Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Woodland View

Inspection report

1 Lightwood Lane
Sheffield
S8 8BG
Tel: 0114 271 6688
Website: www.shsc.nhs.uk

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This unannounced inspection took place on 27 and 28 October 2014. Woodland View provides accommodation and nursing care for up to 60 people who are living with dementia and have complex needs. The home is level access and consists of four individual 'cottages' linked by corridors.

We last inspected this service in July 2013 and found that it was meeting the requirements of the regulations we inspected at that time.

During our visit we spoke directly with four people who lived at Woodland View and with three relatives. We also spoke with three nurses, seven support workers, two clinical educators, an activities coordinator, a member of the housekeeping staff, the site operational manager, the overall operations manager and the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our inspection identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People's safety was being compromised in a number of areas. This included how people were monitored and how they sought assistance when in their bedrooms. We also found that medicines were not safely recorded and monitored. Whilst the registered manager had reassessed the number of staff needed to meet people's needs and was in the process of recruiting to these positions, our review of records identified that staffing levels were frequently below those assessed as required.

Our review of accident and incident records did not provide an accurate record of the concerns observed during our inspection. Similarly, we found gaps within people's care plans which meant that people may not be protected against the risks of unsafe or inappropriate care and treatment. Care plans contained detailed risk assessments about people's behaviour, however, risk assessment for other areas of care were less detailed or absent.

Most staff had received safeguarding training and were aware of the possible indicators of abuse and how to report these. Appropriate systems were in place to safeguard and manage people's finances. An effective recruitment process was in place.

Whilst there were sufficient staff to support people to eat, we found that the overall meal time experience was not positive and was at times unsafe. Overall, the support observed was task centred with little or no interaction between people and the staff supporting them.

Staff were not always following the Mental Capacity Act (MCA) 2005 for people who lacked capacity to make particular decisions. For example, staff demonstrated varied degrees of knowledge and records provided evidence that the staff were not always making decisions in line with the MCA Code of Practice.

Woodland View had submitted Mental Capacity Act Deprivation of Liberty Safeguards applications for each person living at the home. The safeguards are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom.

Staff received supervisions less frequently than the provider's 6-8 weekly timescale but were not concerned by this. They said that senior members of staff were approachable and felt able to go to them should they need any support or guidance. Staff received a variety of mandatory and other training courses and plans were in place to address any training shortfalls.

Woodland View was in the process of a programme of re-decoration and improvement to make the environment more dementia friendly. Specialist architects had been involved and people, their relatives and staff had been involved in choosing the new décor. Dementia friendly signs to orientate people and pictures to prompt memories and conversations had been ordered.

Whilst relatives were positive about the way in which people were cared for, our observations did not always correspond with these views. We observed some positive and caring interaction but overall found that care was task centred with little interaction with people and few examples of people being offered choice. 'This is Me', books were in place for some people to provide staff with information about people, their preferences and the things which were important to them. We saw little evidence of this information being used. For example, two staff did not know the surnames of the people they were supporting and the records for one person did not reflect their preferred name.

We observed some good practice about end of life care and the plans the registered manager had to further develop staff practice and support relatives.

Activity coordinators were in place; however, we saw few activities or opportunities to engage people who were less active and found that interactions and engagement were often prompted by people and not members of staff.

We identified a number of shortfalls in various aspects of the service and asked about how the provider monitored the quality of the care provided. We were told that the

Summary of findings

operations manager conducted audits of the service and requested copies of these. Copies of these audits were requested during and following our inspection but were not provided. The provider later forwarded some documents relating to monitoring the quality of the service. A comprehensive process to monitor the quality of care was not in place.

The registered manager had been in place since November 2013. We received mixed reactions from staff about management and leadership within the service. The registered manager had clear goals for the service and had made a number of changes since being in post. He was aware that some staff were resistant to the changes and plans for the home and had introduced a weekly 'open door' session to enable him to address any concerns directly with staff.

Summary of findings

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 who used the service were being put at risk because their safety and welfare was not always being appropriately monitored and medicines were not recorded and managed safely.

Records showed that staffing levels were frequently below those as assessed as being required to meet people's needs. Care plans and the recording of accidents and incidents were not always up to date and accurate.

Staff knew how to identify and report abuse and appropriate systems were in place to manage and monitor people's finances. An effective recruitment process was in place.

Is the service effective?

Inadequate

The service was not effective. People were not provided with choice at meal times. Whilst there were sufficient staff to assist people to eat, the support and interactions were task centred and at times unsafe.

Decisions about people's care were not always appropriately recorded. Records and conversations with staff demonstrated inconsistent knowledge and application of the Mental Capacity Act 2005.

Staff received an induction and annual appraisal. Plans were in place to address supervision and training shortfalls.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were positive about the care they received, but our observations did not always correspond with these views. We saw that the care provided was often task centred with little interaction with people. People's privacy and dignity was not always respected.

We found that staff knowledge of advocacy services for people who did not have relatives or friends to promote their rights and represent their views was inconsistent.

We observed some good practice about end of life care and the plans the registered manager had to further develop staff practice and support relatives.

Is the service responsive?

Requires Improvement

The service was not responsive. Care plans were based upon risk. Whilst they contained detailed information in some areas, other areas of the plans were often task centred and did not reflect people's individual needs and preferences. Information was sometimes difficult to locate within the electronic recording system used.

Summary of findings

People were frequently supported by agency staff that were unfamiliar with their needs. Whilst some documents were in place to provide staff with information about people, their preferences and the things which are important to them we saw little evidence of this information being used in practice.

Whilst activities were provided, there were no activities or opportunities to engage people who were less active. Conversations and engagement was limited and tended to be prompted by people and not members of staff.

Is the service well-led?

Requires Improvement 

The service was not well led. Quality monitoring reports undertaken by the operational manager were requested during and following our inspection but were not provided. The provider later followed some governance documents. The lack of these documents, together with the shortfalls identified across various aspects of the service meant that people were put at risk due to the lack of a comprehensive system to monitor the safety and quality of care provided.

Surveys asking relatives and staff for their views of the service had been completed and analysed. However, the outcomes and the way in which the service planned to respond to concerns raised had not been shared with staff and relatives.

The registered manager had clear goals for the service and had made a number of changes to the way in which the service operated. They were aware that staff may find the changes and the way in which they were leading the home unsettling and held weekly 'open door' sessions to enable staff to discuss any concerns directly with them.

Woodland View

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.

Our inspection took place on 27 and 28 October 2014 and was unannounced.

The inspection team for the first day of the inspection consisted of three adult social care inspectors and an expert by experience with experience of caring for people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second day of the inspection was undertaken by one of the adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. We also contacted the doctor who regularly visited the home, the commissioners of the service, Healthwatch and Sheffield Mental Health Advocacy Service in order to obtain their views about the care provided at Woodland View.

During our inspection we used different methods to help us understand the experiences of people living at Woodland View. These methods included both formal and informal observation throughout our inspection. The formal observation we used is called Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke directly with four people who lived at Woodland View and with three relatives. We also spoke with the manager, three nurses, seven support workers, two clinical educators, an activities coordinator, a member of the housekeeping staff, the site operational manager and the overall operations manager. We reviewed the care plans of seven people and a range of other documents, including medication records, staff recruitment and training records and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

During our inspection we observed that doors to people's bedrooms automatically locked on closure. Doors could be opened with a key from the outside or by the person in the room without the need of a key. The operations manager informed us and provided records to show that this system had been put in place after consultation with relatives and key stakeholders to safeguard people and their belongings.

On two separate occasions different members of the inspection team heard one person shouting from their room. Staff held keys to people's rooms and promptly opened the door to this person's room. The person was sat in a soft chair in their room. Support workers informed us that hourly checks took place when people were in their rooms. Whilst our review of records confirmed these checks, we were concerned that people were not able to summon help between these hourly checks.

We observed that call bells (buzzers) were situated high up on the walls of people's rooms. At the time of our inspection the registered manager informed us that the bells were not in use, but other forms of assistive technology such as crash mats and room sensors which alert staff to falls, were provided where needed. The operations manager said that the issue of call bells may need to be considered within discussions taking place about future improvements.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we remained concerned that the lack of any means of summoning assistance for a person when in their bedroom placed their safety and welfare at risk. We requested further information from the provider about the lack of call bells and about accidents and incidents at the service. The provider responded within the requested timescale and reported that there seemed to have been some miscommunication about this issue. They informed us a call bell system was in place and had recently been checked to ensure it was fully operational.

Within their response, the provider informed us that, following our inspection they had purchased 60 new beds which included integrated call alarms to enable people to summon assistance. They informed us that the beds also had built in mattress sensors to alert staff when people left their bed during the night. We asked the provider for information about the progress of this system. They confirmed that installation was completed on 23rd January 2015 and that the system was fully operational.

At the time of our inspection, we judged that the issues identified about call bells posed a major risk to the health and safety of people living at Woodland View. Following the information received from the provider we reviewed our judgement about this regulation. Given that the provider had taken action to reduce risk by purchasing new beds with an integrated monitoring system, we reassessed our judgement and deemed the impact to be moderate.

In two of the four cottages we reviewed the arrangements in place to ensure that people received their medicines safely. We saw nurses administering medicines to people and noted that they had a patient and caring approach. We reviewed the Medication Administration Records (MARs) of five people. The majority of the records were initialled by a nurse to record that the medication had been given; however, the initial boxes in some records were blank and the reason for the medication not being administered had not been recorded. This meant that the nurse undertaking the next medication round would not know if the person's prescribed medication had been administered or why it had not been given. Additionally, it was difficult to check whether medicines had been administered as the MAR did not reliably record stocks of medicines delivered and medicines 'carried forward.'

Similarly, it was also difficult to consistently see evidence that the medication in stock corresponded to that recorded within the MAR charts where the number of medicines delivered had been recorded. For example, one person's MAR documented that they had taken 17 of the 28 delivered tablets. We counted this medication and found that 26 and not 11 tablets remained. Woodland View used a 'bio-dose' medication system for some medicines. This is a system where people's medicines were dispensed into pre-sealed pots. We found that two tablets remained in one person's bio-dose pot yet the MAR chart stated that the person had taken these medicines. Two further tablets were absent from this bio-dose pot and had not been

signed for. These shortfalls meant we were unable to establish that medicines had been safely administered and there was no accurate audit trail to account for the medicines in stock.

We found that there were gaps in the daily recordings of the temperature of the medication fridge in one of the cottages; for example, no temperature was recorded for 7 days. This meant that nurses could not be sure that medicines inside the fridge had been kept at the correct temperature as recommended by the manufacturer and therefore if they were safe to use.

Some people were prescribed, 'as and when needed,' (prn) medicines. Permanently employed nurses were able to describe the behavioural changes and signs people may exhibit to indicate a need for these medicines. However; at the time of our inspection, agency nurses were often being used to cover nurse vacancies and sickness. We found that there were no extra guidelines (protocols) to enable nurses to identify when to offer these medicines to people. This meant that these medicines may not have been being used in the right way, or as intended by the doctor.

We spoke with nurses and the registered manager about medicines audits and training. Nurses had received medicines training as well as an annual refresher course. Competency checks to ensure that medicines were administered safely, and audits of medication, were not in place. The registered manager informed us that the trust's pharmacy team were going to provide support with medication audits and medication competency checks would be part of the newly implemented clinical educator's role. This meant that, at the time of our inspection, no processes were in place to monitor the safe use and management of medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager informed us that they had undertaken an analysis of the number of staff required to meet people's needs and, from May 2014, this had resulted in an additional staff member being added to each shift. Interviews were underway to recruit the necessary 20 permanent support workers, and to recruit to 2.5 vacant nurse posts. Agency staff were being used to cover the vacancies whilst recruitment took place. The registered manager told us that agency staff familiar with Woodland View were used whenever possible.

Throughout our inspection a number of staff talked about there being insufficient staff at times to meet people's needs. For example, on arriving at Woodland View, a clinical educator commented, "Staffing today is not good; it's a Monday morning." We reviewed the staff rota for the day of our inspection and found that the staffing levels were below that assessed as being required for three out of the four cottages. Two cottages each required one additional member of staff. The remaining cottage required three additional staff members; a support worker from one of the cottages which was already short of one member of staff was sent to work at this cottage.

The operations manager provided a copy of the staffing rota for the previous six weeks, and an analysis of the staffing numbers of each cottage for that period. In one cottage, on 35% of the shifts, staffing levels were below that as assessed as being required. Across the entire home 23% of shifts were understaffed. Our findings evidenced that over a six week period Woodland View had failed to ensure there were sufficient numbers of staff to meet the needs of people living at the home.

Whilst no impact upon people was evident on the day of our inspection, information received prior to our inspection identified that people had been placed at risk as a result of staffing shortfalls. For example, we were aware that one person had sustained a serious injury and required hospital treatment as a result of being supported by only one support worker and not two, as stipulated within their care plan. We checked the staff rota and identified that an additional support worker was needed to meet the assessed staffing levels at the time of this incident. This again evidenced that the provider had failed to ensure sufficient numbers of staff to safeguard the health, safety and welfare of people living at Woodland View.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the reporting and management of accidents and incidents and found these did not correspond with our

Inadequate

Is the service safe?

observations. For example, on the first day of our inspection a member of the inspection team observed an incident between two people. A member of staff was present at the time of this incident but, when asked, said they had not observed it. We checked the recording of this incident on the second day of our inspection. An incident form had been completed as if the staff member and not an inspector had observed the incident. We reviewed the daily notes for this person and found that the incident had not been recorded. We also noted that there was no record or body map to document a bruise we observed on one person's face. A clinical educator sat with us in order to locate the documents needed on Insight, the electronic recording system used by the service. They agreed that people's records did not provide an accurate account of the concerns observed during our inspection.

We identified some gaps within people's care plans. For example, one person's care plan made reference to them having an x-ray but did not detail the outcome of this.

We looked at how the service managed risk. Each care plan reviewed contained a detailed risk assessment and management plan (DRAM). Risk assessments about people's behaviour were detailed and clearly reflected risks and strategies individual to the person. For instance, one person's risk assessment listed their favourite music and that playing this could decrease their agitation. Where interventions were needed to reduce risk, such as 'safe holding,' the possible triggers and situations where this may be needed were recorded together with the intervention to be used. However, other risk assessments were not always as detailed and contained gaps. For example, one person's risk assessment documented that there were current and historical risks to their physical health but did not detail what these were. The gaps in records meant that people may not be protected against the risks of unsafe or inappropriate care and treatment.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of inspection, the cottages at Woodland View were at various stages of a programme of re-decoration and making the environment more dementia friendly. Whilst the provider had taken appropriate steps to minimise disruption to people, we were concerned to find that a toilet shared by two bedrooms still contained a number of building materials which could pose a risk to people.

People and relatives spoken with felt that Woodland View was safe. One person commented, "Yes it's safe enough." A relative stated, "[My family member] is very well looked after here. It's brilliant. Yes, I am happy to leave him here because I know he's safe." Staff were able to tell us about different types of abuse and the actions they would take if they suspected that abuse had taken place. A review of the provider's training matrix showed that most staff had received safeguarding training and that courses were planned for the remaining members of staff. Woodland View support a number of people with their finances. The site operational manager talked us through the records and checks undertaken. We found that appropriate systems were in place to safeguard and manage people's finances.

Our conversations with the manager, staff and our review of records evidenced that an effective recruitment process was in place. The five staff files reviewed contained the required information and checks. Nurses had also provided a copy of their professional registration certificate. Each file also contained evidence that a Disclosure and Barring Service (DBS) check had been undertaken before staff began to work at the home. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

We looked at how Woodland View met people's nutritional needs. The site operations manager said they had recently begun to look at menu options with the cook. The registered manager identified meal times as an area he planned to focus upon. He reported that he had encouraged staff to set tables and use the dining areas in each cottage and said that this had yet to be put into practice by staff. The registered manager showed us the dining area within one of the cottages. We found that the dining areas available within the cottages were not used. Instead, some people sat at small tables within areas linking sitting rooms and bedrooms, whilst the majority of people were given their meals on wheeled tables in front of the chairs or sofas where they were sat throughout the day. This did not promote a positive meal-time experience for people living at Woodland View.

Lunch-time was observed in each of the four cottages, as was the evening meal in two of the cottages. People had a cold lunch of sandwiches and chocolate pudding. The evening meal consisted of steak and mash or fish pie, carrots and gravy. Alternative options and pureed meals were provided for people who had swallowing difficulties. We did not observe any examples of people being offered a choice about their meals and heard three people from different cottages asking about the meals which were placed in from of them. The fish pie looked particularly unappetising and led a member of staff to audibly state that they would not eat it.

There were sufficient members of staff to assist people to eat. We observed some good interactions from some staff members but overall found the interactions and support provided to be task centred. For example, when assisting people to eat, we noted that a number of staff did not talk to people nor did they explain the food and the support they were providing to people. Some people were able to eat independently but needed verbal encouragement to do so. The encouragement these people received was not discreet. One person kept resting their head on the table; a support worker assisting someone in another part of the room frequently roused them by calling their name, followed by instructions such as, "wake up" and " eat your dinner."

A comment from a relative within the relative's survey undertaken in June 2014 corresponded with our observations. It stated, "I feel residents who struggle to, or are unable to feed themselves need more support to eat and drink. I think the staff need to give them more time to get interested in eating as they often seem too busy to do this so people just give up saying they are not interested."

We saw a particularly unsafe example of practice which we discussed with the registered manager and senior members of staff at the end of our inspection. A support worker assisting one person did not allow them sufficient time to chew and swallow their food prior to giving them the next mouthful. At one point, the person grabbed the support workers arm as if to stop them giving them any more food. The support worker ignored this and continued. This person's risk of choking was increased by the support worker giving them a drink whilst they were still eating. There was no communication observed throughout this interaction.

Information about people's food preferences and any aids needed to support their independence when eating, such as large handled cutlery, was listed in the kitchen areas of each cottage. We saw that people were weighed each month, or more often if needed, and that each person's care plan included a Malnutrition Screening Tool (MUST) to identify any nutritional risks. A dietician had recently started to visit the home on a monthly basis. We saw that the dietician's recommendations had been entered into the electronic recording system but noted that one person's' MUST did not provide an accurate record of their nutritional risk. It had not been updated with either the person's current weight, or that they had been weighed on two separate occasions during the previous three weeks. The MUST tool reviewed for another person was blank.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people and those important to them were involved in decisions about their care and how Woodland View complied with the Mental Capacity Act (MCA) 2005.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision–making within a legal framework and states that every adult must

be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment and, that any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

As part of our preparation for the inspection we contacted the Sheffield Health Mental Advocacy Service. Some people living at Woodland View did not have relatives to represent their views and the service had been involved as Independent Mental Capacity Advocates (IMCA's) to advocate and ensure decisions were made in people's best interests. The service felt that there was a lack of consistent knowledge about the MCA throughout the home, with staff not always being able to identify when capacity assessments and best interest decisions were needed. Our conversations with members of staff and our review of records confirmed this.

Staff members demonstrated varied degrees of knowledge about the MCA. Some staff members demonstrated good practice and a considered approach, for example, a nurse told us of the importance of, "giving people time to settle and get used to the home" prior to undertaking a capacity assessments. However, the knowledge of some nurses and support workers was mixed. Some support workers had an understanding of the MCA, whilst others told us that they heard of it but did not know how it applied in practice. Two support workers said they had not received any training about the MCA.

Our review of records showed similar inconsistencies and provided evidence that the home were not always making decisions in line with the MCA Code of Practice. We found that assessments of capacity had not always been undertaken prior to best interest decisions being made. Differing environments can impact upon people's capacity to make certain decisions and we saw that these decisions were not always reviewed after people had moved to Woodland View. For example, a decision to administer one person's medication covertly during a hospital stay had not been reviewed since they moved to Woodland View nearly three years ago.

We talked with nurses and reviewed records about bed rails. Whilst a bed rails risk assessment and checklist was in place, these documents did not make any reference to the MCA. This meant that there was no evidence to show that their use was the least restrictive option available and was in the best interests of the person.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and report on what we find. The safeguards are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom. The registered manager was aware of changes which had been made to the definition of what constituted a deprivation of liberty following a Supreme Court judgement earlier in the year. We saw that DoLS applications had been submitted for each person following this new ruling. The registered manager and other staff members told us that a DoLS assessor had visited the home to provide training to staff.

We looked at the arrangements in place for the training, supervision and appraisal of staff. We found that new staff received a comprehensive induction which included mandatory training and a week of 'shadowing' more experienced workers to enable them to familiarise themselves with people's needs and the home. The registered manger told us of their plans to further develop this with the provision of induction workbooks for new staff. Members of staff confirmed that they had received an induction.

We spoke with staff and reviewed records relating to supervision and appraisal. Supervisions ensure that staff receive regular support and guidance and appraisals enable staff to discuss any personal and professional development needs. We found that supervisions were occurring less frequently than the provider's expected timescale of every 6-8 weeks. We were provided with a document which stated that 43% of staff had not received supervision within a recent eight week period. Similarly, a number of staff had not received an annual appraisal. The registered manager told us that these were areas they were working to improve. They were confident that these shortfalls could be rectified following the recruitment of staff that would be undertaking supervision and appraisal as part of their role.

Inadequate

Is the service effective?

Staff spoken with during our inspection confirmed that the frequency of their supervision and appraisal sessions varied but were not concerned by this. They told us that senior members of staff were approachable and felt able to go to them should they need any support or guidance.

Staff told us that they received regular training and were able to request additional training. Our review of the training matrix showed us that a range of training courses were available, these included, dementia awareness, safeguarding, infection control and equality and diversity. All staff, with the exception of administration staff, undertook 'respect' training. This is a person centred model of preventing and managing behaviours which may challenge. We noted gaps within some training courses and discussed this with the registered manager. Our conversations provided evidence that they had been proactive in addressing these shortfalls. For example they had asked for trainers to attend Woodland View in order for training to be provided to a number of staff at one time, and had supported designated staff to become 'in-house' moving and handling trainers.

Housekeeping staff were visible throughout the course of our inspection. Whilst the environment was kept clean, there were malodours present in each of the cottages. These were more noticeable in the afternoons of our inspection visits. We noted that two of the eight comments about the environment in the most recent relatives survey also commented about malodours within the home.

We spoke with the home's GP prior to our inspection. They told us that Woodland View sought their involvement and advice when needed and were positive about the fact that they, "tend to be over cautious rather than under cautious about people's health." This demonstrated that Woodland View was responsive to people's changing health needs.

At the time of this inspection each cottage was at a different stage of re-decoration and improvement to make the environment more dementia friendly. Throughout our inspection we received a number of negative comments from staff about the re-decoration. Dementia friendly signs were being installed on the second day of our inspection. We did not see any other signs or aids to support people with living with dementia to orientate themselves within Woodland View. We discussed this, as well as the feedback we had received from staff, with members of the management team. The operations manager told us that people, their relatives and staff had been involved in choosing fixtures and furnishings and that a team of specialist architects had been involved in order to ensure the environment was dementia friendly. They also said that new furnishing had yet to be put in place and that aids to orientate people such as large clocks and boards to record information had also been ordered, as had a variety of pictures to stimulate memories and prompt conversations with people. We noted that the activities room was bare and were informed that there were plans to make this a more dementia friendly environment.

Requires Improvement

Is the service caring?

Our findings

Relatives who spoke with us with during the course of our inspection were positive about the staff at Woodland View and the way in which they cared for their family members. For example, one relative commented, "All the staff are pleasant to all the service users. The staff seem to have a calm manner with people." Another relative commented, "I think it is a really good home. I'm sure that [my family member] is happy here."

Our observations did not always correspond with those of relatives in that we saw a number of examples of staff not treating people with consideration and respect. For example, our SOFI and informal observations highlighted that the support provided by some staff members was task centred with little interaction with people. We frequently noted that some members of staff did not talk or acknowledge people on entering areas of the home or as they passed where people were sat. For example, on entering a lounge area, we observed one support worker walk across the room and state, "God, it's too warm in here. I feel really sick." They did not speak to, or make eye contact with any of the people in the lounge. Following lunch we noted that a support worker was sat in one of the lounge areas watching TV for ten minutes. The worker proceeded to clear crockery after noticing our presence.

Whilst staff were able to give examples of the day to day choices they provided to people, we saw few examples of these choices occurring in practice. For example, we did not see or hear any examples of people being given a choice about what they would like to eat during any of the six meal time observations undertaken during the first day of our inspection. We also heard a number of examples of staff members not respecting people's dignity and privacy. For example, we frequently overheard support workers asking colleagues if people's personal care needs had been met. These queries were audible and took place in front of both the person concerned and others living at Woodland View.

Prior to our inspection we received information from Healthwatch about members of staff knowing little information about the biography of people living at Woodland View. Whilst we found that some members of staff were knowledgeable about people's former jobs, interests and the people important to them, we also found examples of some staff knowing very little about people and their lives. For example, two members of staff did not know the surnames of the people they were caring for.

We also found examples of people's records not reflecting their preferred names. On checking the records of one person we noted that the name used throughout their records was different to the name used during our inspection. There was a section within Insight to reflect people's preferred names which had not been completed for this person. The clinical educator updated this on our request.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast, we did see some positive, person centred and caring interactions from some staff members. For example, on noticing that one person had tipped their sandwiches across the table, a support worker fetched some more and sat chatting with the person about the re-decoration of the home and their previous employment. This was a positive interaction which resulted in the person eating their lunch. Similarly, we observed some members of staff explain the support they were providing and talk and consult with people in a kind way; for example, one staff member said, "I'm just going to help wipe your mouth; is that OK?" when supporting someone.

We spoke with members of staff about the availability of advocacy services for people who did not have relatives of friends to promote their rights and represent their views. We found that knowledge of available advocacy services was mixed. For example, one support worker was unsure if advocacy support was available, whereas a nurse we spoke with was knowledgeable about the differing types of advocacy which may be required by people living at Woodland View.

During a staff handover we heard some good, person centred practice about end of life care and how a person's changing needs were communicated and explained to staff. Each member of staff demonstrated a caring approach about the person concerned and fed back the changes they had observed in this person's behaviour and appearance. The clinical educator present at the time of

Requires Improvement

Is the service caring?

this handover explained the reasons for these changes as well as other possible future changes. Staff were also informed that pain reliving medication had been prescribed and was to be used if needed.

Most nurses told us that they felt confident to have discussions with people's families about end of life care. We also heard examples of how Woodland View had acknowledged and respected the things which were important to people. For example, one member of staff told us that they had ensured that the music of one person's faith was playing at the end of the person's life and in the period of time leading up to this. A thank-you card from a relative was complimentary about the end of life care their relative received; it stated, "My [family member] was treated with such care and dignity, especially during [their] final days."

The registered manager told us that they were working with the local hospice to improve end of life care plans. They also told us of their plans to support relatives by scheduling meetings to provide them with emotional support, as well as to discuss end of life care in relation to dementia. At the time of our inspection, nurses at Woodland View had not undertaken syringe driver training. This meant that district nurses had to visit the home in order to administer continuous doses of end of life pain relieving medication. The registered manager informed us of his intention for nurses to undertake this training in order for people to receive consistent care from the staff team at Woodland View.

Requires Improvement

Is the service responsive?

Our findings

We asked about how people's needs were assessed and were informed that a Detailed Risk Assessment (DRAM) was completed when people arrived at Woodland View. A care plan was then developed from the areas identified within this. Given that the care plans were based upon risk, we found that they contained detailed information about behaviours which may challenge and how to respond to these. We noted that other areas of the plans were often task centred and did not reflect people's individual needs and preferences.

Staff often referred to the care plans as, 'unwieldy,' with one member of staff describing them as, "never ending rolls of wallpaper." Our observations confirmed this description as we found that information was not easy to locate within these long continuous documents. Two of the clinical educators said that work was underway to condense the care plans and make them more user friendly.

People's care records were stored on Insight, the provider's electronic recoding system. We were reliant upon staff to access and find information within Insight and noted that information was not always easy to locate. For example, staff often had to look in a number of different sections within the electronic record to find the requested information. We also found that some staff were more familiar with using a computer and could locate information quicker than others.

We asked how relatives contributed to and were involved in reviews of their family members care and were told that families were able to access the information at any time through nurses. We were informed that nurses had recently begun to send out letters to relatives inviting them to a monthly meeting to discuss their family member's care plan. Three of the ten comments made about the quality of care within the relatives survey of June 2014 made reference to relatives not being aware of the content of care plans. One comment stated, "I have not been involved in my mother's care plan and was only very recently aware of any of its contents following a funding review."

Permanent staff members said there were times when a number of agency staff who were unfamiliar with Woodland View were on duty. At times they told us that this could result in delays, particularly when supporting people to get up in the morning. One member of staff said, "The agency staff have to ask questions about people and it takes time." Another staff member commented that agency staff, "Are becoming the norm," describing this as, "A massive problem because they don't know the residents." One relative commented upon the use of agency staff and stated, "There used to be regular staff; [my relative] doesn't get on as well with the different ones." Similar comments were contained within the relative's survey, one of which stated, "Far too many bank staff who do not know the residents requirements."

We saw that the home had begun to gather information about people's preferences and backgrounds in order to provide person centred support. For example, 'My Life Story' books had been completed for some people. These are good practice documents which provide key information to enable staff to get to know people and the things which are important to them. One support worker was particularly positive about the fact that they were being supported to learn about and implement good practice tools to enable staff to get to know about people's lives and preferences. They had attended meetings with the University of Sheffield about life story work and said that they were looking at developing one page profiles listing key information about people to support staff to deliver more person centred care.

Two activity facilitators were employed by Woodland View and were on duty on the day of our inspection. Information about activities was listed on notice boards within the cottages. Activities planned for the week of our inspection included: mug decorating, a countryside drive, a Halloween party and a visit from a pets as therapy group. We observed the poetry group which took place during the first day of our inspection. It was attended by two people and took place in the café area of the home. This was a pleasant area which had been funded by the relatives group to enable relatives to spend time with people as well as provide an area for small groups to take place.

We spoke with one of the activity facilitators. They showed us a list they had compiled of people's individual food and drink preferences to use at the home and when out on trips. Our conversation also demonstrated a responsive approach. For example, they told us that, during a recent trip to a park one person did not want to eat in the café, but

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Is the service responsive?

instead wanted to look at the trees in the park. They said, "I went with them to look at the trees and arranged for their meal to be put into a food container so they could eat it on the bus on the way back home."

Whilst it was evident that activities were provided, other than televisions and radios being on within the lounge areas of the bungalows, we saw few activities or opportunities to engage people who were less active. Our informal observations and SOFI observations demonstrated some positive interactions but overall, interactions and engagement were prompted by people and not members of staff. For example, during our SOFI observation of one of the lounge areas, a support worker sat silently in a chair for ten minutes before responding to one person's request to pass them a daily paper. Informal observations of other lounge areas were similar; when conversations did take place, these were often brief and were instigated by people living at Woodland View. This meant there was a lack of sufficient stimulation and social interaction available to meet people's individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments within the relative's survey of June 2014 corresponded with our observations. One comment stated, "It was an, unfortunately rare, treat to hear a staff member talking to a resident about their war experiences when the D-day anniversary was on the television." In another comment a relative expressed their view that their family member, "Spends too much time without a positive stimulus." A third comment stated, "During the time my relative has been at woodland view the number and range of activities has been very variable. It does seem to have improved more recently. Not all staff show the same amount of care and consideration for resident's needs. Some are much more willing than others to find the time for a friendly chat."

Information about how to make a complaint was displayed within the home. The registered manager said there were no current complaints and provided examples of how they had learnt and responded to previous complaints. For example, they told us a relative complained that their family member had not been supported for a period of time. An investigation identified that their family member had refused the support offered, however, at the time of their complaint, there was no document in place to record that support had been offered. An observations sheet to document the times and types of support accepted and refused by people had been implemented by the registered manager in response to this.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been registered with the Care Quality Commission since November 2013. We received mixed reactions from members of staff about the management team and their leadership at Woodland View. Some members of staff were negative about the recent changes to the service. For example, one member of staff stated, "I don't feel valued and the management team don't listen to the staff." Another member of staff said, "I don't trust the management at all, I've no faith in them." These statements were in direct contrast to a number of positive statements from other members of staff. For example, one member of staff stated, "I have no issues at all with the management. Some people just don't like change." Another member of staff said, "the new management has improved things."

Our conversations with the manger demonstrated that they had clear goals for the service. They had identified a number of issues and had found solutions to address them. For example, they told us that, on arriving at Woodland View they had undertaken an analysis of the staffing levels and the skills needed to meet the increasing needs of people living at the home. This had led to an increase in the number of staff on each shift as well as the creation of the four clinical educator posts to supervise, support and mentor the staff in each cottage.

The registered manager was aware that staff might find the changes and direction in which they were leading the home in to be unsettling. They were also aware that some staff were resistant to these changes and plans. In order to keep staff up to date and enable them to directly discuss any concerns, the registered manager held a weekly 'open door' session. Staff were positive about these sessions and also told us that the registered manager was visible around the home.

Most staff were positive about the way in which the manager and the clinical educators led the service and supported them. For example, the support worker who was implementing more person centred tools into the home commented, "the manager is really behind me about music projects and the, 'This is me documents.' Recently I've seen a really big shift for the better."

Our observations clearly demonstrated the value of the clinical educator's role. They were visible throughout our inspection and we saw them directly supporting people, staff and qualified nurses. We also observed this role in action during our observations of a staff handover, where the clinical educator's explanation of a person's changed behaviours and needs to the staff present was crucial to them understanding the person and the care they required. The clinical educator also gave clear direction and leadership about the tasks required of the nurse and staff on duty for the forthcoming shift. A number of staff commented positively about the role of the clinical educators. One nurse told us that their clinical educator was, "just brilliant. She is really encouraging." When talking about the same clinical educator, another nurse told us, "I get supervision from a clinical educator who is fantastic. Nothing is too much trouble for her and she is really patient."

During our inspection we looked at a range of records and spoke with a number of staff in order to review how the quality of care provided by Woodland View was monitored and safely maintained.

Our conversations with the site operations manager showed that a number of audits took place in relation to health and safety and the premises. The registered manager told us that the operations manager visited and undertook audits of the service. Copies of these audits were requested during and following our inspection but were not provided. Some documents relating to monitoring the quality of the service were forwarded by the provider. One of these documents was completed in August 2014 and contained a section titled, 'What we discovered in 2013/14,' and stated, 'No measure of outcomes or auditing.' During our inspection, there was no evidence to demonstrate that the provider had taken any further action between August 2014 and the time of our inspection to address these acknowledged shortfalls.

During our inspection we identified a number of shortfalls in various aspects of the service. Our conversation with members of staff and our review of records indicated that not all of these shortfalls had been identified through the internal auditing systems. For example, at the time of our inspection, care plan audits, medication 'spot checks' and medication audits were not undertaken. Additionally, whilst our conversations with staff evidenced that staff meetings took place to discuss areas of the service, the registered manager told us that these were not consistently recorded. We were concerned that the lack of these key

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Is the service well-led?

records at the time of our inspection, together with the failure of the operations manager to provide copies of the audits they had undertaken, did not demonstrate that a comprehensive and robust system was in place to ensure the service was delivered as effectively as possible.

A staff survey had been conducted in June 2014. Whilst the survey form stated, "All answers will be treated confidentially and anonymously", a number of staff were sceptical about this. They told us that they did not feel confident to fill in the form as it contained a reference ID and it had to be returned by e-mail. Our review of the staff survey identified that Woodland View were not capturing the views of a number of staff. 22 members of staff had completed the survey (approximately one quarter of the total staff employed at the home). Whilst the results of the survey had been analysed, no action plan had been produced to inform staff how the service planned to respond to the concerns raised within the survey.

A survey to obtain the views of relatives had been undertaken in June 2014. We reviewed the results of this and found them to be mixed, with some relatives expressing concern about a number of areas of the service. Many of these concerns corresponded with the findings of our inspection. As with the staff survey, whilst the results of the survey had been analysed we did not see an action plan to respond to the concerns expressed by relatives.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that a number of documents had been produced to consult with relatives and keep them up to date about the refurbishment programme and staffing changes within the home. Comment cards were also placed next to post boxes within each cottage to enable people, relatives and staff to make suggestions or comment upon the quality of the care provided.

A number of staff were positive about the weekly 'Wednesday Club' meeting and the way in which this provided updates about different areas of practice. They told us that this meeting was used in differing ways. For example, journal articles about best practice were read and then discussed, staff were encouraged to do presentations about best practice and subject matter experts were invited to speak on specific topics. One member of staff commented upon the positive impact the Wednesday Club had upon their work, saying, "I'm learning such a lot. I'm getting more confident with my job."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not assessed the risks to the health and safety of service users and done all that was reasonably practical to mitigate any such risks.** **Service users were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person did not have suitable arrangements in place to ensure choice and support, where necessary to enable service users to eat and drink sufficient amounts for their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place to ensure that people's dignity and independence were maintained as far as practicable, or to enable service users to make, or participate in making, decisions about their care.

People were not always treated with consideration and respect or provided with opportunities to promote their autonomy, independence and community involvement.

The registered person did not have suitable arrangements in place to ensure that care was provided to people with due regard to their preferences and beliefs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records reviewed were not always sufficiently detailed to provide an accurate record of the care observed during our inspection. This meant people were not protected from the risks of unsafe or inappropriate care and treatment, arising from a lack of proper information about them. The registered person did not have effective systems in place to monitor the quality of the service delivery.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining, and acting in

This section is primarily information for the provider

Action we have told the provider to take

accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.