Woodland Care Ltd

Woodland Care Home

Inspection report

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17 June 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15 and 17 June 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Woodland Care Home on 27 January 2014, at which time the service was compliant with all regulatory standards.

Woodland Care Home is a residential home in Bishop Auckland providing accommodation and personal care for up to 15 people living with a range of mental health needs. There were 14 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service, as well as to ensure premises were clean and well maintained.

People who used the service and their relatives expressed confidence in the ability of staff to protect people from harm. Staff we spoke with displayed a good knowledge of safeguarding principles and how to look out for signs of abuse.

We saw there were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks, to reduce the risk of unsuitable people working with people who may be vulnerable.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

We found all areas of the building to be clean, although areas such as the first floor toilet and bathroom were in need of further refurbishment and urgent repair.

We saw individualised risk assessments were in place to manage the risks people faced. One risk assessment we saw was not sufficiently detailed and the deputy manager rectified this immediately.

Visiting professionals had confidence in the experience and knowledge of staff and told us they liaised well with them. There was regular liaison with GPs, nurses and specialists to ensure people received the treatment they needed.

Staff were trained to meet people's needs and provide appropriate care, for example food hygiene, health and safety, medication, safeguarding, moving and handling and dignity. Staff were supported through regular supervision and appraisal processes.

We saw people had choices at each meal although people with diabetes were not always supported or encouraged to choose healthier options.

Group activities were planned via a weekly activities chart but we found more could be done to ensure people's individual likes and preferences contributed to activity planning. Care plans were regularly reviewed but we found the registered provider had failed to deliver the person-centred, goal-orientated care they described in company literature.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was welcoming, relaxed and homely. People who used the service, relatives and external stakeholders told us staff were familiar to them, caring and kind and we saw numerous instances of warm interactions.

The service had built and maintained good community links.

Staff, people who used the service, relatives and external professionals we spoke with knew the registered manager and deputy manager and spoke positively about their approachability, flexibility and knowledge of people who used the service.

Quality assurance and auditing systems were not effective and meant concerns were not always identified, nor were opportunities to share good practice. The registered provider did not play an active role in auditing aspects of the service to ensure service delivery could be improved.

We found the service to be in breach of two of the regulations. You can read more about the action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were safe systems in place for ordering, receiving, storing and disposing of medicines. Staff were appropriately trained and there were sufficient safeguards in place.

Pre-employment checks of staff including Disclosure and Barring Service (DBS) checks reduced the risk of unsuitable people working with vulnerable adults.

There were sufficient numbers of suitably skilled staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People were generally happy with the range of meals on offer although staff did not always prompt people with diabetes to consider choosing healthier alternatives.

Staff received a range of relevant training as well as regular supervisions and appraisals from management to support them in their roles.

The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives spoke consistently highly of the caring and compassionate attitudes of staff.

Staff communicated well with people with a variety of mental health needs and ensured people were supported to make decisions.

Care plans were written with the involvement of people who used the service and their relatives to ensure they were involved in the planning of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained comprehensive information about people's likes, dislikes and personal histories although we found the registered provider had failed to deliver the person-centred care they described in company literature.

Staff liaised regularly and promptly with healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

Some people were able to pursue hobbies and interests meaningful to them and there was a weekly activities plan in place. There was a consensus that the service could be improved by offering more activities tailored to peoples likes and interests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance and auditing systems were not effective and meant concerns were not always identified, nor were opportunities to share good practice. The registered provider did not play an active role in auditing aspects of the service to ensure service delivery could be improved.

People who used the service, their relatives, staff and external professionals we spoke with were all complimentary about the knowledge and approachability of the registered manager and the deputy manager.

We found the culture to be caring and focussed on people's needs and that the registered manager and deputy manager were integral to this.

Woodland 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.

We visited the service on 15 and 17 June 2016 and the inspection was unannounced. The inspection team consisted of two Adult Social Care Inspectors.

We spent time speaking to people who used the service and observing people in the communal areas of the home. We spoke with eight people who used the service, one visiting relative of a person who used the service and one visitor who previously used the service. We spoke with seven members of staff: the registered manager, the deputy manager, the registered provider, the cook and three care staff. Following the inspection we spoke with a further two relatives of people who used the service.

During the inspection visit we looked at five people's care plans, risk assessments, three staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning teams, safeguarding teams and Healthwatch. No concerns were raised regarding the service by these professionals. We spoke with three external health and social care professionals who also raised no concerns about the service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe at Woodland Care Home. One person told us, "Yes, I feel safe. Staff are lovely in here, you can go to them if you have any problems or anything". Relatives similarly told us they were happy and they felt their family members were safe. One told us, "Yes, I do think they keep them safe. They keep an eye on [Person]".

Staff members we spoke with were aware of who to contact to make referrals to or to obtain advice from if they had concerns regarding people's safety. Staff had attended safeguarding training. One staff member was currently completing the local authority's safeguarding training and showed us the workbook for this. They said they felt confident in whistleblowing (telling someone) if they had any worries. One staff member told us, "I have reported a safeguarding issue. I know how." Another staff member told us, "I'd report it to a senior or manager, ring the social worker or police. We have all the numbers in the office." We looked at safeguarding records and found them to be sufficiently detailed, with actions taken clearly recorded. We found the provider had ensured staff were consistent in their knowledge of safeguarding procedures.

People who used the service and staff members told us they felt there were enough staff in the home. At the time of the visit there was a registered manager, deputy manager, senior carer, carer, cook and cleaner on duty. We saw from the rota that there were sufficient staff to meet people's needs during the day and overnight. We observed during the inspection that staff were able to respond to people's needs in a timely fashion and that people were not placed at risk due to understaffing.

We saw all staff had received risk assessment training. When we reviewed risk assessments we found they identified specific risks individuals faced in day to day life and instructed staff how to reduce these risks. For example, one person was at heightened risk of falls and we saw there were clear instructions in place regarding how to staff should support this person to reduce the risk of falls. We found one example of a risk assessment that could have been more detailed and, when we explained this to the deputy manager, they made immediate, appropriate amendments to the risk assessment in question.

We looked at three staff files and saw the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, two previous employer references and a Disclosure and Barring Service (DBS) check, which was carried out before staff commenced employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. We also saw proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates.

We saw the storage, administration and disposal of medicines was in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw people's individual medicines records contained their photograph, allergy information, relevant contact numbers, medicine information and people's preferences regarding how they liked to take the medicines. We observed medicines being

administered in line with the medication policy, with staff seeking people's consent and clearly explaining what the medicines were.

We saw a recent audit by the pharmacy used by the service had confirmed systems in place for the administration of medicines were appropriate and safe. We saw regular medicines audits were undertaken by the deputy manager and that staff had been trained to safely administer medicines. Staff had their competence assessed at least annually.

Staff told us they were regularly observed giving out medications by the deputy manager and were asked questions about what they were doing. One staff member told us, "The deputy manager checks it's the right person and it's the right method", whilst another stated, "They check so I don't make mistakes". We also saw the deputy manager had recently improved the competency assessment following advice from the pharmacist.

We saw the treatment room was tidy. Medicines were housed in a locked cabinet and a locked fridge. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits and the controlled drugs cabinet was locked and secured to the wall. Controlled drugs are drugs that are particularly at risk of misuse. We undertook a stock check of controlled drugs and found there to be no errors. We reviewed a range of people's medication administration records (MARs) and found them to contain no errors. This demonstrated people were not put at risk through the unsafe management of medicines.

With regard to infection control, we saw appropriate personal protective equipment (PPE), paper towels and liquid soap were in place and available in bathrooms. We also saw alcohol gel dispensers had been affixed intermittently throughout the home to help protect against the spread of infection. We found the home, whilst in need of some refurbishment, to be clean and free of any unpleasant odours. People's bedrooms were clean and when we asked relatives what they thought of the home's upkeep one relative said, "It's an old building; they are keeping it up to standard as much as possible." We found examples of disrepair where prompt replacement was required, such as a cracked bath panel in the first floor bathroom, along with a towel rail that had yet to be affixed in this room. The w/c on the first floor was also in need of repair, with the edging between the wall and the floor coming away. On the first floor there was a shelf above a radiator with exposed plaster that required repair; in its current state it could not be adequately cleaned. The microwave was rusted on the inside and therefore could not be cleaned adequately. A replacement was required. We pointed out these issues to the registered provider and they assured us they would promptly make, "Whatever changes need to be made."

On the ground floor of the home there was a laundry room with cupboards containing cleaning products. These cupboards were labelled as containing 'Control of Substances Hazardous to Health' (COSHH) products. The cupboard doors and the main room door were unlocked. This meant that people who used the service were able to access these products freely. We raised this with the registered manager, who ensured the cupboards were checked and locked immediately. We also reviewed people's care plans and risk assessments and found there to be no one presenting a particular risk of ingesting such products.

We saw Portable Appliance Testing (PAT) had been recently undertaken, whilst emergency systems such as the emergency lighting were tested regularly. We saw fire extinguishers/equipment had been serviced and shower heads had been regularly disinfected and descaled to protect against the risk of water-borne infections such as legionella and that a legionella risk assessment had taken place. We also saw water temperature checks had been undertaken regularly to protect people against the risk of burns, whilst the gas boiler had been serviced. We saw window restrictors were in place. Staff told us they had fire training

and they took part in fire drills. We saw that regular fire evacuations took place with staff and people who use the service. We also saw there were individualised evacuation plans in place for people who used the service.

We saw incidents and accidents were acted on and documented in a manner that allowed for easy analysis to identify any trends and patterns.

Requires Improvement

Is the service effective?

Our findings

External professionals we spoke with confirmed staff successfully and consistently incorporated advice into people's care planning and delivery. One told us, "Staff know people's needs well and stick to what we put in place." We saw evidence that external help was sought regularly to meet people's health needs, such as referrals to doctors and specialists. One visiting healthcare professional told us, "I've never come here and found something that could or should have been dealt with sooner." Another told us, "I support four different people and they are able to meet all their needs." There was a consensus amongst external health and social care professionals that staff and management sought prompt help when required to meet people's health needs.

We saw individual staff supervisions and appraisals took place regularly. Supervisions are when staff have dedicated time with their manager to discuss their progress and working practices. Staff we spoke to told us they had completed, "A lot" of training and were able to list recent training attended, including training updates. We saw in training records that staff had completed a range of training the provider considered mandatory including first aid, health and safety, fire awareness, manual handling, food hygiene, medication, mental health awareness, safeguarding and risk assessments.

Staff told us training was discussed at supervision and appraisal and they felt it was comprehensive. We saw appraisals were held annually to develop and motivate staff and review their practice and behaviours. From looking in the supervision files we could see the format of the supervisions gave staff the opportunity to discuss any issues. One member of staff told us, "I have a supervision every couple of months. I've done loads of training."

We saw evidence of discussions about prospective training in the staff files. We saw that two members of staff had yet to have accredited first aid training refreshed in line with company policy, despite the due date having expired. We saw the two people had recently completed in-house first aid training. We asked the registered manager about this and they committed to ensuring these staff received the appropriate training, in line with company policy. We also saw the registered manager and deputy manager had recently adopted a new method of tracking people's training history and needs. They had recently started using an online system provided by Skills for Care. Skills for Care are a national organisation providing practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce. This system provided live reminders to the registered manager about when people were due to refresh relevant training.

For any new employees, their induction was a two week in-house induction programme. We saw that one new employee had not completed the 'Care Certificate' induction training to gain the relevant skills and knowledge to perform their role. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The registered manager told us this staff member had almost completed a National Vocational Qualification (NVQ) and that some aspects of this training supported the Care Certificate. CQC guidance to providers is that staff new to social care should complete the Care Certificate as part of an induction, within a twelve week period. We questioned the member of

staff, the registered manager and looked at relevant paperwork. We saw they were appropriately supported and mentored completing tasks where they had yet to be sufficiently trained. This meant people who used the service were not at risk of harm, but still meant the registered provider had failed to ensure a member of staff was well supported to achieve a level of competence in line with good practice or in a timely manner. The registered manager agreed to implement the Care Certificate for any new staff member in future.

With regard to nutrition people who used the service were positive about the range and type of meals available. We saw people were given a choice of meals via a 4-week menu system, as well as access to snacks such as fresh fruit and refreshments. One person told us, "The choice is excellent." They told us there was always food available for snacks and there was, "Always fruit about". One staff member expressed concern that the food budget had been cut. Other staff, however, told us that there was plenty of food available. One person who used the service told us, "They used to get Asda Price stuff but it's better now."

We saw how one person who used the service had been supported with their diet and nutrition. One staff member said; "[Person] was really poorly, and wouldn't eat anything, but now they are doing really well". Staff told us this person had been supported with a food diary, had been prescribed dietary supplements and had been given calorific meals (for example grated cheese was added to meals). We saw this person had been at significant risk of malnutrition when arriving at the home but had reached their target weight since moving to the home. This demonstrated staff were able to follow advice from specialists to ensure people's assessed needs were met.

Whilst we found people who required fortified diets had their needs met, we found staff knowledge of how to provide healthier options for people with diabetes required improvement. Three people who used the service had diabetes and we saw there was a file in the kitchen with a detailed range of healthy food choices. This was based on advice from Diabetes UK. We saw people with diabetes were supported through regular visits from district nurses and were supported to attend diabetes clinics and eye screenings. However when we asked one staff member how they prompted people to try these healthier options, as per people's individual care plans, they stated they did not always do this, and that people with diabetes were not on a specific diet. They stated the only options available were those on the menu. People's care plans clearly stated they were to be offered healthy alternatives and that staff were to prompt people to try healthy alternatives. This meant, whilst staff had access to best practice advice regarding how to provide people with healthy alternatives, they had not always actively done so, meaning people were more at risk of receiving a diet that increased the risks they faced. We found, whilst there was a good availability of appropriate guidance, people with diabetes did not have their nutritional needs personalised as per care plans and people could be better supported and encouraged to choose healthier options at mealtimes through better informed staff encouragement. The registered manager committed to reviewing and improving their approach to supporting people to choose healthier meal options.

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff considered people's capacity to make decisions and they knew what they needed to do to make sure decisions were taken in people's best interests. Staff we spoke with were knowledgeable about people's level of capacity and how to support them to make decisions. Staff knew which people who used the service were not able to leave the home freely because of a Deprivation of Liberty Safeguards (DoLS) authorisation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

Relatives told us that they were contacted regularly and were involved in decisions about their relatives' care. One relative told us, "They let me know about hospital appointments, they always ring and let me know. If [Person] asks for anything they let me know. They involve family as much as possible."

With regard to the premises and their suitability, we found heating levels were inconsistent, with some radiators very hot and some cold. One very hot radiator on the first floor could not be turned off independently and two people we spoke with who used the service stated it was, "Too hot" on this floor. We reviewed people's care records and found that no one on this floor was at risk of falling or unable to call for help should they fall, meaning the radiator did not present a significant risk of harm. The registered manager acknowledged the heating system provided inconsistent heating levels and stated they would raise this issue with the registered provider.

We found an example of the registered provider not maintaining the facilities in a timely manner. At the last CQC inspection of 27 January 2014 the inspector noted a communal television was in need of repair or replacement. We noted this same fault was discussed in residents' meetings on 16 June 2015 and 25 August 2015, meaning the provider had not resolved the issue in this timeframe. At this inspection we saw the television had been replaced. Following the inspection the registered provider told us they had initially purchased a new set top digital box, which only made a partial improvement, before buying a replacement television.

Good

Is the service caring?

Our findings

When we spoke with people who used the service they told us staff were caring and supportive and helped them with day to day living. One person who used the service told us, "Staff know you, how to support you. I do my washing but not my ironing. Staff help with that because I struggle doing it". Another person who used the service told us, "I like being here because they are all lovely people here," whilst a relative said, "The staff are lovely and always make me feel welcome."

We spoke with relatives about how staff supported people and how they were able to protect people's dignity and respect their wishes. One relative told us, "They do care, [Person] is very well looked after there" and, "They [staff] always knock on [Person's] door, they never just go in." Another relative said, "They give [Person] privacy, they are not intrusive. They always watch out and are there if needed". One family member said that knowing their relative was well looked after gave the family, "Peace of mind". One visiting healthcare professional who delivered training at the service stated, "The staff were lovely and very accommodating. This setting seemed to have a lovely friendly feel about the place."

Several relatives and people who used the service told us they felt, in terms of the caring attitudes of staff, this home was better than other homes they had been to or visited. One relative said, "This home stands out, it's far, far better."

Staff generally knew the people they were supporting very well. They were able to tell us about people's life histories, their interests and their preferences. Staff were able to explain to us how best to communicate with people who used the service and we saw staff altering their communication styles to speak with people, as per the information and guidance in people's care plans.

We observed staff interacting with people who used the service. The atmosphere was relaxed and staff and people were comfortable with each other, smiling and interacting in a positive and warm manner. We observed someone who used the service asking a staff member if they should have a shower. The staff member said it was their choice if they wanted to have a shower. When the person confirmed they would like to have a shower the staff member said, "Come on then, I'll get your toiletries and towel ready". We also observed a staff member patiently helping a person who used the service to work their mobile phone. This showed us that people were encouraged to make choices about their day to day care.

One relative told us, "The staff are very friendly, very helpful. If you have a question they answer it straight away." One staff member told us, "I look at people here like my family" and we found the atmosphere in the service to be homely during our inspection.

We asked staff how they promoted people's independence and they told us they take people out to the shops and that they offer to go with people to bars or for walks. They told us that people make their own drinks and that some people make their own breakfasts and we saw this happening during the inspection. One staff member told us they were a 'keyworker' and this involved, "Washing hair, going for walks, seeing how the person is doing and if they need any help doing things." We found people who used the service

knew who their keyworker was and that the continuity of care people received was good, with turnover levels of staff low.

People who used the service told us they felt their independence was supported. They said, "I go out when I want" and, "I go into town with the staff. We walk and look around the shops". One person said, "I'm very independent. I go in the taxi on my own and I look after my own money. They've help us here." Another person said that staff helped keep their bedroom clean, and said, "Staff do my bedroom out, I help them. They do the hoovering and that." People who used the service also told us that they could get hot and cold drinks in the dining room when they wanted, use the toaster or microwave. One person who used the service said, "We have a washing up rota. I do twice a week".

Staff told us about a person who moved out of Woodlands Care Home and now lived in their own flat. This person still visited the home on a regular basis to see friends and to have a meal. This person visited the service whilst we were inspecting and we saw they were encouraged to maintain the strong bonds they had made whilst staying at the home. We observed one staff member saying, "[Person] has got a lovely flat. I took [Person] up to see it." This demonstrated people were supported to maintain friendships.

People in the home were also supported to maintain relationships, for example, one person told us they regularly visited their partner who lived in another care home. Another person regularly visited their parents.

We saw staff were completing 'End of Life' care training. Whilst no one in the home needed this level of care currently this demonstrated the registered manager took seriously the need to respect and prepare for people's end of life wishes by ensuring staff were equipped to deal with these needs sensitively.

We saw rooms were personalised with people's belongings and decorated in varying styles to meet people's tastes.

We saw people's personal sensitive information was securely stored in locked cabinets and on password-protected computer systems, in line with the confidentiality policy. We found care plans to contain good levels of information regarding people's preferences and wishes and, where people were able to consent to their care and treatment, they had done so.

We found one example of a person's religious needs not being met. In the latest surveys returned to the registered manager this person had stated, "I would like to go to the church and pray," but that they were no longer able to do this since moving into a care home. We raised this with the registered manager who stated they had not reviewed the responses from the surveys yet but would ensure this person's religious needs were met.

Requires Improvement

Is the service responsive?

Our findings

We saw there was a weekly activity plan in place and people achieved some outcomes which were meaningful and important to them. For example, one person loved to draw and paint and we saw they regularly did this. One person had a regular volunteering role litter-picking, which they told us they enjoyed. Another person enjoyed crosswords and jigsaws and we saw them enjoying these activities during the inspection. Some people we spoke with enjoyed good levels of independence and when we spoke with external health and social care professionals they were positive about the knowledge and ability of staff to support people to achieve their goals. During our inspection we found this support was not as structured as the registered provider indicated in their company policies and literature.

The Provider Information Return sent to CQC stated the registered provider ensured people's needs were reviewed and met through a bi-monthly meeting between people who used the service and their keyworker. The registered provider stated, "The support worker works with the resident on a bi-monthly meeting to monitor all aspects of their care plan. They will work alongside the resident to set new targets for the next two months. These targets or goals cover all aspects of the residents life." We found these meetings did not deliver the person-centred, goal-orientated care the registered provider stated in their Philosophy of Care Policy and Statement of Purpose. For example, we reviewed records of one person's bi-monthly meetings and found there were no details of what goals the person had or how these goals would be achieved.

We looked at another person's care documentation and found they were particularly interested in improving their cookery skills. When we spoke with this person they stated, "I don't do Sunday dinners now. They won't let me do it in case I get burnt. I can't touch the oven or the pans, staff do that. I used to cut up the vegetables but I don't now." We noted there was a sign on the kitchen door that stated, "No residents to be in kitchen area at any time". We discussed this with the registered manager, who acknowledged this was a missed opportunity and at odds with the statement of purpose, which stated people are supported to "carry out the tasks of daily living unaided." We reviewed people's care plans and found that, for example, one person was not at any significant risk by being in the kitchen. In fact, their "Cooking skills care plan" stated, "[Person] has shown knowledge in using kitchen equipment and could do with some more encouragement to grow their confidence in this area." Whilst there were regular group baking activities whereby people who wanted to could mix ingredients to make cakes, this was done in the dining room, with staff only going into the kitchen. This meant people were not encouraged to develop or improve the skills they valued and wanted to pursue.

We looked at another two care files and found the bi-monthly meetings were not used as the registered provider had stated. Person-centred goals were not recorded or evidenced. We asked the registered manager about this and they confirmed the bi-monthly meetings currently were not used to set specific goals and to support people to meet those goals. Likewise, when we asked staff how they supported people to develop skills and achieve goals, they were unable to explain this. This meant the registered provider had failed to ensure people were receiving person centred care.

In the last inspection report we noted as a concern that there was no specific activities fund nor an activities

co-ordinator. We saw that this was still the case. We reviewed responses from surveys recently returned from people who used the service and saw the most common area of concern was a lack of activities at the service. One visitor said, "I feel that more social activities are needed to stimulate people," whilst another said, "There doesn't seem to be much going on." We saw the registered manager and deputy manager did put in place activities but that this was constrained by the resources available. For example, where one person stated they wished to do crafts/painting, we saw the manager had download large numbers of colouring-in patterns from the internet for the person to paint. We saw the person had enjoyed painting and given the registered manager a completed picture to put on the wall. Similarly, the registered manager, in response to requests by people who used the service to have a karaoke night, had purchased a karaoke machine (although this had since broken and was in need of replacement).

We found the registered manager and deputy manager sometimes sought ways to creatively meet people's leisure and hobby needs but that they were not always supported in this by the registered provider. We also found activities were not always determined by people's preferences. For example, when we asked the registered manager how the weekly activities plan was decided they stated they, "Just made it up," rather than consulting with people who used the service. We saw the last residents' meeting had been held in November 2015 and that people had not been given the opportunity of this forum to put forward their suggestions. The Provider Information Return had stated residents meetings occurred monthly, whilst we noted a previous residents' meeting of August 2015 confirmed, "Residents would like the residents' meetings monthly." When we asked why people who used the service had gone on a recent visit to a railway museum the registered manager acknowledged the reason was because entry was free rather than anyone' preference for visiting a railway museum. This meant the registered provider had not provided care that met the needs or reflected the preferences of people who used the service.

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did find evidence of one person being supported in a structured way to meet their goals. They had a weekly planner on their bedroom wall with the tasks they wanted to complete that week with help from their support worker. The registered manager and deputy manager acknowledged this was a more positive approach to achieving person-centred care and something they would pursue for other people who used the service.

We also found evidence that people did partake in some activities. On the day of our inspection we were able to speak with people who used the service. They told us that they had been on a trip to the seaside the previous week to our visit. They told us they could go into town shopping, see friends or go to out to cafés. One resident said, "Every day I go to the shops, I go to the market on Saturday to buy flowers". Another resident told us "I went to the pub on my own; it was a sunny night so I wanted to go". A staff member told us they supported residents to do, "Bingo, singing, dancing, cards and 'Swingball'". We found people who used the service had experienced the visit of a singer and a dog-petting service recently. On the day of our visit people who used the service were listening to music and singing. Some people who used the service were out visiting friends or at a day centre. One staff member told us that people who used the service had previously been on holidays to Blackpool and Primrose Valley. We also saw some suggestions by people who used the service were met, for example a trip to a coffee morning at a local church and a visit to the town hall.

We found all operational staff, including the registered manager and deputy manager, had a sound understanding of people likes, dislikes, needs and interests. We also found, despite the failure to implement person-centred goal-orientated care, that care files contained a good degree of information regarding

people's backgrounds. We saw the deputy manager was in the process of ensuring all care files contained an updated person-centred profile at the front of each file.

From speaking with staff and people who used the service we were able to establish that staff did enable people who used the service to maintain day-to-day choices, wants and wishes. One person who used the service told us, "I always have a choice". A staff member told us, "[Person] is very independent but sometimes chooses not to do things". Likewise, external health and social care professionals acknowledged that staff had a good knowledge of people's needs and supported them to choose on an ad hoc basis.

Staff, relatives and people who used the service were knowledgeable of the complaints procedure. One person who used the service said, "If I had a complaint I'd go to a member of staff. I'm champion now, but if I did I'd go to any of the staff". One relative told us, "If I had a query I would approach [the manager's name], I'd ask her who I needed to go to" and, "They would absolutely help".

Aside from the concerns noted above about the provision of activities, all surveys returned from people who used the service, relatives and professionals were positive about the service.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and deputy manager had extensive experience of caring for people with mental health needs. We observed numerous positive and supportive interactions between the management team and people who used the service. When we spoke with the registered manager and deputy manager they displayed a comprehensive knowledge of the needs of all people who used the service. Staff told us that they were supported by the registered manager, whilst relatives we spoke with expressed confidence in their ability. One member of staff told us, "The manager is brilliant and will actions things. If you tell them they will sort things out." Another staff member said, "The manager and the deputy are great," whilst a relative said, "The manager seems really caring." External professionals we spoke with were similarly confident, stating, for example, "The deputy manager is really good at supporting transition from place to place," and, "The manager is always approachable."

Staff we spoke with told us the registered manager was approachable and they felt supported in their role. One staff member said they had regular supervisions with the manager and said, "I can talk to them about everything".

Several staff and people who used the service raised concerns about the levels of support by the registered provider, particularly with regard to the upkeep and improvement of the home. One staff member said, "The owner doesn't do anything for the residents, they waited for months for a television." We received differing opinions from staff and a number of people who used the service about the registered provider and what they saw as a reluctance to maintain the premises adequately and provide sufficient resources. Other than the refurbishment plan (see below), we did not see documentary evidence of delays by the registered provider in responding to requests from members of staff.

We found staff were supported by a registered manager and deputy manager who set an example of caring and compassionate approaches to people's needs. When we spoke with the registered provider we found they did not have a good knowledge of people's needs. They stated, "I have no involvement with them but I say hello."

We saw positive links had been formed with the community, for example a community centre, a town hall and various day centres. The registered manager acknowledged there was an opportunity to build even more community links given the service's central location.

Whilst the medication audit process was extremely thorough and care file audits were in place we found other auditing procedures to be ineffective and not robust enough to identify either patterns of concern or areas of best practice. For example, the registered manager performed an intermittent check of people's daily notes to confirm there were no concerns in the content or areas of practice staff needed to improve. The registered manager stated this happened on a weekly basis and consisted of them signing the daily record book in pen at the end of each week's notes. In the notes we sampled however we found gaps of over a month with no entries by the registered manager. They confirmed they had not always, "Stayed on top of this." Where we did see entries, we saw this was merely a signature and that there was no system to

document and concerns noted or improvements that needed to be made. The registered manager and deputy manager stated they had recently lost administrative supported in the office, which had previously been provided by another member of staff for ten hours per week.

Other audits were similarly inconsistent. For example, whilst we saw we evidence that walk-around checks by staff had the impact of identifying, for example, trip hazards and lightbulbs in need of replacement, these checks were not audited. Likewise, there was no audit of infection control checks undertaken by staff as a means of reviewing whether there were consistent problems occurring over a period of time. This meant when errors were made they were not always identified and where opportunities to share good practice existed, these were not identified. The statement of purpose indicates the registered manager is the "quality management representative" and should, "Evaluate the effectiveness of the quality systems as a basis for making improvements." The statement of purpose also states, under the 'Owners/Directors' heading, that they will undertake "Monthly audits." The registered provider confirmed they undertook no audits of the service and we found they did not take an active role to improve service delivery.

The home had a programme for refurbishment and we saw that some areas of the home, the office and dining room for example, had been redecorated recently. Staff and people who used the service we spoke with explained they felt that not all decoration and upkeep of the home took place in a timely manner and they felt this was down to a reluctance on the part of the registered provider. We looked at the registered provider's refurbishment plan and saw it was not sufficiently detailed with regard to timescales. The plan had no start date and no specific plans for each area of the home. The plan stated that each area was reviewed yearly but it was unclear which areas had been reviewed and what the outcome was. For example, the "small toilet" on the first floor had no entry in the '6 monthly' review column, stated "To be Reviewed" in the 'Yearly' column and "Redecoration to take place if necessary" in the '2 Yearly' column. The yearly columns had no corresponding dates so it was impossible to know whether each room had actually been reviewed and what the opinion of the registered provider was regarding each area. The small toilet was in need of repair and refurbishment. The registered provider's refurbishment plan was not effective in supporting improvement nor was it accountable.

The registered manager acknowledged auditing was an area the service did not do well and needed to improve. This meant the service had not ensured it was able to identify patterns or trends that could present ongoing risks, or opportunities for ongoing improvement of the service.

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

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided and we saw appropriate notifications had been made to CQC where required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not provided person-centred, goal-orientated care that reflected the preferences of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established or operated effectively to ensure compliance with the regulations