place to keep abreast of daily housekeeping chores, individual bedroom and communal area checks. The manager had begun spot checks to ensure the work had been completed. There were very few records for us to see as this was such a new system. From a recent audit only 14 out of 34 actions had been completed. Work for domestic staff to complete was at times compromised as staff were taken to help the care staff with their work, which was the case during our inspection. Deep cleaning work could only be undertaken when three domestic staff were on duty we were informed by staff, but the staff rota showed there were usually only two on duty. This compromised the cleaning programme and put people at risk of living in an unclean environment and a risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section (h).

People told us they felt safe living at the home. Although several people told us they had experienced other people wandering into their room at night. One person said, "I'm safe. I get the odd person wandering in at night so I ring my bell." Another person said, "I feel safe inside and sitting out." The person told us they were a smoker and the smoking area was in a garden area. A relative told us, "100% she's safe." Another relative told us, "I can go to bed now with peace of mind that [named service user] is alright." People told us their belongs were safe, but they could not lock their rooms to prevent people entering. One person said, "My money is in the office safe." A relative told us, "Everything is kept safe."

People told us their needs were being met, but that there were times of the day when staff were busy. Only two people out of the six we asked about staffing told us staffing levels were fine. One person said, "I think staffing is ok." Another person said, "At night time when we need them most, there's not enough. We wet ourselves before they come. It happens more and more just lately. They're short staffed." A relative told us, "There are just not enough of them. At night time I can come in 5-6pm and not see a soul, just residents sitting there."

Staff told us that the staffing levels were stretched and that at certain times of the day it would be beneficial if more staff were available. One member of staff said, "Now it's better, we've got some extra staff." Another staff member said, "It's better since we've had an extra staff member from 4-7pm." Staff told us they could voice their concerns about staffing levels to the manager and they were listened to by them. One staff member said, "[Named staff member] is sorting this out now." Staff told us that there had been some short term sickness amongst staff, but that the manager was liaising with certain staff members about their sickness levels of absenteeism.
The manager told us there was a recruitment programme in place and interviews were taking place to increase the staffing levels. In the meantime permanent staff were filling gaps in the staff rota. One staff member said, "At least the management team come and work alongside us now if someone phones in sick

at short notice or is on holiday."

We observed during the day that staff were always busy and did not have time to sit with people to give them quality time. We observed that during the afternoon people were left in sitting room areas for periods of 30 minutes at a time without any interaction from staff. This could result in people feeling isolated and for those unable to communicate verbally that their needs were not being met. Staff attended immediately to people's needs who could shout out their wishes.

People told us the response to their call bells being activated could vary greatly. One person said, "I use it quite a lot. Sometimes they're very quick, sometimes very slow." A relative told us they activated the call bell when their family member needed the toilet facilitates. They said, "It can be quick or can be half an hour. Meal times is when they have the main shortage." We observed during the day there were periods when staff took a long time to answer call bells, but saw staff were all busy on tasks. The last call bell audit had been in February 2016 which showed similar results to what people had told us. The manager told us it was an audit that was to be recommenced.

The manager told us there were no current calculations of the numbers of staff required to meet people's needs. Therefore, they did not know whether the numbers of staff on duty could meet people's needs. The manager told us the provider had the final say about the staffing levels and that they regularly liaised with them.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a new process in place for reviewing accidents, incidents and safeguarding concerns. Only one month had been completed so far. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through shift handover periods and meetings when actions needed to be revised. We saw details of changes required in the staff handover diary and the manager's handover records.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls. A falls assessment had been completed over a number of days. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely around the building.

Staff and people's records confirmed that assessments had taken place on the capability of people to smoke unsupervised. Staff had assessed each person's capabilities and encouraged their independence by showing them where they could smoke on the premises. For people unable to smoke unsupervised we observed staff sitting with those people and ensuring burnt ash did not drop on clothes and ciggerates were disposed of safely.

We looked at three personal files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. Each

file had a photograph of the staff member on the cover for ease of identification.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. One person said, "I have eye drops at the moment and they do me fine." Another person said, "They stay with me and my pills." Medicines prescribed had been explained by GPs' and staff within the home. One relative was concerned about how their family member was taking their medicine, so we informed the manager, who spoke to them. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in a locked room. There was good stock control. Records about people's medicines were completed and there was clear information about pharmacy arrangements. However, we brought to a senior staff member's attention that staff were not always recording the codes when people, for example, refused their medicine. This could lead to confusion as to whether a person has taken their medicine or not. A new medicine audit had been commenced for use at the staff shift handover period. Staff told us they found this useful. The local pharmacy had completed an audit in June 2016 and all actions had been signed as completed. The medication policy was due for renewal in August 2016. However, we did not see a policy in place if the refrigerator storing medicines broke down. The manager told us they would write a protocol.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions. Staff administrating medicines had all received training. Staff told us this had found this training useful.

Good

Is the service effective?

Our findings

Staff members we spoke with told us how long they had been employed by the provider and the length of service varied. Two staff members told us their induction had been suitable to their needs at that time. This included assessments to test their skills in such tasks as manual handling. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. The manager told us that the provider was embracing the principles of the care certificate for all staff. This would give everyone a new base line of information and training and ensure all staff had received a common induction process and core standards to follow.

People we spoke with told us they felt some staff were more skilled than others. Other people thought staff were capable in doing their job. One person said, "They seem capable enough." A relative told us, "I think they are well trained, not all brilliant though."

Staff said they had completed training in topics such as manual handling and infection control. They told us training was always on offer and it helped them understand people's needs better. The training took the form of completing work books, with test certificates and external trainers attending the home or staff attended training elsewhere. The training records supported their comments. Staff had also completed training in particular topics such as dementia and dietary needs of older people. This ensured the staff had the relevant training to meet people's specific needs at this time. Staff told us the manager was encouraging them to expand their knowledge by setting up courses on topics such as supervising other people and higher vocational training courses.

Staff told us a system was in place to test their competences through formal supervision sessions. They told us that they could approach the manager at any time for advice and would receive help and supervision until they were competent in a task. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a planner on display showing when the next formal sessions were due.

The 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).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS, but no applications had been made to the supervisory body. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

People told us they could make choices, such as choosing their bedtime, clothing and where to relax. We observed staff attending to people's needs and allowing them choose where to sit for lunch and having a window open near them.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. The manager told us they were still checking to see that all the relevant capacity assessment had been completed and had an action plan in place for completion. The records showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Three people were subject to a court of protection order. This meant in these cases they had no one to manage their affairs. We saw in the care plans when this had been discussed at best interest meetings and the manager was obtaining the documents to support the court orders.

People told us that the food was good. One person said, "The food is a bit old fashioned really, but it's quite nice." Another person said, "It's good. We get a choice or can ask for something different." A relative told us, "[Named relative] put weight on. [Named relative] eats everything they put in front of [named relative]. They even offered me lunch today as I hadn't realised the time. It looks excellent." One relative was concerned about a family member's weight so we informed the staff and they went to speak with them.

During the morning we observed staff asking people what choices they would like for lunch. Some people did not want the choices on offer so the cook prepared a pizza for one person, an omelette for another and soup for a third person. We observed the lunchtime meal. Tables were laid with no cloths, but there was basic cutlery, a cruet and a posy vase. One person required easigrip cutlery, which they were offered. The food was well presented and looked fresh. A choice of squash or water was offered to drink.

Four people required assistance with their meal and two care staff sat at the same table and ate their meal whilst assisting them. A member of staff told us this was because they had found this helped the people eat their meal better. Interaction between staff and people in the dining room was good and unhurried. A member of the kitchen staff offered second helpings.

We observed people being offered hot and cold drinks throughout the day that were in sitting rooms. We did not see drinks offered to people in bedrooms and there were only jugs of water in some rooms. In the afternoon a member of staff arrived with a trolley in a sitting room and said, "I'm here. I've got the tea and coffee and lots of biscuits folks." The staff member then offered people choices of drinks, whilst a second staff member, wearing gloves, offered the biscuits. However, everyone was offered two biscuits, with no choice and the biscuits placed on tables near each person. No plates were used. This could be an infection hazard to the people eating.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans of people living their permanently; such as when a person required a special diet and for someone who needed assistance to eat their meals. This ensured people received what they liked and what they needed to remain healthy. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs when required. The kitchen kept separate records of people's special requests and allergies. These were on paper records and on a white board in the kitchen.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. Staff used a staff handover book to write down specific tasks which needed

completing. We saw entries about medical appointments and medicines.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to walk during the day to help their mobility. We heard staff speaking with people about hospital appointments and other appointments. People told us staff treated them with dignity and respect at all times.

People told us staff obtained the advice of other health and social care professionals when required. One person said, "I go out the dentist. I don't like the chiropodist as my legs shake." A relative told us, "The optician has been in to check [named relative] eye problem." In the care plans of people staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as opticians appointments. We also saw in the records when people had visited the chiropodist and dentist. Several of the people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a better rapport with other health professionals now and felt supported by them when they required assistance. One staff member said, "I don't' think other health professionals realised how well we know our residents. The atmosphere is better between us all now." This has ensured people are offered the services of other health professionals to maintain their health and well-being.

Good

Is the service caring?

Our findings

People told us they were well cared for by staff. They said that staff were always kind and protected their privacy. One person said, "They're good at privacy." Another person said, "They give me good privacy upstairs." A relative told us, "I tend to leave the room while they're doing things for [named relative] and I know they shut the curtains."

We observed staff being friendly and caring towards people. People told us staff were always the same. A relative said, "They're always caring, without exception and are considerate." Another person said, Oh yes, they're very very good." However, another person told us, "Some are kind, some not quite so, but they're helpful."

People were given choices throughout the day of what they wanted to do. Some people joined in activities in a sitting room, whilst others choice to be in their bedrooms to relax in. Staff respected people's choices. One person said, "I have to reply on them to help. They let me choose my clothes as I know what I've got." Another person said, "They don't really encourage me as I need their help all the time."

However, people told us staff had little time to sit with them for quality time. One person said, "There's never time for them to sit." Another person said, "The staff don't come and sit with me, just do jobs." A relative told us I'm with [named relative] most of the day. We don't see anyone else." Staff were busy throughout the day. They did not ignore people, but had no time to sit for any length of time and relax with people. When they did sit down with people they asked questions about people's days and remind people of forth coming events; such as a forth coming birthday celebration.

All the staff approached people in a kindly manner and were knowledgeable about each person. They were patient with people when they were attending to their needs. For example, a staff member was helping some-one to move from a dining chair to another room. They encouraged the person to slowly stand and held their hands until they obtained their balance. The staff member knew the person had a stiff knee and suggested some light exercise by saying, "Little knee bends to get your poorly knee moving again." The person did this before walking on.

Staff could tell us about each individual person who lived at the home, their likes and dislikes and their family connections. People told us staff listened to them and knew their needs. One person said, "They always call me [named themselves], not by my first name as they asked me what I prefer." Another person said, They always listen. They know me so well." A relative told us, "They seem to know [named relative] well."

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, when asking people about their choices of what book, magazine or newspaper they would like. Staff asked them if they were comfortable and had everything they

needed to hand.

We observed some staff knocking on doors prior to being given permission to enter a person's room, but some staff did not observe this practice. One person said, "They always do ask." A relative told us, "They do ask [named relative] and explain as [named relative] can understand even if [named relative] gets confused." They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment. We observed staff ensuring people had suitable clothing on when going out of the building.

Staff told us that they had never witnessed any poor practices in the home between staff members, the people who lived there or visitors. They told us how they would approach this if it occurred, which followed the provider's policy on dignity and respect. One staff member said, "I've never witnessed anything like that and the manager would not tolerate such poor behaviour."

People told us they could have visitors whenever they wished. We saw several signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis and they were offered refreshment and opportunity to speak with staff. This was recorded in the care plans. One relative said, There are no restrictions for me, and my times do vary." People told us staff would telephone their family members when they wanted to speak with them.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Staff knew how to contact the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

People gave us mixed views about the personalisation and effectiveness of the care they received. Some people told us they received care in a way they liked, whilst others told us they felt staff helped them using the quickest and easiest method for them as staff. One relative said, "To be honest, yes I do think [named relative] gets the care that [named relative] needs." Another person said, "They don't' get me to the toilet in time, they need to be quicker."

People we spoke with gave us mixed views about their involvement in the care planning process. Some families told us they did not feel involved in the care planning process. One person said, "My key worker does it and keeps me up to date." Another person said, "They talk to me about it and I check before I sign." A relative told us, "They don't' involve me at all and don't keep me updated on what's happening."

Family and friends involvement had been recorded in the care plans, but this was not consistently written. There were some details about visits made by families and friends, but people told us of events which had occurred which had not been recorded; such as visits to hospital appointments. No nationally recognised assessment tools were used for people who had impaired cognitive ability or other communication difficulties. However, staff had recorded when people had, for example a hearing or sight problem which needed equipment to help them function better; such as a hearing aid or spectacles. This meant people may not understand their care plans.
There had been no auditing for care plans since the last inspection, but the manager was just revising the care plan system in use and beginning an auditing process. This will ensure staff are recording all events accurately. The care plan reviews for each person were just being completed at the time of our inspection. Staff had been working through each care plan and ensuring the details were correct. They had been helped by commissioners of services to re-assess some people's needs and to develop care plans for each person.

People told us staff had the skills and understanding to look after them and knew about their social and cultural diversity, values and beliefs. People told us that staff knew them well and about their beliefs and how those beliefs could influence their care needs. Staff knew how to meet people's preferences with suggestions for additional ideas and support. This means people had a sense of wellbeing and quality of life.

People told us that staff took time each day to discuss their care and treatment. As well as the opportunity to speak with other health professionals. This had not always been recorded in each care plan. For example being able to see a chiropodist for both routine and urgent foot care. People had told us when events had taken place, which were not recorded in the care plans.

People told us that some good activities were arranged and others felt that at times these could be lacking. They told us outing opportunities were limited. One person said, "No, we don't do much, not at all. They look at the TV a lot." Another person said, "We don't get out a lot. We have bingo now and then. I've made a few good friends here and we sit together." One person said, "I like the Wednesday musical movement. We get singers come in an evening. We get a film afternoon too. A carer might walk you into town as we don't go on outings now."

Any activities which had occurred in the last year were recorded in the care plans. This was mainly group events such as art sessions, music to movement and entertainment. Staff told us no one had any current hobbies that they were involved in. People and staff told us one to one support was offered to people who did not like to leave their bedrooms. This included word search, reading and news discussion. This had only been spasmodically written about in the care plans.

People confirmed that a religious leader from a local church visited once a month to offer support for people's spiritual needs. There were notices on display about the date of the next service and details on the activities board about a televised songs of praise.

The garden area was being redeveloped because of the building work. The activities co-ordinator had purchased some planters, which people had painted and decorated, whilst other people had planted them with bedding plants and strawberry plants. One person told us, "It's beginning to look very cheery out here."

People are actively encouraged to give their views and raise concerns or complaints, but told us they were given very little feedback when concerns were raised. People told us they were happy to make a complaint if necessary and felt their views would be respected and staff always listened to any concerns. Each person knew how to make a complaint. People told us they felt any complaint would be thoroughly investigate, but did not receive feedback. We saw the complaints procedure on display.
The complaints log detailed the formal complaints which had been received. It recorded the details of the investigations and the outcomes for the complainant. There were no details whether people had been informed of the outcomes. The manager had completed a report in April 2016 of issues which had arisen and action plan of how to deal with each one. This was in the process of being completed.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post. The manager had only been at the location for a short while and the provider was overseeing the running of the home.However, they had submitted their application which was in progress. We are still waiting for the outcome to be decided by the CQC registration team. There were mixed views from people about the availability and approachability of the manager and the provider. One person said, "The top man comes sometimes, who I see around." Another person said, "I often see her around and can talk to [named staff member]." Another person said, "They're alright. I could talk about a problem." Another person said, "I think there's a man and a woman."

People told us the atmosphere in the home was friendly and staff were caring. Although one person told us, "It's sometimes a bit solemn." People said they could talk openly. People told us they were well looked after, could express their views to the manager and felt their opinions were valued. However, they did not feel they had any say about the environment they lived in or the proposed building works. One person said, "I'd talk to my key worker." A relative told us, "I could talk to anyone on the staff." They went on to name the manager.

Relatives and friends had completed questionnaires about the quality of service being received earlier in the year. One person said, "Some time ago I had a form." The last questionnaire had been in May 2016 for family and friends who used the service and was positive. Staff told us meetings were held with people who used the service, but these were infrequent. We saw the minutes of the last meeting, which was in February 2016. There were no details of whether issues raised in the questionnaires or meeting had been actioned. People had told us they received little or no feedback of issues raised. This could result in people feeling their comments were worthless and they had not say in the running of the home. We saw a poster on display advertising a residents meeting for a few days after our inspection but people were not aware of that or previous meetings.

The manager had just commenced a new checking system to see whether the services being provided suited the needs of people living at the home, but these had only commenced in July 2016. However, the registered provider did not have a system in place to demonstrate that they regularly reviewed the quality of the service that they were providing. This meant they could not assure themselves or others that the services provided met people's needs and were on an acceptable standard.

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working, but did not know whether the provider took any notice of their views. We saw the minutes of the staff meeting for February 2016. The meeting had a variety of topics which staff had discussed, such as; rotas and care plans. There was no record of whether actions identified had been completed. This ensured staff were kept up to date with events, but the staff meetings did not occur very frequently. Staff told us they felt they were not included in the development of the home and the building work in progress. Although we were shown the results of a staff survey from February 2016, the staff we spoke with were not aware the survey had taken place. In addition, as the registered provider lived abroad and communication could be limited, there was no system for the registered provider to assure

themselves that they were able to gather the views of staff and act on their feedback.

There was no evidence to support how the provider was liaising with staff within the home. The provider does not live in the United Kingdom and visits infrequently. Staff told us this was by email and telephone, but no evidence was produced to support the process.

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

Staff told us they worked well as a team and felt support by the manager. One staff member said, "It's more relaxed now and I feel very well supported." Another staff member said, "I feel the manager has a tough job, we are behind her as she is behind us."

The manager was seen walking around the home during our inspection. They talked with people who used the service and visitors. They could immediately recall items of information about each person. They gave support to staff when asked and checked on people's needs. Where necessary they also assisted with some personal care tasks; such as assisting someone with their personal needs.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken

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 There were no systems in place to ensure infection prevention procedures were being adhered to and people were free from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises were in a poor state of repair and there was no system in place to monitor the environment for the safety and comforts and safety of people living there and visitors.

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 There were no systems in place to monitor the quality of the services on offer and no clear guidance from the registered provider to staff.