Bupa Care Homes Limited

# Woodlands View Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection was carried out on 20 June 2017 and was unannounced. This was the first inspection under their new registration. Prior to registering with the CQC there were breaches of regulation. At this inspection we found that although they had made some improvements, they were not meeting all the standards. Woodlands View Care Home provides accommodation for up to 120 older people, including people living with dementia. The home also provides nursing care. At the time of the inspection there were 116 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run.

People's individual risks were assessed, however, this was not consistent and some needs were not risk assessed. Staff knew how to recognise and respond to abuse, however, there were some issues observed and documented that had not been reported.

There were sufficient staff to meet people's needs however during the evening needed to be reviewed and recruitment processes were robust. Staff had received training but some of this needed to be developed and updated. Staff felt supported but one to one supervisions were infrequent. People's medicines were mainly managed safely but there were issues that needed to be addressed.

The service was made up of four units. We found that standards differed significantly across the units. For example, interaction between staff and people they supported was positive on some units, and not so positive on other units.

People did not always have their dignity and privacy promoted. We found that confidentiality was not always promoted.

People told us that staff were kind and we saw staff speak kindly with people. However, people and their relatives were not always involved in planning or reviewing their care.

The service did not always adhere to the principles of the Mental Capacity Act or conditions imposed by DoLS authorisations.

People who were at risk of not eating and drinking enough had their intake monitored, however we found that this may not be identified as a need by staff on one unit. People had access to health and social care professionals as needed.

People's personal care needs were met but there was a lack of person centred care in some instances. People's care plans were in place but some areas of needs did not have a plan and people's views on activities were mixed.

There were quality assurance systems in place and we found that in some areas these had been effective. However, we noted that many issues identified by audits or regional manager visits remained an issue so the process had not been effective. Formal complaints were responded to. There were systems in place that had identified some issues within the home. However, these were not yet resolved.

People, relatives and staff were positive about the management team. Staff felt the home had improved since the last inspection.

## 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 consistently safe.

People's individual risks were assessed, however, this was not consistent and some needs were not risk assessed.

Staff knew how to recognise and respond to abuse, however, there were some issues observed and documented that had not been reported.

There were sufficient staff to meet people's needs and recruitment processes were robust.
People's medicines were managed safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The service did not always adhere to the principles of the Mental Capacity Act.

People who were at risk of not eating and drinking enough had their intake monitored, however we found that this may not be identified as a need by staff on one unit.

Staff had received training but some of this needed to be developed and updated. Staff felt supported but one to one supervisions were infrequent.

People had access to health and social care professionals as needed.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People did not always have their dignity and privacy promoted.

People and their relatives were not always involved in planning or reviewing their care.

Confidentiality was not always promoted.

People told us that staff were kind and we saw staff speak kindly with people.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's personal care needs were met but there was a lack of person centred care in some instances.

People's care plans were in place but some areas of needs did not have a plan.

People's views on activities were mixed.

Formal complaints were responded to.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

There were systems in place that had identified some issues within the home. However, these were not yet resolved.

There were shortfalls that had not been identified by the quality monitoring within the home.

People and staff were positive about the management team.

Staff felt the home had improved since the last inspection.

# Woodlands View Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and 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 we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

The service had previously been inspected under their previous registration. Following that inspection they sent us an action plan setting out how they would make the needed improvements. We reviewed this plan to help us check on their progress.

The inspection was unannounced and carried out by three inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 15 people who used the service, seven relatives, 16 staff members, the regional manager and the registered manager. We received information from service commissioners and health and social care professionals. We viewed information relating to 15 people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

# Is the service safe?

## Our findings

Staff were knowledgeable about safeguarding procedures and how to report their concerns internally and externally to local safeguarding authorities and they were knowledgeable about whistleblowing procedures. One staff member told us, "We report our concerns to the nurses or the unit manager. They will do what needs to be done in case of bruising or skin tears." Another staff member said, "I would always report to the manager. I would escalate to the unit manager or if necessary the police or CQC if I had to." However, there were some issues observed and documented that had not been reported. We found incidents recorded in people`s monitoring charts which were not reported to management or the local safeguarding authorities. For example staff monitored a person for adverse behaviour and recorded incidents on ABC forms. One recording detailed that the person had inappropriate behaviour towards another person on the unit. Staff recorded that this behaviour caused embarrassment to the second person and staff. However there were no safeguarding measures put in place to protect the second person and stop this behaviour and the registered manager was not aware that this had occurred.

People told us they felt safe at the home. However, one person told us, ""I ring the bell and if they don't come then I ring it again and they tell me off.  I want to go to the toilet and I've been waiting 10 minutes." Their relative told us, "They tell [them] off if [person] uses the bell too much." Another relative told us, "I think [person] is safe here because [they] can't get out but there are not always enough staff in the evening." We passed these concerns onto the registered manager who told us that they would investigate.

The units all had key coded doors and fire exits were linked to the fire alarm so that they unlock in the event of the alarm sounding. Some bedrooms had French doors out into the car park and these were open on the day of inspection. We asked the registered manager how they promote people's safety with these doors being open. They told us, "At night we lock the gates so the site is secure and we check all the doors are locked." However, they told us that they had not thought about the implications and risks of the doors being open during the day. Some people were assessed as being unable to go out alone and they had access to these doors and in addition it meant that unauthorised access could be gained to units which supported vulnerable people. We discussed the need to promote people's safety while not impacting on the rights of the people who wished to have their doors open.

We also found that if people had been prescribed medicines which could cause thinning of their blood and therefore they were more prone to bruising, there were no investigations carried out for unexplained bruises. Staff told us that if people could not tell them how it happened they assumed the bruises were due to the medicines people were taking. We saw on one of the management teams meetings they had noticed unexplained bruising for two people but this had not been reported to the commission and we were unclear as to if it had been reported to the local safeguarding team.

People's individual risks were assessed, however, this was not consistent and some needs were not risk assessed. Staff were knowledgeable about risks associated with people`s daily living. Staff told us they knew people well and knew how to mitigate and manage risks to keep people safe. We observed staff using

the hoist to transfer a person from their wheelchair to a more comfortable chair and they carried out the manoeuvre correctly. However some identified risks were not recorded and no risk assessments were carried out. For example we observed some people having pureed diets and thickened fluids. We asked staff why people needed this diet and they told us they were at risk of chocking. However there were no chocking risk assessments carried out and no measures recorded for staff to know how to manage this. We asked a staff member what they would do if a person was showing signs of chocking whilst they were assisted to eat and they told us they would stop assisting the person sit them up and call for assistance.

We observed another person who staff told us they were at risk of chocking and were on soft diet and thickened fluids walking around the unit and going in other people`s bedrooms. They were laying on other people`s beds and were clearly not aware that the room they were in was not theirs. We found that there were drinks left out for people in their bedrooms and this person could have easily drank fluids which were not thickened. Staff told us they were monitoring people and they completed hourly checks, however there was no risk assessment done in this person`s care plan to list measures for staff to take and mitigate the risk for this person.

Following the inspection the registered manager sent us a template of a choking risk assessment that was to be put in place for those who needed it.

On the day of the inspection all of the units were hot but we found the dementia unit was extremely hot. The registered manager told us that they were working in accordance with the local authority's heatwave plan. Staff had opened windows and had some fans on in communal areas; however there were very few rooms where a fan was available. Staff told us that only people whose relatives brought one could have one. One person who had breathing difficulties told us, "I am finding it difficult in this hot weather, my family bought me a fan yesterday." We raised this with the registered manager who told us that they had ordered more fans. However, we noted that we had been experiencing this heatwave for a number of days and these were not already in place throughout the home. Although people were offered drinks regularly and the management team had raised awareness of increasing fluid intake due to the heat, they were only recorded fluid intake for people who were identified by the nursing staff as needing this level of observation. Nursing staff told us they relied on staff reporting and recording in daily notes if a person was not drinking sufficient amounts and then they considered commencing a fluid monitoring chart. We discussed with the team that in this extremely hot weather everyone in the dementia unit at least would benefit from being monitored temporarily for fluid intake. This was evident for one person who had no care notes written for a period of eight hours. We observed this person who refused to come out of their room and according to staff they were not themselves on the day of the inspection. Staff were guessing that maybe it was the heat causing the person not to eat and drink much, however they had not monitored this person`s fluid intake.

People's medicines were mainly managed safely, however, there were some issues that needed to be addressed. Medicines were administered by staff who were appropriately trained. We saw that staff followed safe working practice while administering medicines and records checked were completed consistently. We observed staff administering medicines to people and they did this in a personalised way. In most cases they did not interrupt people if they were having their meals and asked people if they wanted their medicines before they proceeded to help people take them. People told us that there was not a problem with medication. We observed the staff member administering giving out medicines on one unit and they were very clear about what they were giving to people. For example they were heard saying, "This is [name of medicine], it is for you, just two spoonsful, is that alright?"

We counted 15 boxed medicines and found that they were accurate in most cases. However, two of the boxed medicines contained the incorrect quantity. For example, one had three tablets more in the box

which indicated that a person who had this medicine prescribed for their Parkinson's may not have had it on three occasions although staff had signed the records to indicate that the medicine had been given. The other box had one too many tablets also indicating that it had been signed but not given. In addition, at 1.30pm we found a tablet on a person`s clothing. We asked the nurse on the unit to come to the person's room. The nurse told us that they didn't recognise the medicine found and it could have been administered by the night staff. This meant that this person had not taken their prescribed medicine and the processes in place for the safe monitoring of medicines had not been adhered to in this instance.

Therefore, due to the concerns about people's safety and some practice issues in relation to the management of medicines, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we found that there were sufficient staff to meet people's needs. People told us that staff came to them in a timely fashion in most cases. One person said, "They are usually very prompt." Another person told us, "They do come fairly quickly when I ring the bell." However, relatives felt during the evenings there were not always enough staff available. This was possibly due to the staffing levels changing at 8pm during the period when people were getting ready for bed. This requires review from the management team.

Staff told us they felt there was enough staff to meet people`s needs and this was an area that had significantly improved since the last inspection. They said that the increase in staffing since the last inspection had a positive impact on people's care and welfare as well as boosting staff's morale. One staff member said, "Staffing is much better and we are more permanent staff now. Rarely we are not able to cover a shift and then we work short." Another member of staff said, "We cover vacancies with agency staff or permanent staff but we don't use much agency now. If permanent staff cannot cover and agency cannot cover then we will be short but rarely now." A third staff member told us, "We have enough staff and definitely the team works better together now. It all depends what staff you have on and you know how the work is going to be done." However we found that there were only two permanent nurses allocated to one of the units. The available nursing shifts were covered by agency nurses which put pressure on the two permanent nursing staff to share all the tasks relating to care planning, medicine management and staff management on the unit. The regional manager was working on a recruitment drive to help employ more nurses.

We reviewed the rota and saw that shifts were covered consistently. The regional manager told us that they had added an additional member of staff at night to provide 'floating' support across the four units.

People were supported by staff who had been through the appropriate pre-employment checks as the recruitment processes were robust. We saw that perspective employees had given a full employment history, criminal records checked, verified references and proof of identity. Professional qualifications were verified and monitored to ensure their remained up to date. This helped to ensure that staff employed were fit to work in a care setting.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that staff were knowledgeable about the principles of the MCA and the need of best interest decisions to ensure the care and people received was in their best interest. However we found that on some occasions MCA`s were not carried out for decisions which could have affected people`s life. For example a person had been assesses as lacking capacity to take an informed decision about using bedrails on their bed to keep them safe. A best interest process was followed in this instance where the person`s family and staff considered that the use of bed rails was in the person`s best interest. We found recorded and staff confirmed that this person was refusing to be seen by their GP and they were refusing to take any treatment. However there were no MCA in place to consider if this person had the capacity to take this decision and if it was in their best interest to do so.

Another person had medicines administered to them covertly. There was a covert medicine assessment form completed by staff where they recorded that the decision had been discussed with the person`s family and GP. However there was no MCA carried out prior to this to establish if the person had capacity and a best interest decision was not completed to evidence what other options were considered before this decision was made.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that staff were knowledgeable about the people who required an authorisation as they had some restrictions applied to their liberty. We saw that applications were submitted to the local DoLS authorities and some were granted. However we found that three people had conditions listed on their authorisations which meant that the only way these were lawful if the conditions were met. For example the DoLS for one person requested staff to keep a record of regular conversations held with the person`s next of kin about this person`s needs and also staff to develop a care plan to reflect the restrictions placed on this person`s liberty and this to be regularly reviewed. We found that staff were not aware of these conditions and although they told us they had conversations with the person`s next of kin these were not recorded. There was no care plan developed to detail all the restrictions on this person`s liberty.

For another person the DoLS asked for a protocol to be developed for a medicine prescribed for as and when needed (PRN) and administered by staff in case the person was anxious. We saw that a PRN protocol was in place however it instructed staff to administer the medicine when the person showed signs of anxiety. There was no detail about what these signs were.

Therefore due to the inconsistent approach in relation to adhering to the principles of the MCA, this was a

breach of Regulation 11 of the Health and Social Care Act (regulated Activities) Regulations 2014.

Staff asked people for their consent to care before they carried out any tasks. For example we heard staff asking people if they were ready to get up in the morning or if they wanted to stay in their rooms or sit in the lounge. One staff member told us, "If people say `no` we will leave them and go back later. It`s their choice."
The management team had identified MCA and best interests as an area that needed further development prior to our inspection and were working on ways to improve this. We saw that this was discussed at the management teams meetings, using a workbook and examples.

Staff we spoke with understood the importance of promoting peoples independence with choice and the right of people to make choices. One staff member said, "We are always taught that we assume people have full capacity and from there we try our best. We all encourage choice and maintain independence."

People were supported by staff who had received training in some areas, such as moving and handling, fire safety and infection control. We saw that some of these subjects were overdue for an update to training. For example, safeguarding people from abuse. Other areas, such as dementia care, were very basic. This was evident on one unit in particular which predominantly support people living with dementia. The regional manager told us that they had identified a need for more advanced dementia care training but this was yet to be arranged. Staff told us that they felt well equipped for their role. One staff member said, "The training is very good. We have five days induction training about the company and other stuff and then induction on the unit and shadowing." However, this was an area that required improvement.

Staff we spoke with confirmed they had received induction training and shadowed other staff until competent. They told us that they felt supported and could go to any member of the management team if they needed to. One staff member said, "I do feel supported and the managers are all approachable. I had training recently." Another staff member told us, "I had training relevant to my new role and that was good." However, we noted that one to one supervisions were irregular and some staff they had not received these lately.  We did note that there were regular meetings throughout the home where staff were kept informed.

People were supported to eat and drink a variety of foods. However, there were mixed views about the quality of food. Some told us they enjoyed the food, others told us that this standards varied. Meal choices were taken the day before which may have been an issue for people living with dementia. However, we noted that when people said they didn't fancy what they had chosen, they were immediately offered an alternative with no fuss. We saw that in addition to the two menu choices, people also had other options available such as a salad, sandwiches or egg on toast. Menus were on the tables and the tables were set in advance of mealtimes.

There was a list of people's dietary requirements and allergies plus the support required for them to eat, staff signed their initials against the person's name they were serving. There were examples of specialist equipment used to support people's independence. For example, there were plate guards, two handed beakers and adapted cutlery.

People received assistance to eat and drink. However, we noted at times that the person being assisted to eat did not have the staff member's full attention. For example, we saw on one occasion that the staff member talked to their colleague throughout the person's mealtime, which meant they did not engage with the person at all.

On one unit, where they supported people living with dementia, the lunchtime experience was extremely

disorganised. We watched one person start to eat their meal and then halfway through push it in front of another person. Staff did not notice and started to cut the food up and encourage the other person to eat it. We needed to intervene to ensure they did not eat someone else's food. We also saw that one person was missed and needed to prompt staff to serve them. The experience was rushed and not enjoyable and was an area that required improvement.

Following the inspection the management completed mealtime observations to enable them to resolve issues identified.

Some people who were assessed as being at risk of not eating or drinking enough had their food and fluid intake monitored, and where there were concerns, referrals were made to health care professionals. Food was fortified to increase calorific intake and people were weighed regularly. However, we asked staff what would prompt them to start a food and fluid chart for a person. We were then showed where the person they had lost weight on the monthly checks. However, we raised the question how would they know if a person was not drinking enough and were told it would be in people's daily notes. However, we reviewed the daily notes for a person who appeared to not have any support for a number of hours and found that there had been no entries made since 5am. This was at 1.30pm. We discussed our concern in relation to this with the management team as this was more of a concern due to the heatwave that was being experienced and the units were very warm. Although we saw no obvious signs of dehydration and staff did go round offering drinks, with the lack of accurate monitoring and record keeping, with the weather so warm people may become dehydrated extremely quickly. This was an area that required improvement.

People had access to health and social care professionals as needed. One person told us, "I had a physio come in but I couldn't do it so they went away but my [relative] and a carer (staff) have just sorted it out so they will come back and I can try again." Another person said, "If I go to the hospital, then they arrange the transport and either a carer or my family come with me. I can't see so I couldn't manage without them it would make me frightened. They do it for me, they are very good." People told us that an optician, chiropodist and GP visited the home regularly. We saw that there was a record of these visits in people's care plans.

Requires Improvement

# Is the service caring?

## Our findings

The service was made up of four units. We found that standards differed significantly across the units. For example, interaction between staff and people they supported was positive on some units, and not so positive on other units.

One three of the four units we found that in most cases people's dignity and privacy was promoted. There were some issues but the main issues were in relation to Wellfield unit, which predominantly supports people living with dementia.

People's bedroom doors were open with the exception when personal care was in progress. People who were in bed were often uncovered not wearing any clothes on their bottom half only the incontinence product covering their private areas. They were visible to anyone walking past their bedroom door. Staff told us that it was easier to keep an eye on people if they left the doors open to ensue people were safe. One staff member said, "[person] always uncovers themselves. But if we leave the door open we can make sure we keep an eye on them and they are safe." However staff had not considered the impact this had on the person`s dignity as they laid in bed only in their pad. Although we have asked staff repeatedly during the morning if they thought this practice was promoting people`s dignity and privacy they continued to leave the doors open not taking any action. We observed a person who pulled the covers on their head. We asked staff to check on this person as we were concerned that they may have had difficulties breathing under the covers due to the heat. Staff told us the person was often doing this to block out the noise. Although staff knew this they continued to leave this person`s bedroom door open not giving them the quiet private time they were asking for.

During meal time staff referred to assisting people as `feeding` which does not promote people's dignity. For example we were concerned that every person in the dining room had their meals and they were eating with the exception of one person. The person watched other people having their meals and on occasions they were trying to get up from their chair and lean towards other people who were eating. We asked staff if the person had had their meal or they were still waiting. Staff told us loudly "Oh [person] is for feeding." We overheard other staff asking each other several times "Who is feeding [Person's name]" or "Anybody else need feeding." This was an area that required improvement.

Therefore, due to people not consistently having their dignity promoted, this was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not always involved in planning their care. We saw some instances where people had signed to indicate their involvement. One person told us, "They ask me what I want doing." However, did not recall seeing their care plans. Relatives were not always involved either when people were unable. One relative told us, "They haven't asked me anything, not what [person] likes or doesn't or what I used to do for [them], I was the person who looked after [them]." Another relative told us, "They haven't had a conversation about how they can help [person] or what [they] might need done, nobody talks to you." The regional manager had identified this as an issue on one of their previous visits. However, this was an area that requires

improvement.

Confidentiality was not always promoted. We saw throughout the day that care plans and care notes were accessible to people who may not be authorised to have access to these records. This was an area that requires improvement. Following the inspection the registered manager informed us that self-closing door mechanisms were being installed to ensure confidentiality was maintained.

People told us that staff were kind. One person said, "They are very nice indeed." Another person told us, "The staff are wonderful and so kind." Relatives also told us that staff were kind. One relative said, "Most of them are very kind. I've been here at different times of day and never heard anything that would worry me." Another relative said, "They are very kind [staff] and they do talk to them but not really talk or chat, just in passing." We observed sensitive and kind interactions between staff and people who used the service. The way people related to staff demonstrated good relationships between them based on trust. Staff addressed people using their preferred names and it was clear that staff knew people well.

Staff were seen appropriately supporting and guiding people around some of the units by holding a person's hand or touching their shoulders. We also observed staff ensuring they came down to the person's level to take time to talk and explain what they were going to do. We saw staff moving furniture to support people whilst walking around the units to ensure they did not trip or fall. We saw one person who had become breathless whilst walking from their chair to the dinner table. The staff member immediately found a spare chair and offered for the person to take a rest. They did this with care and compassion, speaking with the person throughout to reassure them.

Visitors and relatives were welcomed at any time. One person told us, "Oh they can come anytime they want to, they can just pop in and out if they want to." Relatives also told us that they could visit at any time. One relative said, "We can come whenever we want to. If I wanted to come at 3 in the morning I could."

Requires Improvement

# Is the service responsive?

## Our findings

People had their basic care needs met. One person said, "They are excellent, anything you need, they do it for you." Another person told us, "I like to get up and have a shower every day and they do that for me. A third person told us, "I am terrified of having a bath, I can't see and it's frightening and so they give me a bed bath, they are very kind." We noted that there were no odours which indicated people had been offered the toilet at regular intervals. Although we noted that one person told us they had been waiting for 10 minutes to use the toilet. In addition we also observed a person sitting in their bedroom with an extensively stained shirt on, unshaved with unbrushed hair. We observed the person sitting in the same position throughout the morning and through lunch. When we checked this person`s notes we found no evidence that the person had any personal care on the day or when was the last time they were checked by staff. The hourly observation charts filled in by staff recorded that the person was in the lounge although we didn't see them leave their bedroom on the day. Staff only started to assist the person when we raised the issues and the nurse them prompted care staff to assist the person to change.

We also noted that two people we spoke with needed hearing aids but did not have them in. One person told us the hearing aids were broken, confirmed by the carer who stated there was an appointment in 17 days' time. This resident was profoundly deaf and quality of life was being affected by not having any hearing aids. The registered manager told us that they were not broken but the batteries needed replacing frequently, however this had not been done. The other person told us that they needed help putting the aid in and said, "The carers (staff) haven't helped me today." We noted the time was 2pm.

Care plans were not always effectively completed or reviewed and contained little information about people`s likes dislikes and preferences. We found this varied across the units. Some included more information than others. For example, in Astonbury unit we found them to be person centred for the most part but in Welfield unit they had not adequately captured people's needs. We observed people with behaviour patterns which were known by staff, however a care plan had not been created to ensure that staff had a consistent approach to manage this behaviour. For example, we observed a person who was walking around the home frequently. They went in other peoples` bedrooms if they were not in there and lay on their beds. Staff told us this was a usual behaviour pattern this person had, however they not considered the risks of infection control or chocking risks for this person. Staff had not considered locking bedroom doors if people were sitting in the lounge or removing stained linen before they left the room to control the risk of infection. WE also found that one person at times refused personal care and this meant they were at times sitting in wet clothes. One staff member we spoke with told us, "[Person] likes the older staff members to assist [them]." However there was no plan in place to advise staff of this to help ensure they accepted care on a regular basis.

In some of the care plans we checked there was information about people`s preferences towards the gender of staff offering them personal care, however there was no information about what time people liked to get up or go to bed, although one person we spoke with told us that they were assisted to get up at the time which suited them. However another person told us, "They don't ask what time you want to get up, they just come and wake you up." and went on to tell us, "There's not really a choice about bed. They come

about 8.30pm and sort of ask but they just want to get everyone sorted, sometimes they don't come till 10pm, who knows!"

Activities across the different units differed in consistency and variety. One person told us, "Yesterday was open day, we had such a lovely time. We were in the garden and we even had WW2 songs, it was so lovely. That's the only time, mostly there's nothing. Oh sometimes a couple of games of bingo but not enough." Relatives also told us they felt this needed improving. One relative said, "I come in at all sorts of times. Sometimes there is an activity for a short while but mostly nothing, just TV. A meal, then nothing, then another meal. It would be nice just to see some interaction apart from 'alright'." Another visitor told us that their relative enjoyed flower arranging but this wasn't offered so now they didn't do it anymore." On one unit, the activity organiser was on holiday so no provision had been made to cover activities while they were away. On another unit, there were several entries made stating 'Watched TV' or 'In bed, to unwell to join in'. This was a reoccurring theme which indicated that these people did not have the opportunity or encouragement to join in. On another unit there seemed to be a whole day of activities ongoing. However, people and their relatives told us that this was not the norm. One person said, "There is an activity of some sort every day but it's usually very quick."

On the fourth unit there were no individual activities observed on the day of the inspection although a considerable number of people were permanently in bed according to staff. People did not have individual activity programme records to indicate that they had individual sessions according to their preferences. On the day of the inspection there was a themed `On the beach` reminiscing activity which entertained the people participating.

Staff told us they thought people in their bedrooms would benefit from tailored one to one activities as there was mainly the `watching TV` option for them on a daily basis. One staff member said, "I would say that individual activities need to improve for the people in bedrooms who are not able to come out. We put the TV on for them." We observed this on the day of the inspections people in their rooms had the TV on, however in their care plan there was no reference that they liked or disliked this and if they liked TV what sort of programs they preferred. We also not that subtitles were not routinely put on for people. Only one or two staff members thought to offer this for people.

The registered manager and regional manager told us that activities were an area that they were working on. They acknowledged that they were not yet providing person centred and regular activities.

There was a need for person centred care to be developed and to ensure that activities were available to everyone in the home and complimented hobbies or interests. Therefore this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Complaints were responded to appropriately. We saw that there was a full investigation and a log of action taken. The outcome of these investigations was shared with the relevant staff teams to help reduce the repeat of an issue.

People and their relatives had stopped attending meetings in the individual units therefore the registered manager told us they were not getting their feedback. In response to this, they set up a cheese and wine evening which invited people and relatives from all units in the main reception building. They told us that this was well attended and gave opportunity to give people feedback about the home and spend time mingling and chatting after the formal meeting. The registered manager told us it was a success and as it gave relatives a chance to mix with relatives form different areas of the home, they had planned the next meeting in the same format.

Requires Improvement

# Is the service well-led?

## Our findings

There were quality assurance systems in place and we found that in some areas these had been effective. However, we noted that many issues identified by audits or regional manager visits remained an issue so the process had not been effective. For example, the need for more dementia training and consistently adhering to the MCA and DoLS principles.

We also found that some of their audit systems did not include an action plan which had clear roles, responsibilities and timelines. The registered manager told us that this was something being developed by their recently appointed clinical manager. We noted that the recent action plans that had been completed by the person in this role were much more robust. The management team carried out regular daily walk rounds the home at intervals throughout the day. Staff told us that they were visible and offered guidance and support. One staff member told us that the regional manager had recently given them feedback after a mealtime observation and they really appreciated it. The registered manager headed up a daily 'Take ten' meeting where they met with all heads of department to check for any issues, allocate actions and share feedback. We reviewed these meeting notes and found that they were thorough and regular.

There was a home improvement plan that the management team were working through. This identified where areas were declining such as staff performance and training statistics. We saw that there were actions in place and where needed, issues were escalated to the provider. The regional manager was providing regular support to the management team at the service and also knew the home well.

The registered manager and regional manager were responsive to our feedback throughout and at the end of our inspection. Following the inspection they sent us a list of documents implemented and carried out immediately after our visit. For example, they sent us a copy of mealtimes and environment observations used to identify any remedial actions. We saw that they identified some areas for improvement, for example, showing a visual choice to people living with dementia, asking staff to slow down during interactions and ensuring people were offered to have their hands wiped prior to eating. However they also identified many positive areas of practice. For example, staff responding to a person who needed a tissue and good communications, such as holding good eye contact. They also sent us copies of templates of documents to be completed to address further shortfalls, such as choking risk assessments.

However, due to the issues identified on inspection, management systems were an area that required improvement.

The management team completed a monthly analysis of accidents, incidents, people's health and weights and various other monitoring in the home. They sent us this each month ahead of the inspection. We found that the daily meetings and improved communication had been effective in enabling them to keep a clear overview of the people's need. This meant that they had been able to address any areas of practice impacting on people's health promptly.

People and their relatives were positive about the management of the home. One relative told us, "I moved

my [family member] here two years ago and have never looked back. It's very clean and I never have to worry when I leave to go home that they are safe and cared for as they should be." A person told us, "I am very happy with all the carers, they treat me well and I have never had to complain. However the food could be a bit more interesting as we had the same pudding four days out of seven the other week." We noted that the chef was invited to the recent resident and relatives meetings to take ideas and comments about food. Another person said, "They do their very best as I know they have so much to do ,for so many of us but they always do it with a smile."

Staff told us they felt that the home was well run and the managers were approachable. They told us they felt that the home was improving. One staff member said, "The home is in a much better position now. The team is really pulling together." Another staff member said, "The home is really improving now. There is more training available." A third staff member told us, "It is a different manager and all the managers have different style. We got used to it now and it is better."

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive person centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People's dignity was not always promoted. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The service was not consistently applying the principles of the Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service did not always promote people's safety. |