Woodfalls Care Limited

Woodfalls Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on 21 and 22 May 2018. The first day of the inspection was unannounced. We previously inspected the service in April 2017 and found there to be one continued breach in legal regulation. We issued the provider with a requirement notice to ensure improvements were made.

People living at Woodfalls Care Home received accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Woodfalls Care Home is registered for up to 24 people to live at the service. Whilst registered for 24 people, only 23 can be accommodated. At the time of the inspection there were 18 people living at the home and one of these people was receiving treatment in hospital.

There was a manager in post. The manager was awaiting registration with CQC at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At the last inspection in April 2017, we found that medicines were not always managed safely and the service was unclean in places. We also identified that people's care plans did not always contain enough information to ensure their needs were being met. At this inspection, some concerns from the previous inspection had been addressed. However, most shortfalls remained of concern. The manager was aware of some of the areas that required improvement and an action plan was in place to address these.

There were some improvements in the record keeping for daily medicine administration. However, records for medicines administered on an 'as and when required' (PRN) basis were not recorded safely. They did not provide an overview of how often people received the medicines. The protocols for administering PRN medicines were inconsistent and not always in place for some people. This left people at risk of not receiving medicines in accordance with the prescription directions.

The protocols for the administration of topical medicines, such as creams and lotions were not in place. This meant there was no guidance as to where specifically people required their prescription.

Areas of the home were unclean. We found a build-up of dust on ornaments and cobwebs that had clearly been in place for some time. The condition of the fixtures and fittings prevented thorough infection prevention control during cleaning. This meant there was increased risk of cross infection.

We saw that audits identified that parts of the building required redecoration and repair. However, this had been put on hold due to having empty rooms at the home.

People had pressure relieving equipment in place, such as air mattresses. Staff did not record information provided by the community nurse, to check mattresses remained at the correct setting. It was not possible for the service to know if the equipment was at its most effective setting.

Staff practice for recording fluid intake was inconsistent. They recorded fluid intake in different places and at times did not complete the records fully. There was no overview of people's fluid intake where it had been assessed as a need to do this in monitoring their health.

There was no overview or monitoring of infections. Staff recalled from memory who had been diagnosed with an infection. There was no monitoring in place to identify the frequency or duration of infections.

Staff understood how the Mental Capacity Act 2005 (MCA) applied when people lacked capacity. When people had been assessed as having mental capacity to make decisions, staff told us they would still stop them from leaving the service if they wished. This practice would mean that staff detained people unlawfully.

There were no records identifying who had the legal right to be involved in decisions about people's care.

The quality of care plans varied. We saw that care plans had in places minimal and generic information recorded. The service used an electronic care planning system, which auto-generated statements that could be used in care plans. The aim of this was that staff would then tailor the automated information to make it person-centred, but this was not being done.

Relatives praised the service for the care and support their family members received. We saw positive feedback had been received in 'thank-you cards'. This positive feedback was particularly around how comfortable and cared for family members had been while receiving end of life care.

The provision of activities was very minimal. Staff told us people could, "watch the TV, listen to the radio, read a magazine." The manager told us, "People have got dementia so we don't like to put too much on. On one day they do have the hairdresser and the doctors round." We saw people seeking engagement with the staff and little social stimulation being offered due to staff completing care duties.

There were short periods of kind and caring interactions between people and staff. Staff spoke with compassion about the care they provided and were proud of "being able to make a difference." The availability of staff did not enable people to receive longer periods of caring engagement with staff.

Staff routines were task focussed and not always considerate of people. We saw two staff discussing shift cover at the dining table, while one person was next to them eating their afternoon tea. At the same time, the manager was at another dining table completing the payroll. This did not contribute to a homely environment.

Management overview of the service was not always possible. The training matrix was in the process of being created to provide an overview of who had completed what training and when training was due. The audits did not identify concerns that we found at the inspection. Individual staff meetings to discuss their performance and feedback were not up to date. Policies and risk assessments for the home were out of date and in the process of being updated.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the third time that the service has been rated as Requires Improvement. In line with our published guidance for repeated Requires improvement CQC considered what enforcement action to take. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We have requested that the registered manager provides a monthly action plan with updates as to how the service will address the shortfalls highlighted at the inspection and detailed in this 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?

Requires Improvement

The service was not safe.

Timely action was not taken to address risks.

Medicine protocols were inconsistent and not always in place.

The kitchen was unclean.

The environment presented risks to people's safety and prevented safe infection control processes.

Is the service effective?

Requires Improvement

The service was not effective.

The principles of the Mental Capacity Act 2005 were not always followed or understood.

There was no recorded overview of people's health care needs or interventions required.

People chose what they would like to eat.

Referrals to health care professionals were made in a timely manner.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the caring approach.

Compliment cards were received from relatives who had family members cared for at the service.

Relatives could visit when they chose.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records were task focussed and did not include if action had been taken to follow up on concerns.

Care plans did not always reflect the support people required.

There was not always enough for people to do.

People had access to the garden and could spend time outside.

Staff were enthusiastic about providing good quality end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had not addressed issues raised at previous CQC inspections. There were continued breaches in Regulations.

There was no clear management overview of the service.

The management team were not always aware of leading by example.

Staff spoke positively about the support they received from the management team.

Woodfalls 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 checked 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.

Before the inspection we reviewed information from notifications received from the service regarding accidents and incidents. We also looked at information provided by the service in their Provider Information Return (PIR). The PIR tells us what the service feels is working well and any areas they have identified as requiring improvements.

This inspection took place on 21 and 22 May 2018 and was unannounced. The inspection was conducted by one inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with three people who used the service and one relative. We spoke with seven members of staff, either by formal interview, or in informal conversation throughout the inspection. These included care staff, the chef, the housekeeper, deputy manager and registered manager.

To gather evidence relating to people's care, we reviewed care plans for four people and daily records for three people. We also looked at the medicine administration records for each person. We spent time observing the way staff interacted with people who use the service.

We reviewed records relating to the management of the service. This included looking at audits, policies, and the manager's action plan. We also looked at training and recruitment records for five members of staff.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in April 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). This was because medicines were not always managed safely and not all areas of the home were clean. At this inspection we found that although there were improvements in some aspects of medicine administration, action had not been taken to address all concerns.

The records of administration for people who required PRN medicines did not evidence that safe practices were being followed. One person was prescribed a liquid morphine solution on a PRN basis. The records of this administration were being made in one of three different places. This meant that there was a risk that staff would not see when the medicine was previously administered as it had not been recorded on the Medicine Administration Record (MAR). This could result in the person receiving a higher dose of their medicine than prescribed.

Where PRN medicines should be recorded on the MAR, staff were not completing this at all. This meant there was no clear overview of how often a person had been receiving their PRN. PRN medicines are not prescribed for daily use. Completing the MAR to show PRN administration then gives a clear overview of the usage and can prompt medicine reviews where needed.

PRN protocols were not in place for some people and for others lacked quality in information. Protocols direct staff as to when a person requires their medicine and what support should be provided. For example, how a person displays pain and where the pain relief is for, as well as if there are alternative pain relief methods that work well for the person. Not having the protocols in place meant that people were at risk of not receiving their medicines when needed. This could also mean people received medicines without alternative interventions being offered where appropriate.

Inconsistent directions were in place for the application of topical prescriptions, such as creams and lotions. There were no protocols or body maps in place to direct staff as to where exactly the prescription should be applied and when. This meant that people were at risk of not receiving their topical prescription in a consistent manner.

The MAR sheets did not have photographs for four people. Photographs support staff in ensuring they are administering the right medicine to the right person. The medicine audit from 5 April 2018 identified one person did not have their photograph on their MAR. The photograph was not in place at the time of the inspection. Action was not taken in a timely manner to address this issue.

Changes were made to the MAR for prescriptions to be administered. There was no evidence to show if these changes were made by the GP. We saw that one person was prescribed Warfarin. Warfarin is a blood thinning drug, used to reduce the risk of blood clots. There was a single line through the prescription details, with no signature and no guidance recorded to state if this was from the GP. This made it unclear if staff should still be administering the prescription or not.

Action was not taken where issues were highlighted to the manager during the inspection. On day one of the inspection we raised concerns that the eye drops for one person were one week out of date. On the second day of the inspection we found that the eye drops were still in use and we asked a senior member of care staff to remove these.

People received their medicines in small plastic pots or on medicine spoons. These had dark stains around the rim and handles. We saw that the medicine pots were left to soak in a dirty jug of water throughout the day. We asked staff why the pots were like this, they told us, "they're old and don't get changed."

Communal areas and the kitchen were unclean and action was required to control the risk of cross infection. We saw built-up dust on ornaments and cobwebs that had clearly been there for some time. The skirting boards and floors were stained and marked in places in communal areas. We asked the manager if they felt the kitchen was clean; they told us, "No, it's really dirty." Cupboard door handles were sticky. The floor had food debris on it and was stained. Mixing bowls had droplets of liquid in them while stored. This evidenced that thorough cleaning processes were not taking place.

The infection control audit did not include consideration for the concerns found at the last inspection. The most recent audit was completed in November 2017. However, the manager had a new audit that they intended to use in the future which included if floors, walls and surfaces could be wiped clean. If a surface is damaged, it cannot be fully cleaned.

There was poor practice in the disposal of healthcare waste. We saw a waste paper bin in the dining room that contained plastic gloves and aprons. Government guidelines around the disposal of waste (including gloves and aprons), states that these should be in closed bins, away from where food is served.

The concerns around medicines and infection control were a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The maintenance of fixtures, fittings and furniture in communal areas impacted upon infection prevention control (IPC) processes. There were areas of porous wood where the varnish had worn from the dining tables and chairs and damaged edges on the laminate flooring in the lounge. In the upstairs bathroom a new bath had been installed, however this left exposed wood and tiles removed. We also saw in this bathroom that there was a panel in the flooring that did not sit flush with the rest of the floor. Paint was peeling from the walls in two bathrooms. There were unfilled drill holes in the wall of the bathroom. Some skirting boards were damaged upstairs, as well as lots of areas having chipped and scratched paintwork. Radiator covers were damaged in places. We saw one raised toilet seat had flaking paint and rusted legs.

There were also maintenance issues in the kitchen that prevented proper IPC processes. The kitchen door had porous wood exposed as the varnish had worn off. We saw that shelving had dirty and unprotected edges. The hand washing sink was 'out of order' on the second day of the inspection. However, the registered manager took steps to address this concern. Chopping boards were overused and had many grooves in them from knives. There were tiles missing from the back of the draining board, leaving uneven surfaces. These exposed absorbent and uneven surfaces meant it was not possible to ensure effective cleaning, and increased the risk of cross infection.

The garden was not safe. One person found the broken base of a wine glass and was holding it as they walked back into the dining room. On the second day of the inspection one person used buckets that were in the garden to create a step to climb over the garden fence. We also found that the staff 'smoking shed' was very easily accessible. The shed contained a lot of cigarette ends. The staff smoking policy stated that

the cigarette ends should be disposed of regularly, so as not to cause a build-up. The smoking policy had not been followed. People were at risk of contact with hazardous materials and objects.

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

The manager told us that there were challenges with staff recruitment. They said that they had advertised locally, as the service had always done. Due to the rural location of the service, this meant that very few applications were received. The manager said that they had also advertised using an online recruitment website. The service employed agency staff to cover shortfalls in staffing numbers. The manager told us that the same members of agency staff were booked for two months at a time to provide some level of consistency in care.

The recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and reduce the risk of unsuitable people working with vulnerable children and adults.

Risks were assessed, where identified. We saw risk assessments in place in people's care plans. These included risks such as falls and general health. This meant that there were plans in place for staff to follow, to minimise risks, for specific people.

Staff told us the different types of abuse and what they would do if they felt people were being abused. They told us who they would report concerns to within the organisation and that they could contact the local authority safeguarding team, or CQC.

Requires Improvement

Is the service effective?

Our findings

Practices and staff understanding did not always comply with The Mental Capacity Act 2005. 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 legally authorised under the MCA.

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

Mental capacity assessments had been carried out. Assessments were to determine whether people had the capacity to make the decision to live at Woodfalls Care Home and receive care and treatment. Some people were assessed as lacking the mental capacity to make this decision. Where people had been assessed as lacking mental capacity, best interest decisions had been made.

Care plans did not include information around who should be involved in decisions about people's care. We saw generic and auto-generated statements from the electronic care planning system were used to explain who should be involved. For example, "[Person's name] loved ones and/or anyone with any form of LPoA [Lasting Power of Attorney] also to be fully involved, informed and their decision and wishes taken into account." The care plan did not state if the person had an appointed LPoA. Relatives or appointee's with LPoA have the power to take decisions on behalf of the person if they lack mental capacity. These decisions can be regarding health and welfare, or property and finances. This meant that staff did not have access to information regarding who to consult with when making specific decisions about people's care and treatment.

Staff had a basic level of understanding of the MCA, but did not always understand how to apply the principles of the MCA to their role. For example, if a person chose to leave the home. Staff told us they would stop people if they requested to leave. Staff told us that, "capacity should not be assumed" and, "when people lack capacity it is important to take their previous wishes into consideration." This showed that staff understood how to apply aspects of the Act to their role when supporting people who lacked mental capacity. This meant that people's rights were not always being considered or supported in accordance with regulatory requirements.

Care plans did not evidence if the person was involved in decisions around care interventions. For example, one person's care plan stated that they had mental capacity to make decisions regarding their care and treatment. The care plan stated that an alarm mat had been put in place. The alarm mat alerts staff when the person or others step onto the mat. For another person, their care plan stated that they also had mental capacity. A decision had been made that the person should be observed hourly in the day and two hourly at night. For both people, care interventions that constitute continuous supervision were in place. However,

there was no evidence to show that the decisions had been discussed with both people to gain their consent.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records documenting how the service supported people's health care needs were inconsistent. Some people were assessed as needing to have their fluid intake monitored. The deputy manager told us that staff tended to record fluid intake in one of three different places and sometimes records were not completed. The deputy manager said that they had not completed fluid intake records for one person as required. Their reason for this was, "You'll see from the notes I was here until midnight. I put that I was having trouble getting him to drink. It was a nightmare shift." This meant there was no clear overview of a person's fluid intake and records were incomplete. The service had failed to implement proper fluid intake recording processes for people at risk of developing infection.

There was no overview of infections in the home. The service had people who had been diagnosed with a urinary tract infection (UTI). We asked the manager how many people had a UTI. They told us there were "quite a few." The manager was not up to date on this information and asked that we speak with the deputy manager. The deputy manager recalled the information from memory about who had recently had a UTI. There was no analysis around who was diagnosed, for how long they were unwell, or the frequency of their infection. This meant that the service did not promote or always appropriately support improvements in people's overall health.

Pressure relieving equipment was not audited to ensure the settings supported people's skin integrity. The service was unaware of what setting the person's pressure mattress should be set to. The deputy manager and one senior carer told us that this was set by the community nurse, but the service did not record what the setting should be. Settings could easily be changed by people or staff. It would not be possible to check if this was the correct setting for the person's level of need.

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

Staff told us they had completed a range of training. They said this included training around health and safety, the Mental Capacity Act, safeguarding, and first aid. One member of staff told us about their induction. They said they completed The Care Certificate and shadowed more experienced care staff. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The staff member said they had felt supported during their induction.

Staff completed face to face training, as well as e-learning. Staff told us that they preferred face to face training. The manager said they planned to be less reliant on the e-learning training as the service develops. This was the same response as had been provided by the previous manager at the last inspection. This meant that although the overview of training had been identified over a year prior to the inspection as requiring improvements, action had still not been completed.

Referrals were made to health and social care professionals in a timely manner. We saw that one person who had experienced a high number of falls had been referred to the occupational therapist and falls clinic for support. One person had been identified as recently appearing lethargic. During the inspection we saw that they were being visited by the community nurse. Another person, who lacked mental capacity, had

been assessed as being at high risk of leaving the home unsupported. The service had been in contact with the DoLS team to ensure an urgent review of their DoLS application was completed.

People could choose what they wanted to eat at meal times. People were offered a choice of two different hot meal options earlier in the day, before receiving their chosen option at lunch. We saw that one person chose to have something different to the menu options and this was accommodated. When people finished their lunch, they were offered additional portions. People were offered drinks and had a choice of hot drinks or squash. One person chose to have a glass of wine with their meal. The chef told us that the service ensured they ordered food that people with allergies enjoyed, for example, dairy free ice-cream and soya yogurts. People chose where they wanted to sit at lunch time, with some people in the dining room and others having their meal in a lounge chair.

One relative told us their family member had developed an improved appetite since living at the service. They said, "Her health, appetite and weight have improved a great deal. She is happy to be here and has settled well. This is due to the support she has received from the staff." People told us they liked the food and the portion sizes.

No visual choices were offered at meal times and there were no menu options available for people to see during the day. The meals were brought one by one from the kitchen to the person. Whilst people could make choices from options offered verbally, offering a visual choice was a more person-centred approach. This would better support people living with dementia to make choices, as well as those who may have changed their mind on the day. We also saw that one person declined their lunch because they had only had their breakfast an hour before. The staff member did not offer to serve their lunch later in the day, but instead suggested they have a small portion. This evidenced that the approach to offering people choice was not always person-centred.

People's needs were not always met by the design and decoration of the service. We saw that people frequently went into the bedroom next to the downstairs bathroom, because the bedroom was at the end of the corridor. Not all people had signs on their bedroom doors to identify the bedroom as theirs and we saw people walking into other people's bedrooms.

Religious and cultural beliefs were supported. People could attend religious services within the home. We saw this being offered during the inspection. Staff also told us that when people passed away, their friends who live at the home could be supported to attend the funeral service.

Good

Is the service caring?

Our findings

People told us that staff were caring. One person said, "The attitudes of the staff are very caring and friendly. It is never too much trouble to help when I need it." Another person told us, "It's not like your own home, but the staff are very kind."

We saw brief periods of kind and caring interactions between staff and people. Staff spoke respectfully to people and appeared to know people well. When one person was being served their lunchtime meal, staff asked if they would like a glass of wine. This was because the person enjoyed a glass of wine with their meal. Another person felt the cold and some people were feeling very warm. The person who felt the cold was in their preferred chair, staff switched off fans that were near that person and provided the person with a blanket. The patio doors were opened to help people who were feeling warm to cool down.

One member of staff 'stood out' for their dementia friendly approach. We saw the staff member introduce themselves frequently throughout the day. They spoke in a clear and audible tone. The staff member explained each step of the support they were providing and without fail sought consent for each care intervention. We heard the staff member offering choice and conversing with different people throughout the day, adapting their approach to the individual. The staff member shared well received humour with people and spoke in a kind and dignified manner. The impact of this approach was evident through observing how people responded and reacted to the staff member. People recognised this staff member and we saw people gravitate towards them, actively praising them for being "lovely" and, their "favourite", because of the rapport they had built. The member of staff told us they had developed their knowledge of dementia through learning from others and through their own research. We discussed our feedback about the member of staff with the manager. They told us they were keen to develop the staff member because of their positive approach.

Relatives were free to visit when they wished. We saw one relative join their family member for afternoon tea. Relatives spent time in the communal areas and we saw the positive impact this had for their family members. Other people also felt comfortable speaking with people's visiting relatives, and this helped to create a homely and relaxed atmosphere within the service.

Staff told us they would have their relative live at the service. They spoke enthusiastically about the care they provided. One staff member told us, "I love working here. There is no other job I'd want to be in. I feel really proud when I can make a difference to people's lives." They continued by saying, "The staff team are brilliant, they are not afraid to speak out if they see something wrong. Residents come first." Another staff member told us about how they had gone to the shop to purchase some cough sweets for a person in their own time. They said, "I didn't mind going, it's little things like that which show how much we care and support the residents."

The staff member said that staffing restrictions could impact the time staff were able to spend with people. They said, "You haven't always got those ten minutes that you want to spend with someone." Staff felt they did the best they could, but with more staff they could spend more quality time with people.

We observed staff protecting and respecting people's privacy and dignity. For example, one person was in a state of undress in the dining room. The deputy manager was quick to react and kept the interactions light-hearted so as not to upset the person or draw attention to them. The deputy manager recognised that the person was feeling hot, so offered to go and find a cooler item of clothing. The deputy manager asked a member of staff to support the person to change in the bathroom. We also saw that staff knocked people's doors before entering and introduced themselves when greeting the person.

People's data and important information was stored in the manager's office, or electronically on the care system. The office remained locked when the room was not in use. The care system was only accessible to staff with an individual log-in. Staff log-in profiles were set to different tiers of access dependent on their role. This meant that people's data was stored in accordance with the Data Protection Act.

People were supported with their meals by staff with a calm and caring approach. When people who had a smaller appetite had finished their meal, we saw staff praise them for having "done really well." Staff explained the meal to the person when serving their food. For example, "[Person's name], I've got your lunch. It's chicken in a white sauce, with carrots, butternut mash and cabbage, would you like some gravy?" We saw people walking with staff members, arms linked and staff giving positive words of encouragement or offering choice. People appeared comfortable receiving this support as they either thanked staff, or displayed positive facial expressions.

The service received a lot of compliment cards from relatives of people who currently or previously had received care at the service. The compliments included, "Thank you for all the care and love you have given her and for making her last few years as comfortable as possible." As well as, "We would just like to say thank you so much for all that you have done for our [family member]." This showed that relatives felt their family members were well cared for.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we identified that people's care plans contained generic and non-person-centred information. At this inspection we found that care plans did not always reflect the specific support people required. The care plans were created using an electronic system, which allowed staff to complete plans using generic statements. For example, one person had a catheter fitted and their care plan contained no detail around the support that staff should provide. There was only one reference to the person's catheter in the care plan and that was to state, "Catheter is fitted permanent and protective bed linen." We observed staff offering support to the person that had not been detailed in the care plan. The care plan for another person stated, "Continence aids required: Unknown [continence] aid." It was not stated elsewhere what the unknown aid could be. This meant that people were at risk of receiving inconsistent care, especially as the service had new staff starting and employed agency staff.

In the care plans reviewed, we saw only one section in one person's care plan that contained enough detail. This was a dementia care plan and included guidance for staff around how best to communicate with the person. For example, "When communicating with [person's name], make liberal use of facial expressions." As well as detailing the potential triggers for the person to become anxious or agitated and the actions staff could take. This information was specific to that person and meant that there was guidance for staff to refer to in knowing how best to support them. We saw that the quality in care planning was inconsistent.

The daily records were task focussed, lacked detail and did not evidence where action was taken to follow up on concerns. One entry stated, "2 times [person's name] has walked themselves to the bathroom. Leaning a lot from their chair. Diet not good, [nutritional supplement drink] made." This did not explain what concerns there were around the person's dietary intake, or the potential reasons for this. Another entry stated, "Settled on night checks. Mobility not good. Slippers are too big for [person's name], accident waiting to happen." There was no follow up note to state what had been done around the identified risk.

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

Twelve complaints had been recorded as received in the past twelve months. Four of these were raised by people living at the service. One complaint raised in September 2017, was regarding a person not wanting to have their incontinence pads stored in their bedroom. The response to the complaint stated, "[Manager and deputy manager] spoke to [person's name] after stacking them away safely in her room and said that they had to be there for her use. Revisited later in the day as [person's name] was still disgruntled that there was nowhere else for them to go." Practical and dignified alternative storage options were not explored, nor were the reasons why the person did not want them in their bedroom.

One person raised a formal complaint regarding the way night staff interacted with them. The person received a response and this was recorded two weeks after the initial complaint. The response was to schedule a night staff meeting for three weeks after the complaint was received to "discuss training needs." This meant that the person's concerns were at risk of continuing for an additional three weeks before the

staff member responsible was made aware.

An activities coordinator was in place for two days per week and was supported by volunteers for short periods of time on other days. We saw two volunteers delivering a half an hour arts and crafts activities session with two people. The activities coordinator positively engaged with people the following day and also supported the team during the lunchtime service. One staff member told us, "[The activities coordinator] is great, he has lots of ideas and adapts to different people." When the activities coordinator was not present, we saw staff encourage people to use an interactive system. This electronic system displayed images of leaves or bubbles onto a table top and people used dustpan brushes to sweep the interactive images, which moved in response. People were engaged in this activity while receiving support from staff. However, we observed that people did not continue with this for long without staff support.

People had access to the garden. There were plans in place to improve the garden and make it safer and more user friendly. The inspection took place during a period of warm and sunny weather. We saw people accessing the garden, spending time sat on the benches. Staff told us that there had been a garden party to celebrate the Royal wedding. One relative told us they attended and were offered food and drinks as part of the celebrations.

Staff and the manager at times lacked insight into how important the social activities and stimulation at the home can be. The manager told us, "Well they do have dementia, so we don't like to do too much. On one day they have the hairdresser, and the doctors round." One staff member said, "They have the television, or the radio, and we have magazines." Another staff member said, "The activities coordinator sometimes helps with the care. If we need them to they will watch the floor [lounge/dining room] and come away from the activity if the carers are busy elsewhere." And, "I don't think people ever have enough to do really." This meant that for most of the week, people were reliant on care staff for interactions and social engagement.

Routines were at times set around staff tasks and were not always based on the individual person and their wishes. Staff told us they tried to follow a routine throughout the day. They described the routine as including, "Toilet rounds." This was where each person was offered support to go to the toilet at set times of the day. One staff member said, "Getting into routines helps them."

Staff spoke with compassion about providing end of life care. One staff member described the process when a person was assessed as coming towards the end of the life. They said, "The GP is involved and they make sure all necessary pain relief is provided." In addition to the health care support, they described how staff ensured people were comfortable. They told us, "We make them as comfortable as we possibly can. One person, I sat with them after everyone else had gone to bed. I held their hand and spoke gently with them. We want them to go out calm and comfortable; for their last days to be peaceful and as happy as they can be." The staff member explained that they had received training from a local hospice and that they found this useful.

Requires Improvement

Is the service well-led?

Our findings

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

The manager had been in post for four months prior to the inspection. The manager had worked for the service since September 2017, but was employed as the deputy manager for five months. There had been a change in managerial positions at the home. The manager described the service as being "in a transitional period." The previous registered manager was now in the position of deputy manager. This meant that the manager and deputy manager had been at the service as a management team for nine months prior to the inspection.

Since the last inspection, there was a continued breach in Regulation regarding medicines management, the cleanliness of the home, and quality of care planning. Other issues identified at the last inspection that remained outstanding were staff availability, and audits not identifying the depth of monitoring required. We observed that the records for the administration of daily medicines had improved.

The service did not take timely action to address concerns. The health and safety audit stated that cleaning of the communal conservatory (dining room) was on hold, due to costs. The audit was completed in November 2017 and stated, "Conservatory clean on hold due to cost analysis of the home." The audit also stated, "Redecoration of upstairs bathroom on hold because of empty rooms/cost analysis." This showed that the provider was aware there were health and safety shortfalls in the bathroom and infection control issues in the communal areas. Action had not been taken six months later.

Lessons were not learned when things went wrong. Action had not been taken where concerns were identified. The service was in breach of Regulation 12 regarding safe medicines administration at our inspections in 2017 and 2015. These issues still had not been fully addressed.

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

Quality monitoring systems were insufficient in creating a managerial overview of the service. The audits did not always identify concerns that we found during the inspection. Where required actions had been identified, these had been put on hold with no action taken in the six months since the audit. The manager had an action plan in place and there were realistic deadlines for each action, but the plan did not include all areas of concern identified at this inspection.

The action plan prioritised addressing policies and staff training. The manager told us that they knew the policies were not suitable in directing staff. The manager was working with a consultant to update the

policies and improve their quality.

The manager told us they found their role interesting and rewarding. Their plans for the future included addressing the issues highlighted at this inspection. The manager said they had experience of improving ratings for services that had been rated as requires improvement. This was the manager's first post working with older people and those living with dementia. They told us that they would draw on personal experiences and their background in managing learning disability services. The manager said they were continually learning and drawing on experience of the staff team. The manager told us their vision for the service. They said, "I'd like to be able to say that the documentation is carried out properly and more complete. Training is needed and should be completed to the right standard."

There was no overview of staff training needs. The manager had produced a training matrix; however, this was only recently made and had not yet been completed . The manager explained that they would gather all information relating to the staff training to complete this as this was stored in different places. Staff supervisions were not up to date. This meant that staff did not have recorded discussions around their performance, any concerns, or their feedback. One staff member told us, "The supervisions have slipped behind. I think this is because the manager is so busy." However, the staff member told us they knew they could see the manager, or send them a private message if they needed to speak to them about any concerns.

At times, the management team did not lead by example. We saw that some people were feeling very hot, so staff opened the conservatory doors. The manager said to a member of staff, "We could leave them open, but put a rail across, like I've got for my dog. It would secure the home." This comment was in the company of people, it was unclear if this was a joke remark, but it was not dignified. Another example of this was that the deputy manager and a member of staff joined a dining table where one person was eating their afternoon tea. Their engagement with the person was minimal. They then discussed the rota and shift cover. At the same time, the manager was at another dining table completing the payroll, with documents on the table. People were seated at the perimeter of the room, watching staff, without engagement. This did not contribute to a homely atmosphere. There was a manager's office where these tasks could have been carried out.

Staff spoke positively about the management team. One staff member said, "The manager and deputy are very supportive." The member of staff said they knew if they needed to ask anything of the manager, "they will always listen." Another staff member said they knew they could raise concerns using the internal email messaging system. Each staff member had their own company email account and these were used for reminders, communication updates, and to pass care information between staff members. They told us that the manager would then reply and arrange a time to discuss things further. The staff member told us that when a grievance was raised, the manager had dealt with it appropriately and in a supportive manner.

The manager said they were in regular email contact with the owners of the service. They told us they felt supported as the owners visited and meetings took place with the manager on a monthly basis.

To gain feedback, the manager told us they had held meetings with the staff team and senior team. The manager felt staff were comfortable raising any concerns with them and the staff team would put forward suggestions they had around development of the service. The manager said team morale had been low and that initially there was a lack of direction in leadership. They said they had worked to address this by ensuring they listened to staff and were thoughtful in their approach when responding.

The responsibilities of the management team were split between the manager and deputy manager. This

included managing different members of the staff team. The manager said their role was to oversee the kitchen and housekeeping. The deputy manager was responsible for overseeing the care delivery. This split in responsibilities meant there was an increased risk that the manager may not have a consistent overview of the quality of care being delivered.

The manager told us they ensured they recruited new staff by assessing how the candidate interacted with people living at the home. They said they would introduce candidates to people, as well as identifying relevant pre-existing skills from their employment background. The manager told us that recruiting new staff was a challenge, but that they were hoping to attend recruitment fairs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not always have a good understanding of the principles of The Mental Capacity Act (2005). Care plans did not reflect where people had legal representatives that should be involved in decisions about their care (LPoA). There was a lack of evidence to show that people who had capacity were involved in decisions about their care interventions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. The PRN medicine administration records were inconsistent in quality and this made it difficult to see an overview of how often a person had received their prescription. PRN protocols were not always in place, and some protocols lacked important administration directions. Inconsistent directions were in place for the application of topical prescriptions. Photographs were not in place in a timely manner on MAR sheets. Changes were made to the MAR for prescriptions to be administered. Action was not taken to remove out of date medicines from use in a timely manner.

Medicine pots were stained and staff told us they were not changed.

The service was not always clean.

We found the communal areas to have dust and debris, and the kitchen was dirty.

Healthcare waste was disposed of in the dining room.

Care plans did not reflect the specific support people required, they were generic and used standard statements, instead of specific information about the person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The maintenance of fixtures, fittings and furniture in communal areas and kitchen that impacted upon infection prevention and control processes. The garden had areas that were unsafe, this included the staff smoking shed which was easily accessible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Record keeping was inconsistent. Where people had an assessed need to have their fluid intake recorded, this was not always followed. Some staff recorded observations of fluid intake in different places. There was no overarching view to support the person's health needs. There was no overview of infections in the home. Pressure relieving equipment was not audited

and there was no overview of what settings people's air mattresses should be set to.

Lessons were not learned when things went wrong. Timely action was not taken where audits and CQC inspections identified shortfalls. Action taken had not addressed shortfalls identified the two previous inspections.