North East Care Homes Limited

Woodlands

Inspection report

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14 December 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Woodlands is a residential care home based in Wideopen, Newcastle Upon Tyne that provides accommodation and personal care and support for up to 42 people, some of whom are living with dementia. At the time of our inspection there were 25 people in receipt of care from the service.

Our last inspection of this service was carried out in June 2016 to check that improvements had been made, in respect of breaches of regulations, identified at a comprehensive inspection in May 2015. At our last inspection we found that some of the previous breaches had been addressed and compliance achieved, but that serious failings still existed in respect of the safety of the premises and good governance. We issued a requirement notice in respect of the breach in safe care and treatment and issued a warning notice, in respect of the continuing breach in good governance. The service was also placed in special measures at that time.

At this inspection we found that some improvements had been made, but shortfalls still existed in respect of both of the above regulations. We identified further concerns about the way people were treated with a lack of dignity and respect, and established that staff did not always protect people from improper treatment. This inspection found that there was not enough improvement to take the provider out of special measures and the Commission is continuing to work with the provider to improve the quality of the service delivered.

A registered manager was in post who had been registered with the Commission to manage the carrying on of the regulated activity since August 2013. 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.

We found failings in the standards of care delivered which compromised people's safety. Medical attention was not consistently sought in a timely manner for all people, when they presented with changes in their physical or mental wellbeing. Some staff adopted moving and handling procedures that were not safe or in line with best practice guidelines. In addition, we could not be sure that the management of pressure area care was safe, as documented instructions for staff to refer to, were not in place.

The management of medicines was not safe. Some people's medicines had gone out of stock and were not available to them. The recording of the administration of medicines was poor and it was not always possible to reconcile if people had received their medicines or not. In addition, people did not always receive their medicines in a timely manner.

Safeguarding policies and procedures were in place to help protect people from harm and abuse. However, we found evidence of staff not alerting the manager to inappropriate treatment of people by their colleagues, until sometime after the event. Staff had received training in the safeguarding of vulnerable adults but they had not always safeguarded people in practice.

Improvements to the premises had been made since our last visit. Accidents and incidents were appropriately recorded and monitored for any patterns or trends. Health and safety checks and checks on equipment were carried out regularly to ensure they remained safe for use. The environment within the home did not reflect best practice guidance about steps that could be taken to support those people living with a cognitive impairment or dementia. We have issued a recommendation about this.

Staffing levels were appropriate to people's needs, but we found that people's needs were not always met in a timely manner due to the way staff carried out their duties and how they were deployed. Some people had to wait for their care to be delivered, but this was linked to how staff organised themselves, how they completed their tasks and a lack of awareness. By the last day that we visited, an extra staff member was rostered on duty to observe people during busy times of the day such as when people were being assisted to rise from bed.

Recruitment procedures adopted within the service were thorough and robust. Staff had been trained in key areas relevant to their roles and a programme of repeat training was on-going at the time of this inspection. However, we found staff did not always apply what they had learned. There was an outstanding breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Staffing, which the provider was still working to address at this inspection, in line with the action plan they sent us after their last inspection in June 2016. We will review the provider's compliance with this regulation at our next visit to the service. Supervisions and appraisals were in place.

Overall, people's general healthcare needs were met. People and their relatives reflected varying levels of satisfaction with the quality of care delivered and some people said that their needs were not met. Some people had not been supported to bathe regularly and their personal care had not always been attended to. We identified concerns about how some people were treated and spoken to by some members of the staff team. People's dignity was compromised during care delivery.

People were supported to eat and drink in sufficient amounts to remain healthy.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and that they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken and records about such decision making were maintained.

Care records were individualised and reflected the care and support people needed. Not all care records were well maintained and recording processes within the service were not robust. At times, records could not be located when we asked to see them and there was an impact on people's health and wellbeing where entries made on handover records about people's needs had not been properly followed up.

Choices and activities within the home were limited. People's social needs were not always met. We have made a recommendation about this.

Governance and quality assurance systems within the home required improvement. Although a range of audits were carried out, these were not effective in identifying the shortfalls that we found at this inspection. Action plans were not consistently used to drive through improvements within the service and there was a lack of oversight by the provider and registered manager on the quality of service delivered.

We identified five breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely; Regulation 9, Person-centred care; Regulation 10, Dignity and Respect; Regulation 12, Safe care and treatment; Regulation 13, Safeguarding service users from harm and abuse; and Regulation 17, Good governance. The provider has entered into a voluntary agreement with the Commission to suspend admissions to the home until the point at which they achieve compliance with all of the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We will continue to work with the provider to monitor and improve service. We have written to the provider and asked them to submit some specific information to us for review. You can see further action we have asked the provider to take at the back of the full version of 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?

Inadequate

The service was not always safe.

People did not always receive care that was safe. Medical interventions were not always sought in a timely manner and moving and handling procedures were not always carried out safely.

People's medicines were not safely managed.

Staff did not always safeguard people from abuse or improper treatment.

Staffing levels were appropriate but the deployment of staff and how they carried out their duties was not well managed to ensure people's needs were met.

Recruitment procedures were robust. Emergency planning and health and safety checks around the home and on equipment, were carried out regularly to ensure people remained safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People and their relatives relayed mixed feelings about the standards of care delivered within the home.

Our observations confirmed that people did not always receive good care that met their needs.

People's nutritional needs were met but there was limited choice around food.

Staff had received training in key areas relevant to their roles but they did not always apply what they had learned.

Communication within the service could be improved.

The Mental Capacity Act 2005 (MCA) was appropriately applied in line with legal requirements.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with respect.

At times the care practices adopted by staff compromised people's dignity.

Some people were spoken to inappropriately by staff.

Care delivery was sometimes rushed and explanations about the care about to be delivered were not given timely in advance.

People had the option to access advocacy services, should this type of support be required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were in place but not always well maintained. They did not always contain relevant and up to date information about people's care needs or their conditions.

Although people's care records were individualised, in practice people did not always receive person-centred care.

Activities on offer within the home were very limited and staff did not actively promote social stimulation.

Complaints were handled and responded to appropriately. Systems were in place to gather feedback from people using the service and others engaging with it.

Is the service well-led?

Inadequate

The service was not well led.

A registered manager was in post and the registration requirements of the service had been met.

A wide range of auditing within the service took place, but this was not effective in identifying and addressing the concerns we identified at this inspection.

It was not clear what levels of support the registered manager received from the provider in order to drive change and improvements in the service.

Recording within the service was poor and some records used in care delivery could not be located when we asked to see them.

The provider continued to be in breach of relevant legal requirements and remains in special measures.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17, 18 and 21 November 2016 and a further visit took place on 14 December 2016. It was carried out at short notice in response to some concerning information that the Commission received about the standards of care people received at the service. The visits on 17 November and 14 December 2016 were unannounced and those on the 18 and 21 November 2016 were announced. The inspection was carried out by three inspectors.

We did not request a Provider Information Return (PIR) in advance of this inspection due to the short timescales involved. A PIR 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.

We reviewed statutory notifications that the service had submitted since our last visit and obtained feedback about the service from North Tyneside contracts and commissioning team, and North Tyneside safeguarding adults team. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used the information that we had gathered to inform the planning of this inspection.

During our inspection we spoke with the provider's representative who was a regional manager from a management company who were overseeing the running of the service, the deputy manager, five members of the care staff team, seven people who used the service and two visiting healthcare professionals. We carried out observations around the premises and reviewed records related to health and safety matters, infection control, medicines management, governance and quality assurance. We also reviewed six people's care records to establish if they were appropriate and well maintained, and we looked at five staff files to review recruitment processes, training and the level of support staff received to fulfil their roles. Following our inspection we asked the provider to submit further evidence for us to review in relation to our findings.

Inadequate

Is the service safe?

Our findings

At our last inspection we identified concerns in respect of the premises where shortfalls existed which compromised people's safety. At this inspection the previous concerns had been addressed and improvements had been made throughout the building. However, we identified new failings in respect of the standards of care people received which put their safety at risk.

We could not be sure that the management of pressure area care within the home was in line with best practice as records about the pressure area care delivered were not maintained. On the first day of our inspection we asked the deputy manager if repositioning charts were in place to evidence that people were regularly repositioned where they were at risk of pressure damage due to poor skin integrity. They told us that they "should be" but could not locate them in one person's room. Staff told the deputy manager that such charts were not used. The deputy manager told us that people were repositioned on a two-hourly basis. In the absence of appropriate documentation, staff were not informed about how people should be repositioned, and to which area of their body they should be moved, based on how they had previously been lying.

On the second day that we visited "Position Chart Forms" had been introduced to reflect the pressure area care delivered to people. Instructions on these forms showed that people should be repositioned on a two-hourly basis. However, records showed there were time gaps of over three hours where people were not repositioned and some records had not been completed at all for periods of over 16 hours. We could not be sure that people received appropriate pressure area care in line with their needs and neither could the registered manager or provider. Where people were at risk of pressure damage, the risks of deterioration to their health and wellbeing were increased, as their pressure area care was not delivered in line with instructions to promote healing.

Risk assessments had been drafted about a range of people's care needs, but these were not always detailed or followed in practice. Our observations of care delivery throughout our inspection identified that some staff did not adopt safe moving and handling practices. We observed one person was not supported with the appropriate equipment when they could not weight bear whilst being transferred from their wheelchair to a lounge chair. Three staff carried out an unsafe manoeuvre that put both the person involved and themselves at risk of injury. Other examples of inappropriate moving and handling including people being pushed in wheelchairs and told to keep their feet up off the ground as opposed to them being placed on foot plates during transit, in line with safe moving and handling practice. People were at risk of injury to their feet and legs as a result.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

The management of medicines within the service was not always safe. A number of people's medicines had gone out of stock and subsequently they did not receive the medicines they needed. In addition, recording around the administration of medicines was poor. It was not always possible to reconcile if people had

received their medicines as prescribed, as there were gaps in recording where no entry in people's medication administration record sheets (MARs) had been made. On the first day that we visited, the morning medicines administration round took almost three hours to complete and it did not finish until 11.10am. On the fourth day that we visited the service the medication round took over two and a half hours to complete and again did not finish until after 11am. This meant that some people did not get their morning medications in a timely manner. We fed back our concerns about the length of time the medicines round took to the manager, who said they would look into the processes currently adopted and whether these could be altered to ensure that the administration of medicines was not as lengthy as it had been.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

We reviewed the policies and procedures in place for the safeguarding of vulnerable adults within the service. We found that appropriate policies and procedures were in place and staff had been trained in this area, and were knowledgeable about the steps they should take to protect people. However, in practice, staff did not always protect people from harm or abuse. On the last day of our inspection information came to light that numerous staff were aware that some people were spoken to inappropriately by their colleagues, but they had not reported this to the manager and therefore had not appropriately safeguarded the vulnerable adults concerned from improper treatment. Once brought to her attention, the registered manager took the necessary steps to protect people.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safeguarding service users from abuse and improper treatment.

Improvements to the premises had been made since our last visit and high level risks that had previously existed had been addressed, and were now well managed. During this inspection some bedroom doors did not fully close into their rebates, but the registered manager confirmed this was addressed promptly after the last day that we visited. Staff were not always aware of the risks people living with dementia may face, when they left certain items accessible to them and some rooms unsecured. The manager told us she would discuss this with staff and reinforce the potential risks people living with cognitive impairment may face, as a result of their lack of awareness about the environment.

Accidents and incidents were appropriately recorded, responded to, and monitored for patterns and trends that may need to be addressed. Health and safety checks, for example on water temperatures, fire safety equipment and the servicing of equipment used in care delivery, were carried out regularly to protect the safety of people living at the home. Personal emergency evacuation plans (PEEPs) had been drafted and were available as a guide for staff about how to appropriately support people in the event of needing to evacuate the building in an emergency situation such as a fire or flood.

Staffing levels on the days that we visited were appropriate to people's needs, but we found that people's needs were not always met in a timely manner due to the way staff carried out their duties and how they were deployed. We observed that on occasions, people had to wait to be transferred or to have some of their personal care delivered, such as shaving. People asked staff to carry out tasks for them when staff were busy, but they failed to return and complete these tasks once they became free. Some staff went on their breaks without an awareness that people were waiting for support and they did not inform the deputy manager in advance that they would be absent. We discussed this with the registered manager and also the provider's representative. They told us that they were confident staffing levels were appropriate in line with people's dependencies but that they would review staff practices and deployment of staff in relation to staffing levels.

Staff files demonstrated the provider had recruitment and vetting procedures and processes in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and assessed as being physically and mentally able to do their jobs. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children.

Requires Improvement

Is the service effective?

Our findings

People's general healthcare needs were met. We found evidence that people were supported to access routine medical support from professionals such as opticians or chiropodists, and more specialist support such as that from a speech and language therapist, should this be necessary. However, there was evidence that on some occasions, staff had not sought medical attention promptly when people demonstrated a different physical presentation or certain behaviours. Recent handover records showed two people required medical testing to be carried out in response to their physical presentation. Staff and the deputy manager confirmed this had not been arranged. On the third day of our inspection, at our request, these tests were carried out. They revealed that one person required further medical treatment. Records showed there had been a delay of several weeks in medical attention being sought, which meant there was an avoidable risk to this person's overall health and wellbeing.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

This is also a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Person-centred care.

People relayed mixed feelings about the effectiveness of the service they received. One person told us, "I have been told to sit here and wait. I have been told I need a shave but it hasn't materialised". Another person said, "There is good and bad here. The food is 'hitty missy'. Sometimes it is ok and other times it is not. It has been such a long time since I have had a bath or shower". A third person commented, "Oh it is lovely here. I am very happy with everything".

Relatives' opinions of the care they saw delivered echoed people's comments. One relative commented that they believed their family member was not effectively cared for by staff, they had not had their personal care attended to one day in order to maintain their dignity, and that they had not been given their medicines. This supported our findings in records and our review of medicines management within the service. Another relative told us, "We have been a bit concerned about (person's name)'s care to be honest". Further comments made by relatives were, "Overall I haven't been worried" and "It seems very well organised here and staff are caring and patient when I have been here".

Visiting healthcare professionals told us that they had no concerns about the care they saw being delivered at the home. One professional told us, "I have no concerns around the actual care. Staff are there to give us a hand and they seem to know people well". Another visiting healthcare professional commented, "There are no real concerns here. Staff refer people to our care when it is appropriate to do so".

Our own observations confirmed that people did not always receive good care that met their needs. Some care was delivered promptly but on other occasions people did not received the care they needed or asked for. There were periods of time when people were left waiting to be transferred and then moved from one area to another. We saw one person asked to be assisted several times, but staff forgot to return to this

person and they feel asleep before being attended to. One person told us they had been asking to be bathed for many weeks but they had not received this care and support. Staff were able to tell us about people's needs when we spoke with them, but at times, we found they were disengaged to people's needs when delivering care.

Overall the environment within the home was clean and tidy. There were adequate facilities such as communal areas and bathrooms and toilets for people to access. Little consideration had been given to the environment so that people were appropriately supported in line with their cognitive needs. We saw that some people were disorientated and walking around the home looking for their room as there was no signage to aid them or pictorial prompts to guide them. There were no props to stimulate and occupy people, although people had access to outdoor space in the form of an enclosed garden area this was untidy, not used on any of our visits and it was not well maintained.

We recommend that the provider follows best practice guidance about creating suitable environments for people living with dementia so that their needs in this area are fully supported.

People's nutritional needs were met. Where necessary, food and fluid charts were used to monitor that people ate and drank in sufficient amounts to remain healthy, although these were not always completed fully. People were weighed monthly or more regularly if required, to ensure that any significant fluctuations in their weight were identified and could be investigated. Any weight losses and gains were clearly recorded and reported to the manager, who then took appropriate action to mitigate the risk of any weight changes, for example by commencing people on food intake monitoring or making referrals to their general practitioners for input into their care. People's dietary requirements were detailed within their care records, for example if they were diabetic or had swallowing difficulties. Kitchen staff told us that this information was shared with them regularly. People gave mixed feedback about the quality of food provided, some said it was fine, and others that it could be better. We saw there was limited choice around food and drinks although people said if they did not want what was offered or presented to them an alternative, such as a sandwich, jacket potato or omelette would be prepared for them.

At our last inspection we identified failings related to the training staff had received. We issued a requirement notice and the provider submitted an action plan which detailed that staff would receive specific training relevant to these failings and general repeat training in addition to this. We saw that although not all training had been completed by the time of this inspection visit, this was in line with the action plan we had accepted and training was on-going, due for completion at the end of this year.

Records showed the manager and administrator monitored training requirements via a matrix grid and arrangements were made for training to be refreshed as and when required. This ensured that staff were supported to deliver effective care as their skills were kept up to date. However, the findings of our inspection confirmed that staff did not always apply what they had learned from the training they had undertaken. For example, staff were trained in the safe handling of medicines but they did not maintain appropriate records around the administration of medicines, or ensure that people's medicines were in stock and available to them at all times. We observed throughout our visits on the 17 and 18 November 2016, that people were not always treated with dignity and respect, yet records showed staff had completed training in this area in the weeks immediately prior to this inspection. In addition, records showed that in most cases staff had received training within the last year in appropriate safe moving and handling procedures, but in practice they did not always adopt these practices when transferring people. Following this inspection, the registered manager and provider's representative told us that as a result of our findings, plans had been put in place to retrain staff for a second time, in multiple subject areas, to ensure that their skills and competencies were refreshed and their application assessed.

The provider's compliance with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Staffing, and a review of the staff team's application of this training, will be further assessed at our next visit to the service, once the provider has been afforded the agreed time to complete their programme of repeat and additional training.

Staff confirmed that supervision took place regularly and appraisals annually. Records reflected that this was the case. All of the staff we spoke with said they found these one to one sessions with their manager useful and supportive. Supervisions and appraisals are important as they are a two-way feedback tool through which the manager and individual staff can discuss work related issues, training needs and personal matters if necessary.

Communication within the service was not always good. We found evidence that staff had not shared information with the deputy manager relating to people's care and some documentation was not filed in line with protocols. This meant that relevant parties were not always made aware of important information. We discussed communication systems with the registered manager who said she would review how messages to, and feedback from the staff team, were relayed with a view to this being more proactive and efficient. By the third and fourth days that we visited, new communication books had been introduced to share important messages between senior members of the staff team and also between senior staff and the rest of the care staff team. The deputy manager told us that it was hoped this new system would go a long way to improving communication amongst care staff working at the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Information in people's care records indicated consideration had been given to people's levels of capacity and their ability to make their own choices and decisions in respect of the MCA. Applications for Deprivation of Liberty Safeguards (DoLS) had been made to the local authority safeguarding team in accordance with legal requirements. There was evidence the principles of the 'best interests' decision-making process had been followed in practice and records were retained about these decisions. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were in place where people had consented to these, and where they were unable to consent, a communal decision instigated by a clinician had been made.

Inadequate

Is the service caring?

Our findings

People told us they received acceptable care but that at times they had to wait for this care to be delivered. Some people and relatives told us that staff did not always speak to people appropriately and in a respectful manner. Our own observations confirmed this. One person said, "Sometimes staff are ok and sometimes they are not; it depends what type of mood they are in". A relative told us, "Sometimes I get concerned when I hear them (people) asking for the toilet and they are just ignored (by staff)".

On each of the first three days that we visited the home we observed staff practices that compromised people's dignity. We heard staff talking about people and their needs in an undignified manner across the dining area in front of other people. We observed people being made to wait for their care needs to be met and having to ask for assistance on more than one occasion. Some people's appearance was dishevelled; their hair had not been brushed and their clothing was inside out. Some people had food stains on their clothing. Inspectors saw that staff were often oblivious to these matters and it was some time before a staff member noticed and then supported people, for example, to adjust or change their clothing.

Moving and handling procedures were not always carried out in a dignified manner and sometimes people were left exposed during transfers. We observed one member of staff stood up whilst assisting a person to eat, as opposed to promoting their dignity and sitting down at their level, next to them, in line with best practice.

People's personal care was not always delivered to ensure they remained clean, well presented and therefore that their dignity was maintained. One person told us they had not been assisted to bathe for as long as they could remember and they would love a bath or shower, but although they regularly asked for one, staff did not facilitate this. We checked this person's care records and these evidenced they had not been bathed in a bath or shower for many months. We checked other people's care records and found a large proportion of those people had also not been bathed for many weeks, and in some cases, months. We fed back our concerns about a lack of bathing to the registered manager and the provider's representative. They told us this would be reviewed and discussed with staff, but accepted the evidence we had gathered. When we visited the service for the fourth day in December 2016, people told us they had been bathed since our last visit in November and they had thoroughly appreciated and enjoyed this.

We observed one person was left for a long period of time before being assisted to the toilet and when they stood up their clothing was wet. They were supported to change their clothing immediately, but records showed that people were not always taken to the toilet regularly to support them with their continence needs. When people were assisted with their care needs, this was often rushed and they were, for example, reversed backwards in their wheelchairs without much warning and taken to a chair, or out of that area, for personal care. There was a lack of explanations in advance. One person was woken from their sleep and supported to move to a more comfortable chair in the downstairs lounge area but this was carried out in a rushed manner before the person had had time to comprehend what was being communicated to them.

Some staff did not speak to people respectfully and they engaged in argumentative exchanges with some

people whose behaviours may be perceived as challenging. Some staff also expressed their dissatisfaction to some people through the manner and tone that they adopted when speaking to them. One staff member told the inspection team in the dining area of the lounge/dining room in front of people, "People can lie in, unless they are wet, then we get them up". We considered this comment to be disrespectful and it did not promote people's dignity. Another engagement between a staff member and the deputy manager compromised one person's dignity as it referred to their personal presentation and personal care needs, in front of other people.

Some people were left isolated due to their behaviour and we saw they were ignored by staff and other residents were actively discouraged from engaging with them if they went over. We saw one person sat in the same isolated place from lunchtime until tea time and staff did not encourage them to join others in the communal lounge, nor did they sit with the person on a one to one basis, other than to assist them with feeding.

There was little evidence that people were involved in their care, particularly those people living with dementia. Some care records had been signed by some people to indicate they agreed with what was written.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Dignity and respect.

By the fourth day that we visited the service, following our feedback to the registered manager and the provider's representative, we saw some improvements had been made to the staff team's approach to people when delivering care. People were treated with more respect and their dignity was promoted. Care delivery appeared less rushed and staff were more aware of the way they spoke, both to people, and about them, to one another.

The deputy manager told us contact details were available for people to access advocacy services should this be necessary, but that most people had relatives who advocated on their behalf.

Requires Improvement

Is the service responsive?

Our findings

Pre-admission assessments had been carried out before people started using the service to determine their level of dependency and risks associated with their daily lives. People had care plans and risk assessments in place for a range of needs such as mobility, nutrition, skin integrity and medication. Dependency assessments were also carried out, generally monthly, to determine if people's needs had changed. People's care records showed that reviews of their care took place regularly and were recorded, but changes needed to be transferred into individual care plans and risk assessments. In some cases we found dependency assessments in people's care records had not been completed for several months. In addition, important information about people's health and actions taken to address any concerns had not always been recorded in their care records, when it should have been.

Handover records were basic and although they contained important information about people's presentation in any 24 hour period, they were not used to good effect. We found evidence of staff not reading and acting on concerns and requests written on these handover forms. During our inspection new handover forms were introduced which contained a more comprehensive summary of people's needs, their mood and presentation between each shift. These new forms gave more accountability for staff who had to sign to say they had completed and checked certain elements of paperwork in use within the service.

Throughout our inspection, staff and the deputy manager had trouble locating records that we requested to see. Some records that we asked for on the first day of our inspection could not be located until the third day that we visited. The deputy manager did not realise that certain recording systems were in use within the home and that others were not. Where people were at risk of skin breakdown, no recording of the care delivered in respect of positional changes was maintained. We acknowledged however, that this was introduced during our inspection in response to our feedback.

Records related to the delivery of people's personal care were poor and the provider's representative and registered manager acknowledged this. They both told us they recognised the importance of improving record keeping within the service to more appropriately reflect the care that people needed, and that which they received, and they would work with the staff team to drive through positive changes in this area.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance

Some care monitoring tools were used to ensure that people's care was delivered appropriately and changes in their health and presentation were identified promptly. For example, continence charts were in place to monitor people's need to go to the toilet, where this was necessary. People's food and fluid intake was monitored where they had specific nutritional needs and any significant changes in their weights were to be reported to the manager for assessment and for appropriate action to be taken. Night time checks were carried out and recorded to ensure that people had everything they needed.

Care records were individualised, but staff did not always deliver person-centred care in practice, as

demonstrated in the examples given throughout this report. For example, some people did not receive appropriate and safe support when being assisted to transfer from their wheelchairs to chairs and others were not supported to bathe when they wanted a shower or bath.

People relayed varying accounts of their needs being responded to. Some people said their needs were met and others said they were not. This reflected that the quality of service people received, was not good or consistent for all people in receipt of care.

Staff delivered care where they gave people choices about some matters but this was not the case with all aspects of their care. Some people were brought drinks and food without being offered a choice. People who were independently mobile could move around the home as they wished, but other people who relied on staff support to relocate, were, at times, more limited in their choices, as they had to wait for care to be delivered. Sometimes staff forgot to return to assist people and therefore honour their choices.

Activities were very limited on the days that we visited. People could watch the communal television and on two occasions in four days we saw a staff member sitting doing a word search with one person for a short period of time. The registered manager told us that a new activities co-ordinator was being recruited to post but they had yet to start in their role. We considered that in the meantime people's social needs were not met, as there were very few activities to stimulate and occupy people, and staff did not take the initiative or encourage people to engage in any activities with them on a one to one basis. People told us that sometimes singers would visit the home to provide entertainment which they enjoyed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Person-centred care.

Complaints and concerns received within the service were appropriately dealt with and responded to by the registered manager. Records showed that there had been two complaints received since our last inspection of the service in June 2016, both of which had been investigated and letters written to the complainant relaying the findings and outcome. A log of complaints was maintained for monitoring purposes and an appropriate complaints policy and procedure was in place and it was followed.

The provider had systems in place to gather the views of people, relatives, staff and external agencies through issuing surveys and questionnaires. The results of the most recent surveys showed that overall, the aforementioned parties had given positive responses about the care and service delivered by the provider.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a manager in post, who had been registered with the Commission to manage the carrying on of the regulated activity since August 2013. The registration requirements of the service had been met and we were satisfied that deaths and other incidents had been reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

People told us the registered manager was approachable and they had no issues with their management. External healthcare professionals told us they enjoyed a positive working relationship with the registered manager. One relative told us, "Everything I have asked the manager to do for my family member, she has done". Staff gave mixed views about the visibility of the registered manager around the home, with some saying she was often out and about on floor observing practice and talking to people and others saying she was not. The registered manager explained that there had been times in recent months, when, due to workload and a lack of support due to vacant posts within the service, she had not been able to be as actively visible around the home as she would have liked.

We reviewed auditing within the service and found that a range of audits existed that covered areas such as dignity, medication, health and safety and infection control. Whilst we saw that these audits were completed regularly and were extensive, they were not effective in highlighting the concerns and shortfalls that we identified at this inspection. For example, regular auditing of medicines took place, but by the fourth day of this inspection the registered manager had introduced a further daily check on medicines stocks in response to the shortfalls we had identified in the management and administration of medicines. However, errors in the stocks of medicines still existed, as the staff completing these audits had not done so accurately. In addition, we noted in maintenance records that certain bedroom doors were marked as closing correctly, but we found they were not. This meant these health and safety check records were incorrect as they had not been completed accurately.

Some audits had action plans attached to the back of them to demonstrate how any identified actions would be addressed and corrected but others did not. For example, we saw some errors in the recording of the administration of medicines had been identified by one audit but there was no record about what action, if any, had been taken to address this with the staff member who had made the error.

Staff were not appropriately monitored, or their performance appropriately reviewed, to ensure they delivered timely care that was safe, effective and promoted people's health and wellbeing. There was little evidence of practical observations of individual staff practice. Where they were in place, they were not effective. The lack of effective auditing and competency assessments of staff practice in areas such as medicines management, moving and handling and the completion of general care tasks, meant that shortfalls and failings impacted on people's experiences and their health and wellbeing. We identified concerns about the manner in which staff lacked direction and leadership and as a result how they deployed themselves in their roles. There were periods of time during our visits where staff were not observing people for over ten minutes, and other occasions where we saw some staff members return and then go off for their breaks when people were waiting for care to be delivered. The provider did not

appropriately monitor how staff carried out their roles and fulfilled their tasks. Effective accountability systems were not in place to encourage better performance from staff.

When we reviewed records related to supervisions, appraisals and complaints we found evidence that concerns had previously been raised about staff practice and the way in which some staff treated people with a lack of dignity and respect. This supported the observations that we made during this inspection. We saw the registered manager had correctly dealt with any individual concerns or complaints about staff speaking to people inappropriately and rudely, and/or not promoting their dignity, including people looking unkempt, being left with dirty clothing on, and their dignity being compromised when they were spoken about in front of visitors to the location. However, governance systems and the management response to these identified failings had not been effective in addressing inappropriate staff practice, as on the days that we visited the location, people's dignity continued to be compromised by the standard of care delivered by some members of the staff team and a consistently positive culture within the home had yet to be achieved.

The provider's representative told us that they had been visiting the home on a regular basis to provide support to the registered manager. However, it was not clear what form of auditing was carried out on these visits, or what type of practical support was offered to the registered manager to effect change and drive improvements throughout the service. There was a lack of evidence of adequate governance and oversight by the provider.

The provider's representative told us that their visits were not recorded or evidenced and written action plans and instructions were not issued to the registered manager to support them. The registered manager told us that they felt supported by the provider's representative but that more practical help to make the necessary changes and improvements in the quality of service delivered would be appreciated.

Records maintained within the service were not always well organised and could not always be located by staff in the course of their duties, or when we asked to see them. Suitable storage facilities were available to enable records to be stored confidentially and overall we saw that they were.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care that met their needs. Regulation 9(1)(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always spoken to with respect and their dignity was not always promoted. Regulation 10(1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks of unsafe care and treatment as medicines were not appropriately managed. Some people's medicines were out of stock, medicines were not administered in a timely manner and recording around the administration of medicines was not robust. Moving and handling procedures were not always carried out safely and risks to people's health and wellbeing were not always appropriately managed. Regulation 12(1)(2)(a)(b)(f)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

People were not always protected from improper treatment as staff did not always safeguard them by reporting improper treatment to the registered manager for investigation and appropriate action to be taken. Regulation 13(1)(2)(3)(4)(c)(6)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to monitor the quality of the service provided and ensure that shortfalls in the service were promptly identified and addressed. Regulation 17(1)(2)(a)(b)(c)(d)(ii)(f).