Mr & Mrs M Ellis

Woodthorpe View Care Home

Inspection report

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Tel: 01159624556

Date of inspection visit:
07 February 2018
12 February 2018

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 unannounced inspection took place on 7 and 12 February 2018. Woodthorpe View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Woodthorpe View Care Home accommodates up to 28 older people in one building. During our inspection, 16 people were using the service.

Following our inspection on 6 February, 1 March and 8 March 2017 the service was rated 'Inadequate' and placed into special measures. The provider sent us an action plan outlining how they would improve. During our last inspection on 27 July 2017 the service was rated as 'Requires Improvement' as further improvements were needed. The provider told us they would complete their action plan by the end of August 2017 and a new audit system would be introduced. During this inspection we found that actions had not been fully implemented and identified additional concerns in relation to people's safety and the governance of the service.

The service had a registered manager in place at the time of our inspection who was also the registered provider. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from risks associated with the premises, the improper use of equipment or from risks associated with their care and support. People could not be assured that the management and storage of medicines was safe. Not all staff were aware of the action which should be taken when accidents occurred. People told us they did not have to wait for support from staff but improvements were required to ensure that staffing levels were determined by people's needs. The service appeared clean but we were not assured that sufficient action was taken to ensure that robust infection control procedures were in place. People felt safe and were supported by staff who knew what action to take if they suspected abuse.

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 do not support this practice. People were supported by staff who had received training relevant to their role although some staff felt that the quality of training required improvement. People were complimentary about the food at the service but we saw people did not always get the supervision they required to ensure their safety. People had access to health professionals, however, information in care plans about the support people required to maintain good health was not always clear. The premises was suitable for the needs of the people living at the service, however, information was not readily available in the event people needed to move between services.

People told us that staff at Woodthorpe View Care home were kind and caring. Our observations supported

what people had told us. Information about independent advocacy was not made clearly available to people and not everyone living at the service felt they were involved in decisions about their care. People were supported to maintain the privacy and dignity by staff however people's care records were not stored securely.

People were at risk of receiving inconsistent support which was not always personalised to their needs. People's care plans did not always contain information about how staff should support them in line with their preferences at the end of their life. People were supported to take part in limited activities and social opportunities. People felt confident to make a complaint or raise concerns about the care and support they were provided with.

The service was not well led. Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of harm. There was poor oversight of the service which meant that areas for improvement were not identified or acted upon. People were provided with opportunities to provide feedback on the service they received. Staff expressed mixed views on whether the management structure at the service was conducive to driving improvement.

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 take action 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 of overall, we will take action 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from risks associated with the premises, the improper use of equipment or from risks associated with their care and support.

People could not be assured that the management and storage of medicines was safe.

People could not be assured that all staff were aware of the action which should be taken when accidents occurred.

People told us they did not have to wait for support from staff but improvements were required to ensure that staffing levels were determined by people's needs.

The service appeared clean but we were not assured that sufficient action was taken to ensure that robust infection control procedures were in place.

People felt safe and were supported by staff who knew what action to take if they suspected abuse.

Is the service effective?

Requires Improvement

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.

People were supported by staff who had received training relevant to their role although some staff felt that the quality of training required improvement.

People were complimentary of the food at the service but we saw people did not always get the supervision they required to ensure their safety at mealtimes.

People had access to health professionals, however, information in care plans about the support people required to maintain good health was not always clear.

The premises was suitable for the needs of the people living at the service, however, information was not readily available in the event people needed to move between services.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that staff at Woodthorpe View Care home were kind and caring. Our observations supported what people had told us.

Information about independent advocacy was not made clearly available to people and not everyone living at the service felt they were involved in decisions about their care.

People were supported to maintain the privacy and dignity by staff however people's care records were not stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving inconsistent support which was not always personalised to their needs.

People's care plans did not always contain information about how staff should support them in line with their preferences at the end of their life.

People were supported to take part in limited activities and social opportunities.

People felt confident to make a complaint or raise concerns about the care and support they received.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of harm.

There was poor oversight of the service which meant that areas for improvement were not identified or acted upon.

People were provided with opportunities to provide feedback on the service they received.

Staff expressed mixed views on whether the management structure at the service was conducive to driving improvement.

Woodthorpe View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 was also undertaken in relation to some concerns we had received in relation to people's safety at the service.

This inspection took place on 7 and 12 February 2018 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us. The inspection was also informed by other information we had received from and about the service, including statutory notifications. A notification is information which the provider is required to send us by law. This also included previous inspection reports and feedback from the local authority, who commission services from the provider.

During the inspection, we spoke with nine people who were staying at the service for respite or living there permanently and three relatives or friends who were visiting. We spoke with the registered manager, the deputy manager, the quality assurance manager, a cook, three members of care staff and a member of domestic staff. We also spoke with a visiting healthcare professional.

We looked at all or part of the care records of six people who used the service, medicines administration records, staff training records and the recruitment records of three members of staff. We also looked at a range of records relating to the running of the service, such as audits and maintenance records.

Following the first day of our inspection we wrote to the provider and asked them to tell us what action they would take to reduce risks to people by 9 February 2018. We returned to the service on 12 February 2018 to check whether the identified actions had been completed.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2017 this key question was rated 'Requires Improvement' as we concluded that the provider needed more time to embed systems and processes to ensure people were safe. During this inspection we found that safe systems and processes were not followed which had left people at risk of unnecessary harm.

People were not always protected from risks associated with their care and support. We were not assured that the risks in relation to falls were regularly assessed and that sufficient action was taken to reduce the risk of harm. We looked at the care records of five people who had risk assessments in place in relation to falls. Records did not show that risk assessments had been reviewed regularly or when changes had occurred. For example, one person had experienced five falls since their falls risk assessment was completed and this had not been reviewed. In addition, another person had fallen and sustained an injury; however their risk assessment had not been reviewed.

We were not assured that measures required to reduce the risk of harm to people had been fully considered and implemented. During our inspection visit we saw that a piece of equipment was not being used for one person as recommended by an external health professional. In addition, another person's risk assessment indicated that equipment was required to reduce the risk of harm from falls. No equipment was in place for this person until we discussed this with staff during our inspection. This meant that equipment required to keep people safe was not always being used. We received assurances from the provider that this equipment was put into place following our inspection.

People were not always protected from risks associated with the premises or the use of equipment. On the first day of our inspection we found that routine fire checks had not been carried out. For example, records showed that fire alarm tests had not been carried out since August 2017 and emergency lighting had not been tested since March 2017. This placed people at risk of harm in the event of a fire at the service. We wrote to the provider and asked them to take urgent action in relation to this. When we returned on day two of the inspection we found that some fire checks had been completed and that other checks were in the process of being completed.

We saw an emergency evacuation list on display in the service did not contain an accurate list of the people who were living or staying at the service. For example, at the time of our inspection three people were spending all of their time in bed and required assistance to walk. None of these people were included on the evacuation list. In addition, the list did not include information about the support people would need to evacuate the building. This did not assure us that sufficient information was available to assist a smooth and timely evacuation of people in the event of a fire or other emergency. We wrote to the provider and asked them to take urgent action in relation to this. When we returned to the service on day two of our inspection we found that the list on display had not been updated, however we were provided with an up to date list on the 13 February 2018.

People could not be assured that equipment was always used safely at Woodthorpe View Care Home. Bed

rails are sometimes used to reduce the risk of a fall from bed. It is important that consideration is given to whether the use of bed rails is suitable for the person because unsafe use could cause people harm. During our inspection we saw that bed rails were being used for a person whose records showed had sustained a skin injury as a result of the bed rails being in place. A bed rails risk assessment had not been carried out to ensure that the use of bed rails was suitable for the person. We wrote to the provider and asked them to take urgent action in relation to this and they confirmed that a risk assessment had been completed following our inspection.

During our inspection we observed that a piece of safety equipment was being used for one person. We reviewed this person's care records which showed that an external health professional had recommended that staff stopped using the piece of equipment as it could increase the risk of harm to the person. The advice of the health professional had not been followed which left the person at risk of increased harm. We wrote to the provider and asked them to take urgent action in relation to this which they had done when we returned to the service on 12 February.

People could not be assured that all staff took appropriate action when accidents or incidents occurred. During our inspection we witnessed a person fall in a communal area of the service. A staff member assisted that person from the floor using an inappropriate moving and handling technique. The staff member confirmed they had not received moving and handling training. We wrote to the provider and asked them to take urgent action to address this and they confirmed that no staff would assist people with this unless they had received training.

Systems in place to ensure that appropriate action was taken when accidents and incidents occurred and that lessons were learnt to prevent a recurrence, were not effective. We were told that all accidents and incidents were recorded in an accident book and that staff were required to fill out additional documentation for falls. This was to ensure that sufficient action had been taken in response to the fall and that an analysis could be carried out. The accident book recorded that one person had fallen six times between 14 December 2017 and 22 December 2017. Additional documentation had not been completed by staff. Records stated that a referral had been made to the falls team for the person on 18 December 2017. However, there was no evidence that the person had been seen by the falls team or that the referral had been chased up. This meant that the system to ensure that robust and timely action was taken in response to accidents or incidents was not effective. In addition, one person had sustained a skin injury as a result of the use of bed rails on 12 January 2018. Although action was taken in response to this incident to prevent a reoccurrence of injury, this learning had not been applied to other people with bed rails in place. Records showed that another person also sustained a skin injury on 6 February 2018 as a result of the use of bed rails. Therefore there was no learning taken from the first incident, to ensure that appropriate safety measures were considered for other people.

People could not be assured that medicines were managed safely at Woodthorpe View Care Home. Good practice guidance had not been followed which would help ensure that medicines administration was safe. Records showed that medicines administration records had been handwritten. There was no evidence that another member of staff had checked the records for accuracy. This increased the risk of a recording error being made. In addition, no records were kept of the support provided to people with topical medicines, such as creams. This meant we were not assured that people were supported to take topical medicines as required. In addition, sufficient information was not always recorded to aid the safe administration of medicines, such as a photo of the person, information about how they took their medicines and details of their doctor. During our inspection we found that protocols for medicines which were prescribed to be given 'as required' (known as PRN) were in the process of being completed. However, these protocols were not located with medicines administration records and were not in place for all people. This meant we were not

assured that sufficient information was available to staff to ensure the safe administration of medicines.

People could not be assured that medicines were stored safely and securely. At the time of our inspection visit, medicines were stored in a lockable filing cabinet which was not attached to the wall. The use of unsecured filing cabinets is not recommended as it increases the risk of unauthorised access to medicines. Regular checks and audits of medicines were not being carried out to ensure that the management of medicines was safe. For example, good practice guidance recommends that controlled drugs checks should be carried out weekly, which they were not. Controlled drugs are medicines which require special administration and storage. When we checked the stock of one prescribed controlled drug we found this did not tally with the amount recorded in the controlled drugs book. Because regular stock checks had not been carried out it was not possible to establish when the discrepancy occurred. Strict controls are needed for controlled drugs because they may be misused. This meant there was a risk that controlled medicines may not be not used properly.

All of the above information constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about the management of medicines with the registered manager who confirmed that these issues had been raised by an external agency in January 2018 prior to our inspection. They told us of their plans to address these issues. Some of the actions identified by the external agency had been addressed by the time of our inspection, such as all staff being assessed for their competency to administer medicines. We observed that only staff who had been assessed as competent to administer medicines were doing so during our inspection.

People told us they received the care and support they needed from staff in a timely way. One person told us, "I don't have to wait long (for staff) when I press the buzzer." A relative we spoke with said, "There seems to be enough staff." During our inspection we observed that staff responded promptly to people's requests for support on all but one occasion. On this occasion staff had left a hand bell with people in a communal area of the service. We observed that people rang the hand bell three times and then shouted for help from staff as one of the people present in the room was feeling unwell.
The staff we spoke with felt that staffing levels were usually sufficient but that sometimes they were not able to maintain a presence in communal areas of the service due to some people requiring the support of two staff. They told us that on these occasions, the duty manager maintained a presence in communal areas.
The provider did not have effective system in place to assess how many staff were needed to support people. During our inspection, the deputy manager told us that three care staff were required in the mornings to meet the needs of people. During our visit on 7 February we observed that only two staff were providing care. When we informed the registered manager of this they told us they were not aware that only two staff were providing care. We looked at staff rotas for the period 13 January 2018 to 3 February 2018 which showed that three staff were providing care during the mornings on only six occasions. This meant that the staffing levels determined by the deputy manager as being required where not always provided. We were told by the registered manager that the amount of staff required at Woodthorpe View Care Home was determined by the number of people living at the service. This meant that the needs of people were not considered and there was a risk that staffing levels were not sufficient to meet people's needs.

People could not always be assured that safe recruitment practices were always followed. The recruitment records for one staff member were incomplete. There was no evidence of previous employment references being obtained and no photo identification. We spoke with the staff member who told us that the required checks had been completed; however this was not clearly documented. It is good practice to ensure that systems are in place which clearly identify that recruitment processes have been followed and any risks

identified.

People told us the service was kept clean. During our inspection we observed the service appeared clean and records showed that staff had received training in infection control. The service had dedicated domestic staff who completed cleaning schedules and carried out basic checks. Despite this, an external agency carried out an infection control audit shortly after our inspection visit and found that the arrangements for making sure the service was kept clean and hygienic were insufficient to reduce the potential spread of infection. This was because required actions had not always been completed. Management audits of infection control had not been completed to ensure actions were completed and hygienic standards maintained.

People told us they felt safe living at the service. One person told us, "It's safe and I like it here" whilst a person's relative told us, "My relation is safe."

People were supported by staff who had either received training in safeguarding adults or were due to complete safeguarding training shortly after our inspection. The staff we spoke with were knowledgeable about the action they would need to take if they suspected abuse. Staff told us they would report concerns to the management team and were aware of the role of the local authority in investigating suspected abuse. All of the staff we spoke with were confident that the management would take action in relation to any reports of potential abuse, and also told us they felt confident to 'blow the whistle' and report to the local authority if needed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2017 this key question was rated 'Requires Improvement' as we concluded that improvements were required in relation to staff training. During this inspection we found that improvements had been made to staff training. However, further improvements were required to ensure that capacity assessments were carried out when people's capacity to make decisions was in doubt.

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. We checked whether the service was working within the principles of the MCA.

We were not assured that people's rights under the MCA were protected as capacity assessments had not always been carried correctly. We spoke with one person who told us they felt they were not consulted about decisions about their care and support. They told us they were not involved in decisions and "I don't think people (staff) are interested in what I want." This person had very limited information in their care plan about how they had been involved in decisions about their care or whether they had capacity to make their own decisions. We spoke with the registered manager who told us they were not sure about the person's capacity. Despite this, a capacity assessment had not been carried out. The staff we spoke with gave conflicting information about whether other people at the service had the capacity to consent to their care and treatment.

The above information constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people told us they were involved in decisions about their care and treatment. For example, one person confirmed it had been their decision not to use a piece of equipment; however this had not been recorded.

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. Records showed that an application had been made for a person who was a risk of being unlawfully deprived of their liberty.

People did not always receive an assessment of their needs before they moved to the service. The registered manager told us that pre admission assessments should consider whether people had any needs in relation to the protected characteristics under the Equality Act and that care plans would be developed if needs were identified. As pre admission assessments had not been completed we were not assured that people's diverse needs were considered.

We asked the registered manager how they ensured they kept up to date with good practice guidance in relation to care and support delivery. They told us they delegated this responsibility to other members of staff. During our inspection, we found that good practice guidance had not always been implemented, for example, in relation to the use of bed rails and medicines management. Therefore we concluded that the care and support provided did not always reflect current good practice guidance.

People told us they were supported by staff who appeared competent in their role. One person told us, "They (staff) are good and appear to know what they are doing." Another person's visitor told us, "I don't really know much about the staff but I don't have any concerns."

The majority of staff we spoke with felt that the training they received at the service was of a sufficient quality for them to perform their roles effectively. We were provided with staff training records which showed that staff had received training or that training had been arranged in aspects of care delivery such as first aid, moving and handling, fire evacuation and food hygiene. A member of staff told us that when further training needs had been identified, these were provided. For example, they told us that the provider was in the process of arranging diabetes training for staff and that staff were supported to undertake competency based training qualifications such as diplomas in adult social care (formerly known as NVQ's).

Staff told us they received an induction when they commenced working at the service and the majority of staff felt this was of sufficient quality. However, all of the staff we spoke with told us they had spent time 'shadowing' other staff when they commenced working at the service which enabled them to get to know people and learn about the support people needed. Staff told us they felt supported in their role and had regular supervision with a member of the management team.

People were complimentary of the food at the service. One person told us, "The food is very good." Another person told us, "I have a lot of food allergies. They know about them and anything I want, they get."

People were provided with a choice of meal and staff told us they asked each person what they would like to eat on a daily basis. One person confirmed they were offered a choice of meal but we observed people could not remember what they were having for their meal and there was no information on display informing people about what choices were available. We observed people were provided with sufficient amounts of food, offered second helpings and overheard people saying they had enjoyed their meal.

Risks in relation to people's nutritional needs had not always been fully assessed and it was not always clear that sufficient action was taken when a risk had been identified. Records showed that guidance had been provided by a health professional that one person required a modified diet and for their meals to be monitored. The cook showed us guidance they had on display which stated the person required a soft diet and supervision during meals. During our inspection visit on 7 February 2018 we observed that a member of staff was not always present in the dining room during a mealtime to provide supervision. We wrote to the provider and asked them to take urgent action in relation to this. When we returned to the service on day two of our inspection we saw that a member of staff was present in the dining room throughout the mealtime.

People told us they had access to healthcare professionals. One person told us, "The optician comes here." A person's relative told us, "They (staff) ring me if they are concerned (about person's health)." They told us that they were confident that their relative was provided with appropriate healthcare support.

People's care records showed that people had access to a range of healthcare professionals such as their GP, an optician, speech and language therapist and community nurse. However, there was a risk that people

may not receive the support they required with specific health conditions, as staff did not have access to sufficiently detailed information. For example, care records stated that two people had specific health conditions but there was no guidance for staff about these conditions, how the person might be affected and the signs and symptoms that may indicate a deterioration in their health. The staff we spoke with were aware of these people's conditions but had limited knowledge about what signs and symptoms to look for. Despite this, the visiting health professional we spoke with told us they were contacted appropriately for support when people's health needs changed and staff were knowledgeable about the people they supported.

Information was not readily available in the event that people needed to leave the service and go to hospital. The quality assurance manager told us they had plans to address this by engaging with a scheme intended to improve the sharing of information across services but this was not yet in place. They told us that currently staff would write out a person's care and support needs if they were admitted to hospital. This presented a risk that important information about the person would not be available quickly if they moved to a different health or social care setting.

Woodthorpe View Care Home is comprised of one building which was suitable for the needs of the people who use the service. The service was free of obvious trip hazards although we did make the quality assurance manager aware of an area of uneven flooring. The communal bathrooms had been adapted to suit the needs of people with limited mobility and call bells had been installed to assist people to summon help. On the first day of our inspection we observed that a portable heater was being used which was very hot to touch. We wrote to the provider and asked them to consider the risk this may pose to people using the service. When we returned to the service on day two of our inspection this had been removed.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in July 2017 this key question was rated 'Good.' During this inspection we found that people continued to be supported by caring staff. However, improvements were required to ensure people were involved in planning their own care and supported in line with their preferences.

The majority of people we spoke with told us they were involved in decisions about their care and support. However, one person told us, "No one has asked me what my interests are; no one spends time up here." The majority of people we spoke with were aware that they had care plans. One person told us they had seen their care plan, whilst another person told us they were aware they had one. However, another person was not aware that they had a care plan. Records showed that some people who lived at the service had signed their care plan to show they consented to the care and support being provided, other people had not and it was not clear whether they had been provided with this opportunity. We concluded that people who had recently moved to the service had not always had sufficient opportunities to express their views and be involved in decisions about their care.

The quantity and quality of information provided in people's care plans was variable about people's likes and dislikes, what was important to them and how they wished to be supported. One care plan we looked at contained a life history of the person. This was very in-depth and covered the person's family life, work history, hobbies and interests. However, another person's care plan contained no information about their likes, dislikes or preferences. This meant there was a risk that people may not be supported in line with their preferences.

We asked the registered manager if anyone living at the service was using an independent advocate and they did not show an awareness of the role of an independent advocate. Advocates are trained professionals who support, enable and empower people to speak up. However, the quality assurance manager told us that no one was using an independent advocate at the time of our inspection but that people would be supported to access an advocate if required. We saw that information was available in the service about independent advocacy; however this was not clearly displayed.

People told us that the staff at Woodthorpe View Care Home were kind and caring. One person told us, "They (the staff) are very nice" whilst another person said, "The staff are kind." People's relatives were also complimentary of the staff and told us their relatives were happy living at the service. One person's relative told us, "My relation has a much better quality of life (since moving to the care home) and their emotional health and well-being is hugely improved."

The interactions we observed during our inspection were conducted in a kind and respectful manner. For example, we observed a staff member asking a person if they were okay and providing reassurance when the person become upset. The staff member talked with the person for a while and ensured they were comfortable before they left. We also observed a staff member reminding a person to slow down in a caring and polite manner, when they were walking.

It was clear that some genuine, caring relationships had been developed between staff and people who used the service. The staff we spoke with talked about people respectfully and told us they enjoyed providing care and support to people. One staff member told us, "I love 'dressing' the rooms for new people (moving into the service). It gives me a good feeling when the residents remember me." In addition, we saw people joked together and it was clear they had a good relationship with each other as well as staff.

People told us they were supported to maintain their independence. One person told us, "I'm very happy and have my own land line (telephone). I use the wheelchair when I go out to the hairdressers." Another person told us that they received support from staff in relation to their personal care but that staff supported them to do what they could for themselves. They said, "(Staff member) helps me to wash. We do it between us." People told us that family members were able to visit them and they were able to maintain relationships with family and friends.

People were supported to maintain their privacy and dignity. One staff member told us they had identified that people would benefit from the use of privacy screens which would enable them to reserve people's dignity whilst they provided support following a fall. They told us that the provider was in the process of sourcing these. However, we observed that people's care records were not stored securely. People's care records were kept in an unlocked cabinet in an unlocked room off the main corridor of the service. This presented a risk of unauthorised access to people's confidential information.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2017 this key question was rated 'Requires Improvement.' This was because improvements were required to ensure people were provided with support which reflected their needs and preferences. During this inspection we found that sufficient improvements had not been made in relation to this.

People did not always receive an assessment of their needs before they moved to the service. This meant that we were not assured that people's needs were fully considered before they were admitted. We looked at the records of two people who had been admitted to the service in the months preceding our inspection. Neither person's records contained evidence of a pre admission assessment to determine if the service could meet their care and support needs. We asked the deputy manager whether pre admission assessments had been completed and they told us they had not been. The quality assurance manager told us that pre admission processes and procedures were in place but these had not always been followed. The provider told us following our inspection that they would not admit anyone to the service without pre admission assessments being completed.

People's care plans and risk assessments were not regularly reviewed or updated when people's needs had changed. For example, one person's falls risk assessment had not been updated since March 2017 and a risk assessment in relation to their behaviour had not been updated following the advice of an external agency. Whilst staff were knowledgeable about the people they supported and attempts were made to meet people's needs, we could not be assured that the care planning process was robust to ensure that sufficient care and consistent support was provided.

The above information constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of receiving inconsistent support. Each person who used the service had some written information about their needs. However, we found that this information had not always been developed into individual care plans for people. During our last inspection, the quality assurance manager told us that people's care plans would be reviewed and updated by August 2017. During this inspection we found that some people did not have sufficient information available. For example, one person had needs in relation to how they moved and nutrition. A care plan was not in place for either of these aspects of care. Another person had significant needs in relation to how they moved and skin care and did not have a care plan in place for either. Other people's care plans were not complete. For example, several care plans did not contain a life story of the person or information about the support people required in relation to communication, cognition or during the night. In addition, some people had significant health conditions and there was a lack of information for staff about these conditions, how they might affect the person and signs and symptoms to be aware of. This presented a risk that staff might not be fully aware of people's needs and how they should be met.

Only one of the care plans we looked at contained information about how people wished to be cared for at

the end of their life. Although we saw that some people had information about whether they wished to be resuscitated in the event of a cardiac arrest, most people's wishes and needs at the end of their life had not been considered further. Both the registered manager and staff told us that information should be in care plans about how people wished to be supported. The quality assurance ,manager told us that a specific care plan had been in place for a person who had recently passed away at the service and we saw that anticipatory medicine had been available for this person. However, as there was a lack of information about most people's wishes this presented a risk that people may not receive care and support in line with their preferences.

The Quality Assurance quality assurance manager ensures that provisions are made for people with a disability or sensory impairment to have access to the same information about their care as others, but in a way that they can understand. They told us that no one in the service at the time of our inspection had specific needs in relation to their communication or how information was presented to them but that they would ensure information was presented in a way which people could access.

People, relatives and staff expressed mixed views on the activities provided at the service and the opportunities people were provided with to pursue their interests. One person told us, "People from the church visit me and the Deacon comes every Sunday to give communion." Another person's relative told us, "There could be more activities. They do music and motivation on a Wednesday. There was a party last November. It was very good. There isn't enough staff to take residents out."

We saw that information about activities was on display in the service such as dates for an entertainer to visit the home. A member of staff told us, "There is an activities chart which sometimes gets forgotten, but there is usually some sort of activity such as word searches or skittles." We observed that people were given the opportunity to partake in activities such as puzzles, dominoes and word searches during our inspection. However, the range of activities appeared limited. We observed people completing word searches and heard one person stating, "I don't know why they've (staff) asked us to do these again. We've already done them." Another person told us, "I do loads of word searches, too many." Staff also told us that some people at the service were supported by relatives to go out but that with only two staff on, they were not able to take people out.

People and their relatives told us they had not needed to make a formal complaint about the care and support they or their family member received. One person told us, "I would raise concerns if I had them." The person told us they had raised an issue and it had been responded to appropriately and to their satisfaction. Another person's relative told us "I am more than happy and have no concerns."

The deputy manager told us that they had not received any complaints since our last inspection. However, staff knew what action to take if a person wanted to make a complaint and information was on display within the service.

Inadequate

Is the service well-led?

Our findings

Since registering with the Care Quality Commission, the provider has not been consistently compliant with the regulations. At our inspection in February and March 2017 Woodthorpe View Care Home was rated as 'Inadequate' due to serious concerns about the quality and safety of the service. At our last inspection in July 2017 this key question was rated 'Requires Improvement' as quality monitoring systems were still not fully effective in identifying improvements which needed to be made. We identified this was a continuing breach of regulation in relation to governance. During this inspection was found that the service was still not well led which meant that the quality and safety of the care people received had deteriorated.

People had been placed at risk of harm due to the lack of quality monitoring systems at the service. No audits had been carried out in relation to different aspects of service delivery such as, health and safety, care plans or medicines since our last inspection. The registered manager told us they had delegated this responsibility to another member of staff and was not aware that audits had not been completed. This failure to implement effective quality assurance systems resulted in us finding multiple concerns about the safety of the service which placed service users at risk of harm. For example, this lack of oversight meant that essential fire safety and equipment checks had not been carried out for a significant period of time.

The providers system to record, analyse and learn from accidents and incidents was not effective. We found that this system was not always used to ensure that sufficient action was taken in response to accidents and incidents. For example, some people had sustained multiple falls and there was a lack of management oversight to ensure that all required action to keep people safe had been taken. This meant that the system to ensure that robust and timely action was taken in response to accidents or incidents was not effective. In addition, there was not always learning taken when a person had an accident to ensure that other people using the service were safe.

Management systems and processes were not effective as they were either not in place or had not been followed. For example, no checks had been carried out to ensure that pre admission assessments were completed before people were admitted to the service. In addition, risk assessments had not always been carried out and care plans were not in place for people who had specific needs. This meant there was not an effective system in place to ensure that people were provided with an accurate and complete plan of care. This had not been identified by the registered manager prior to our inspection.

The above information constituted an ongoing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had delegated their responsibility to keep up to date with good practice guidance to other members of staff. However, this had resulted in good practice in relation to medicines management and the use of equipment not being followed. This had not been identified by the registered manager prior to our inspection and resulted in people being at risk of harm.

The registered manager did not have sufficient oversight of the day to day running of the service. For

example, the registered manager was not aware that there was only two staff providing care on the morning of our inspection visit on 7 February 2018. They told us they assessed the quality of the service by talking with people and staff. However, this method had not proved effective in ensuring the quality and safety of the service. The registered manager told us their ability to effectively monitor the service had been impacted upon by their health, however robust arrangements had not been put into place to ensure the service was effectively monitored.

The approach to quality assurance was reactive rather than proactive. Following our inspection the registered manager told us of the action they would take to address the concerns we identified. However, it is of serious concern that a number of serious risks to the health and safety of people living at Woodthorpe View Care Home had not been identified prior to visits from external agencies and the Care Quality Commission.

The above information constituted a breach of Regulation 7 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above the majority of people we spoke with were happy living at Woodthorpe View Care Home. One person told us, "I like it here" whilst another person said, "It's very good here." One person's relative told us, "I give it (Woodthorpe View Care Home) 10 out of 10 and five gold stars. I can't fault the place." We observed that the service had a homely and welcoming atmosphere.

There was a registered manager in post who was also the provider and people we spoke with knew who the provider was. However, we were not assured that the provider ensured they fulfilled their responsibilities. For example, we had not received a notification in relation to an incident which had occurred at the service. A notification is information which the provider is required to send us by law. The quality assurance manager told us this was a genuine mistake and the notification was sent by the provider following our inspection.

Staff expressed mixed views as to whether the management structure at the service was effective. This was because some staff were aware that improvements were needed and did not feel that there were clear lines of accountability to ensure that sufficient action was taken. Following our inspection the provider told us of plans they had to change the management structure to ensure that improvements were identified and action taken when required. We saw that the current rating of the service was on display in accordance with legal requirements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We were not assured that the provider always acted in accordance with the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people

The enforcement action we took:

We imposed conditions of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems and processes were ineffective in identifying issues of concern and areas for improvement.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not always demonstrate they had the skills and competence to manage the service.

The enforcement action we took:

We issued a notice of proposal to cancel the managers registration.