SHC Clemsfold Group Limited

Woodhurst Lodge

Inspection report

Old Brighton Road South
Pease Pottage
Crawley
West Sussex
RH11 9AG

Tel: 01444401228
Website: www.sussexhealthcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 July 2017 and was unannounced.

The inspection was planned due to a previous rating of 'Good' published for Woodhurst Lodge in July 2015. However since that inspection, services operated by the provider had been subject to a period of increased monitoring and support by commissioners. Woodhurst Lodge had been the subject of one safeguarding concern about a person not receiving care as planned with their funding authority. As a result of concerns raised, the provider is currently subject to a police investigation. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and August 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Woodhurst Lodge is registered to provide accommodation and nursing care for up to 10 people with a range of neurological conditions and/or acquired brain injury. At the time of our inspection, the home was at full capacity. Communal areas include a dining room, sitting room, multi-sensory room, and spa facility. All rooms have en-suite wet room facilities and overhead tracking hoists. Woodhurst Lodge has extensive grounds which are accessible to people living at the home. The home is purpose-built and located in a rural setting, but within easy reach of the A23.

At the last inspection, the service was rated Good overall and in each domain, apart from Responsive, which was rated Requires Improvement. The rating of Requires Improvement was because there had been a change in the provision of activities which limited the opportunities for people to be involved in activities and spend time out in the community. However, at this inspection we found that the quality of safety and care had deteriorated and we identified three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, the registered manager had recently transferred to one of the provider's other homes as manager, but had not cancelled their registration at Woodhurst Lodge. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider told us that a new manager had been recruited and was due to take up their post in September.

Staff had not always completed the training needed, and as required by the provider, to ensure their competency in providing support to people.

Care was not delivered in a personalised way and staff took little account of people's documented interests

when arranging activities. Care was not person-centred and staff did not always obtain people's agreement when interacting with them. Care delivered by staff to people was task focused. People's likes, dislikes and preferences were recorded in their care plans, but these were not taken into consideration when staff supported people.

Systems were not robust or effective in identifying the issues we found at inspection that have resulted in breaches of regulation. No system was in place to show how people were involved in developing the service and no formal feedback was obtained from relatives.

People were safe living at Woodhurst Lodge. The majority of staff had been trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place. Risks to people were identified, assessed and managed appropriately. There was comprehensive information and guidance for staff on how to support people safely. Staffing levels were sufficient to meet people's needs. Due to staff vacancies, the service relied heavily on agency staff to meet any shortfalls in staffing levels. However, agency staff were vetted before they worked at the service and a senior manager told us they tried to use the same agency staff to provide consistency of care. Safe recruitment practices were in place. Medicines, in the main, were managed safely.

Staff received regular supervision with their line managers and attended staff meetings. New staff followed an induction programme, including training, and shadowed experienced staff before working more independently. New staff studied for the Care Certificate, a universally recognised qualification. Staff understood the requirements of the Mental Capacity Act 2005, but from our observations, this was not always put into practice. People had sufficient to eat and drink and had a choice of meals. Special diets were catered for, for example, food was pureed due to people's swallowing difficulties or risk of aspiration. People were supported to maintain good health and had their health needs met by a range of healthcare professionals.

Staff met people's care needs, but care was delivered in an impersonal manner. Relatives confirmed they were involved in decisions relating to people's care and with their care plans. People told us they were treated with dignity and respect.

Care plans provided detailed information and comprehensive guidance for staff on how to support people. Some parts of people's care plans had been written in a person-centred way and in an accessible format. Complaints were managed, in the main, to the complainant's satisfaction.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe living at the home and staff knew what action to take if they suspected people had been abused.

Risks to people were identified, assessed and managed safely. Detailed guidance was in place for staff to ensure that people received safe care.

Staffing levels were sufficient, although there was a high use of agency staff due to staff vacancies. Safe recruitment practices were in place.

In the main, medicines were managed safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Some staff had not completed training that was considered to be mandatory by the provider.

Staff received regular supervision meetings and attended staff meetings.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 but did not always put this into practice.

People had sufficient to eat and drink and were encouraged in a healthy diet. They had access to a range of healthcare professionals and services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff had little communication with people when supporting them. Care was provided in a task orientated way.

People's preferences, which were recorded in their care plans,

were not always taken into consideration by staff.

People were, in the main, treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Staff did not take account of people's preferences when organising activities. Care was not person-centred.

Care plans provided detailed information and guidance to staff about people's care and support needs, but this was not always put into practice.

Complaints were managed appropriately.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People and relatives' views were not formally obtained in order to obtain their feedback about the service.

At the time of this inspection, no registered manager was in post. An acting manager oversaw the day-to-day running of the home.

A system of audits was in place, but these were not robust enough to identify the issues we found at inspection or to drive continuous improvement

Staff spoke positively about working at the home.

Woodhurst Lodge

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.

The inspection took place on 19 July 2017 and was unannounced. Two inspectors undertook this inspection. Although this comprehensive inspection had been planned, the inspection plan was informed, in part, by partner agencies notifying CQC of a safeguarding concern about this location related to a person not receiving care in line with their assessed needs and funding arrangements. A number of safeguarding and quality concerns in relation to the provider, Sussex Health Care, are the subject of a police investigation and safeguarding enquiries although only one quality concern relates to Woodhurst Lodge. As a result this inspection did not examine the circumstances of the specific allegations made about the registered provider. However, the information of concern shared with the indicated potential concerns about deployment of staff and delivery of person-centred care. Therefore we examined those risks in detail as part of this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI) during the lunchtime period. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day of our inspection, we met with two people living at the service and spoke with one relative. Due to the nature of people's complex needs, the majority of people were unable to answer direct questions about their experiences. However, we observed people as they engaged with their day-to-day tasks and activities. We spoke with the head of quality and therapies, two area managers, a registered nurse, a care assistant and the administrator.

Good

Is the service safe?

Our findings

People were protected from the risk of harm and potential abuse. A relative talked about their family member and said, "I do think she's safe". They told us about an incident explaining, "When she hurt her hand, they called my Nan and told her. They keep us informed of any changes". We asked staff about their understanding of safeguarding adults at risk. One staff member told us about the various kinds of abuse, "There's sexual abuse, financial, neglect – like people not being fed or showered - verbal abuse or physical". When asked what they would do if they had any concerns, they told us, "I would have to let the manager know. They would 100 per cent take action. If there were any problems at Woodhurst Lodge I would just leave". Some staff had completed annual safeguarding training, which was considered mandatory by the provider. However, not all staff had received recent refresher training according to the staff training plan. We have written about this further under 'Effective' in this report.

Risks to people were managed so they were protected and their freedom was supported and respected. People's risks had been identified and assessed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments provided detailed guidance to staff on how to support people safely.

Risk assessments had been drawn up for people in relation to moving and handling, the use of slide sheets, bed rails, pressure ulcer prevention, choking, malnutrition and osteoporosis management. Risk assessments were reviewed monthly. Information was provided on the identified risk, related hazards and the steps to be implemented to reduce risks. Within each risk assessment, there was space for the person's view or opinion to be recorded. A risk assessment relating to one person's risk of developing pressure areas informed staff that the person needed to lie on a pressure relieving mattress and that they also required pressure relieving pads when using their electric wheelchair; these were in place. Daily checks were completed for this person's skin integrity and recorded in their daily notes. Waterlow assessments had been completed and were reviewed monthly. Waterlow is an assessment tool that measures a person's risk of developing pressure ulcers by analysing specific types of information about the person, for example, their age and mobility. At the time of our inspection, no-one living at the home had a pressure ulcer or pressure areas that were a cause for concern.

People's needs in relation to moving and handling were assessed appropriately and recorded within their care plans. The risk assessment detailed how many staff were needed for each transfer, what equipment and types of slings were needed. The risk assessment contained a photograph and description of the sling which was used to ensure that staff used the correct sling. We asked one staff member about their knowledge of one person's moving and handling needs. They were able to tell us the type of support this person needed to be supported safely. We looked at risk assessments in relation to the use of bed rails. The risk assessment provided staff with information about the person's health condition and asked specific questions to determine whether bed rails were required. These questions included whether the person would climb over their bed rails, whether they needed to get out of bed at night without assistance, the risk of entrapment in the rails and whether their mental state placed them at high risk. There was detailed

guidance for staff in relation to people's risk of developing osteoporosis, for example, in the use of calcium supplements and a balanced diet. One person was referred to a dietician because they had lost weight. The dietician recommended the person's diet included soya milk and to add-in steak once a month in their diet. These recommendations were acted upon by staff. In this person's notes we read, "Her diet is very good and she is very pleased". People living with osteoporosis also have an elevated risk of skin tears and we saw padded bed rails were put in place to reduce this risk.

People's risk of choking had been identified and guidelines for staff were in place with regard to their eating and drinking. For example, one risk assessment advised staff to ensure the person's 'comfy chair' was elevated and a small head cushion be used to support the person's posture when eating to prevent the risk of aspiration. Where people's diets needed to be of a soft or pureed consistency, appropriate advice had been sought from a speech and language therapist. People's risks had been assessed when they were fed through a flexible feeding tube or PEG. PEG stands for percutaneous endoscopic gastrostomy, where a tube is placed through the person's abdominal wall and into the stomach. PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. Where people required a tracheostomy tube to keep their airways clear, advice was provided to staff on when to suction the person and included an upper airway suctioning care plan. There was information for staff in relation to catheter care, for example, where people required a catheter to empty the bladder of urine.

Staffing levels were sufficient to meet people's needs. Two people required 1:1 care support and the rotas confirmed that additional staff were assigned to meet their needs during the day and at night. In addition to this, there was a registered nurse and two care staff on duty during the day and a registered nurse and one care staff at night, to support the other eight people. We looked at staffing rotas between 10 and 31 July. These showed that several shifts were covered through the use of agency staff whose suitability was vetted by the agency before they started work at the service. One person said, "The full-time staff that are here are very good, but there aren't enough of them. They have a lot of agency. It's hard on the permanent staff having to tell the agency staff what to do, but it's better than it has been". The area manager told us the provider was in the process of recruiting new staff, including for the position of registered manager, which had been recently advertised. We were told that, where agency staff were used, they tended to be the same agency staff who knew people well and how they needed to be supported. A registered nurse, when asked about the staffing levels, felt there was enough staff on duty during the day and at night; they said, "We can manage very easily during the night". A comment from a relative who had completed a questionnaire in April 2017 stated, 'I think you could do with more nurses and carers', alluding to the lack of permanent staff.

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting. Registered nurses had up-to-date PINs which meant they had been validated to practice through the Nursing and Midwifery Council.

Medicines, in the main, were managed safely. Only registered nurses administered medicines to people. We looked at the storage of medicines and at Medication Administration Records (MAR). The MAR had been completed by nursing staff to confirm that each person had received their medicine as required. Medicines were stored in a locked facility and temperatures recorded daily to ensure that medicines remained efficacious. Where medicines were administered covertly, that is without the person's knowledge, we saw a best interest decision had been made that involved the person's GP, the previous registered manager and relatives. Audits of medicines were completed monthly and MAR checked weekly to ensure there were no gaps in the administration of medicines. We saw that a bottle of eye drops prescribed for one person did

not have the date of opening recorded on the container. We discussed this with the registered nurse who agreed this was an oversight and would take steps to ensure a similar incident did not reoccur. Eye drops usually need to be used within a 28 day period. Not recording the date of opening could mean that the person receives the medicine outside of the 28 day time frame which could impact on its effectiveness.

Requires Improvement

Is the service effective?

Our findings

Staff had not always completed training to ensure their knowledge was up to date. We looked at the staff training plan which showed the training topics which were considered mandatory by the provider to be completed or updated on an annual basis. Topics included abuse/safeguarding, control of substances hazardous to health (CoSHH), infection control, mental capacity, food hygiene, moving and handling and fire safety. One staff member had only completed fire safety training this year, in February 2017. We looked at the supervision record dated 31 March 2017 which stated, 'To complete mandatory training for 2017 by December 2017'. However, no progress had been made by this person in terms of undertaking any training since March 2017, when the issue was identified. Another staff member had completed fire safety training in May 2017, but no other training had been recorded as being completed in 2017. This person had not refreshed their safeguarding training since November 2015, even though there was a requirement by the provider that this be completed annually. Another staff member had not completed any training since March 2016. Some staff did not have their knowledge and skills updated to enable them to carry out their roles effectively. In the Provider Information Return (PIR) submitted on 8 June 2017, the previous registered manager had written, 'All staff are required to attend mandatory training annually to ensure they are competent in all areas relevant to their post'. In the section of the PIR which asked how many staff had completed training in some identified key areas, the section entitled, 'Staff Training and Qualifications' had been left blank. During this inspection we found that people were in receipt of safe care and treatment from staff who understood their individual needs and risks. However, failure of staff to complete training meant their competency was not assured.

The above evidence shows that staff did not always receive appropriate training to enable them to fulfil the requirements of their role. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about their training and supervision. A registered nurse was positive about the training they had received and said they could ask for additional training. They told us, "We have a programme of training, safeguarding, manual handling. We get that twice a year, as well as food hygiene and fire training". The nurse told us that a trainer came to the home to deliver moving and handling training, which included practical training for hoisting. They referred to their supervisions and said, "We have supervisions about once every three months, usually from the manager. We talk about if we need any more help. It's helpful, we talk about individual service users". Records confirmed that staff had regular supervision meetings and an annual appraisal which focused on their development and any addition training needs. The nurse said, "It's very helpful; it's good to get feedback". Staff meetings took place and we looked at the minutes of a meeting held in June 2017. The notes recorded that team working, hospital passports, CQC, activities, heat and hydration and training were amongst items discussed.

Staff told us that the induction they received when they joined the service was detailed and comprehensive. One staff member told us about their induction and the time they spent getting to know people and reading their care plans. They spent two days shadowing the previous registered manager which enabled them to understand the needs of people living at the home and how they should be supported. All new staff were

required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff were also encouraged to study for additional qualifications, such as diplomas in health and social care.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments were completed by a GP and then applications for DoLS were completed as needed. Mental capacity assessments were reviewed when required, to ensure that people's capacity was assessed on a regular basis, since some people's capacity might fluctuate. Where restraint was used, for example, lap belts for people using wheelchairs, 'restraint assessments' had been completed and this information was included in DoLS applications. Where people had capacity to give their consent, and where they were physically able, they had signed agreement of their care plans. Best interest meetings were convened as needed and we saw the record of a meeting that had taken place in relation to one person's end of life care and that rigorous medical interventions would be inappropriate. We asked staff about their understanding of the MCA and one staff member told us that their induction included training on this topic. They spoke about respecting people's decisions and allowing them choice. They also referred to best interest decisions and said, "We have to make sure decisions are made in their best interests".

We observed people during the lunchtime period in the dining room from around midday. We found that care and support provided to people was not always delivered in a person-centred or responsive way to meet people's needs when eating and drinking. We have written about this further in the Responsive section of this report.

People were supported to eat and drink in sufficient quantities to maintain a balanced diet. People were offered two choices at lunch and supper and one of the options was always vegetarian. The chef had details of people's dietary requirements and spoke knowledgeably about people's individual needs. He spoke about four people who had soft diets and they all needed their food to be pureed. The chef told us that he regularly spoke with staff about changes to people's dietary needs and the manager also provided updates on any changes. The chef also told us about one person who had previously lost weight and of the need to fortify their diet. The chef knew people's food preferences and told us that he always tried to ensure there were stocks of food that people enjoyed. He told us that he spoke with people and their relatives or friends to find out about people's likes and dislikes when people came to the home. The chef said, "I'm in good communication with the family and they will tell me people's likes or dislikes. I like to make them happy. Someone asked for prawns, so we got prawns". Monthly meal checks were carried out and if a meal was not popular with people, the chef would take it off the menu. For people who were unable to communicate, the chef said he would judge their views by how much they ate and also their facial expression when he spoke with them.

People's risk of malnourishment had been assessed using the Malnutrition Universal Screening Tool (MUST), a tool specifically designed for this purpose. In one person's care plan, we read that they had lost weight

when they were admitted to hospital, but that since their return to the home, their weight had gradually increased and their body mass index was within normal limits. They were weighed weekly, due to concerns with their weight, but were now weighed monthly. A member of staff explained, "If I was worried I would speak to the chef and also make sure [named person] gets enough to eat. The manager would call the dietician and then update his care plan". The staff member added that details of how much people ate at each meal was recorded as a percentage of the meal consumed. A relative told us they were happy with the amount and quality of food that their family member was offered. They said, "We're happy with her diet. She needs it to be liquidised and it's always done when I visit. She always has a drink nearby too". We asked one person about the food on offer and they said, "The chef is very good, but when he's away they have a carer who steps in and the food's not very good"; they added that the chef always got healthy food in for them.

People were supported to maintain good health and had access to a range of healthcare professionals and services. A physiotherapist was employed by the provider to support people with exercises and treatments appropriate to their health conditions. Care plans recorded when people were visited by their GP, dentist, optician or podiatrist. On the day of our inspection, one person became unwell and care staff carried out regular checks on their blood sugar levels as this may have been a contributory factor. A schedule was put in place for this person's blood sugar levels to be checked at four hourly intervals during the day and night. Hospital passports had been completed for people and we saw copies of these within people's care records. The aim of a hospital passport is to provide hospital staff with important information about them and their health when they are admitted to hospital. On the day of our inspection, a GP was visiting some people at the home and it was clear that he knew people well, including knowledge of their specific health needs. In one person's care plan we read that a GP was involved when there were concerns about their foot and that a referral had been made to a podiatrist by the GP.

Requires Improvement

Is the service caring?

Our findings

In the dining room, we observed that staff were task orientated and interactions between staff and people were limited. Staff walked into the room and did not acknowledge or speak with people in the room. We observed one member of staff check and reposition one person's head to ensure they were comfortable. However, the staff member did not greet the person or explain what they were going to do. No attempt was made to gain the person's consent before the staff member adjusted the person's position.

Between 10.30am and 2pm, the television in the dining room was tuned to a music channel and the music was very loud. It was not clear whether anyone living at the home had chosen the channel or volume of the music. After lunch, we asked a member of staff to turn the volume down, unless people had asked for the music to be played loudly. In one person's care plan, we read that they did not like a noisy environment, yet we saw this person was sat in the dining room during this time and had no option but to listen to the loud music. In another person's care plan we read that staff were to maintain a calm environment and suggested that relaxing music would aid this. The care plan also advised staff to check with the person whether they would like to watch the television and how to obtain their consent. No attempt was made to establish what people might like to watch on the television or whether they wanted the television switched on at all. We observed this person spent time in the late morning and early afternoon when the music was playing loudly and lots of noise was being created with musical instruments.

A relative spoke about the weekends and the use of agency staff. They said, "Agency staff come in at the weekends and put on the news; Mum gets upset and agitated". The relative said they had spoken to the manager and to staff about the channel being changed to the news, but said that when they visited at the weekend, the news channel was always on. People's needs were not recognised and staff did not always understand or support people in a caring way.

We have written about our observations further, including a breach of Regulation 9 (person-centred care), in the Responsive section of this report.

A relative told us about their family member's care plan. They said, "We've seen her care plan, we go through it once a year". They felt their family member had a choice in the care they received, such as what time they got up and went to bed. They added, "In the mornings she can sleep in. They leave her be if she wants to sleep in". The relative felt the staff were kind and caring and said, "I would feel comfortable speaking with the manager if I had any concerns".

People felt they were treated with dignity and respect by staff. In one person's care plan guidance was provided to staff on how to maintain their dignity whilst carrying out personal care. We asked staff how they ensured people maintained their privacy. One staff member referred to supporting people with their personal care and said, "I would first speak to the person, make sure they were happy to be helped, then make sure the curtains and door were shut". They added, "Just take your time, that's the most important thing". People were also encouraged to be as independent as they were able, for example, in relation to personal care. In another care plan there was information about the personal care tasks that the person

could do for themselves. We met with this person who confirmed that staff encouraged them to be as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, we wrote that some people were unhappy about changes to the provision of activities. There was a lack of opportunities for people to be involved in activities and to spend time out in the community. In our report, we stated that people had individual activity schedules, but these did not accurately reflect the opportunities that were available. At this inspection, we found that little account had been taken of organising activities that reflected people's interests, even though these were documented in their care plans.

We were advised of one concern raised by local authority commissioners about a person who was not receiving the care and treatment for which they were funded. Following a review of this person and their needs, this matter had been resolved and closed. However we considered this information in reviewing how people's one to one care and therapies were planned and delivered to meet these needs.

People did not always receive personalised care that was responsive to their needs. Care plans provided detailed information about people in a person-centred way, but staff did not take account of this information when supporting people. Two people were meant to be supported by staff on a 1:1 basis. One person was supposed to receive 1:1 support and care and had been funded for this, but did not always received this support. Their relative explained, "She's supposed to get one to one, but when I visit no-one's with her unless she's eating a meal". The relative said they had spoken with the manager about this lack of 1:1 time, but it had not been resolved. The relative has visited at different times of the day, weekdays and weekends, and felt there had been no change, that their family member rarely had 1:1 time from staff. From our observations, we agree with this statement. The person had 1:1 time while a member of staff supported them with their lunch and then spent 10 – 15 minutes looking at a soft toy and some photos. Another member of staff made an attempt to look through a magazine with the person for approximately five minutes, but for the rest of the day, the person was in their chair at the back of the dining room. The member of staff who supported the person with their lunch and looked at the photos remained in the dining room, but had very little further interaction with the person. We discussed our concerns with the area manager at the time of our inspection and they agreed they would look into this issue.

We were told that an activities co-ordinator worked part-time at the home. On the days when the activities co-ordinator was not at work, care staff organised activities for people. We were told that there were plans to recruit another activities co-ordinator so that activities were organised for people on a daily basis. We saw activity plans were on display for the period 3 – 16 July, so these were out of date at the time of our inspection; there was no current information on display. Activities listed were limited, for example, reading a book, watching TV or physiotherapy. Physiotherapy is not a social activity but a medical intervention to help restore movement and function related to an injury, illness or disability.

We completed an observation in the dining room from 11.30am when five people were in the room, sitting around tables, with music playing on the television. There were four members of care staff present. Staff put out various items on the tables such as colouring books and pens, magazines, books and games. People were not interested in engaging with these activities. Staff members spent time colouring in the

books and showing them to people. We saw one person's head was tilted up by staff to make sure they could see the colouring. From the facial expressions made by this person, they did not appear to be interested in looking at the colouring. We saw another member of staff bring in a box of various hats. They were party style hats and some had faces on them. The staff member then placed hats on two people's heads, without asking first if they wanted a hat on. It was not clear if people wanted the hats on or not. A large, inflatable, blue ball was placed on another table, although it was unclear why. No-one used the ball.

Another staff member brought out a box of musical instruments and emptied them onto a table. The staff member picked up a drum and started to bang it whilst walking around people sat at tables. One person had their eyes closed and appeared to be sleeping. The member of staff took the person's hand and started banging the drum. The person opened their eyes and looked confused. The staff member then walked towards another person, still banging the drum. A short time later, the staff member returned to the first person, who again appeared to be asleep. We saw the staff member took the person's hand and used it to bang on the drum. The person was still asleep and only woke up because they had been forced to bang the drum. From our observations, they did not want to participate in the activity.

We observed another person sitting with a member of staff. The staff member chose a magazine and lifted it up to the person's eye-line. The person moved their head and appeared to be trying to move away from the magazine. The staff member followed them with the magazine to ensure it was in front of their eyes. From their body movements and facial expression, it appeared the person did not want to read the magazine, but staff ignored their body language. A little later, two staff members tried to play a board game at this person's table and sought to gain their attention. The person appeared disinterested in the game and did not make eye contact with either staff member, moving their head away from where the game was on the table. The staff then tried to encourage another person, who was clearly asleep, to engage in the game, saying, "[Named person] look", but the person remained asleep. Another member of staff brought out a small mirror and put this in front of one person's eyes to let them see themselves. The staff member did not speak with the person to explain what they were doing and then took the mirror away after a few seconds.

The activities offered to people were not meaningful and were not personalised to reflect people's interests or hobbies. For example, in one person's care plan, we read they liked to watch films, listen to music by particular artists and to reminisce about the past. They also enjoyed talking about animals and being read to. However, no activities were organised that took account of this person's likes and dislikes and they spent the majority of their day disengaged from the activities that were on offer. We also saw in this person's care plan that they disliked group activities, yet staff continually tried to engage this person in a group activity. In another person's care plan, we read that participation in social activities would help to prevent isolation and loneliness. The care plan went on to state the person should be offered all activities and given the opportunity to participate or not. However, from our observations in the dining room, this person was not asked by staff if they wanted to take part in the activities or not. We observed from people's body language and facial expressions that they did not want to take part in the activities organised that day.

We saw one person sitting in their chair in front of the television in the dining room at 10.30am and they were in the same position at 3.30pm. There had been little interaction with staff and they were sat watching the same music channel on the television during this time. At the same time in the morning, we observed another person was in their chair and asleep in the dining room; they were still in the same place at 1.45pm.

We asked a relative about the activities organised at the home. They said, "It would be nice if she was going out and about more, even if it's just in her chair going around the gardens. It's quieter at weekends too. Sometimes it can feel empty in here. No-one's showing her pictures or taking her for a walk. She likes to listen to music and people to sing with her". They added, "I haven't seen her doing anything like puzzles.

Someone used to come and do finger painting, but I haven't seen that for a long time".

We asked one person about the activities organised at the home. They told us they preferred to be independent of these organised activities and enjoyed surfing the net and online shopping. They told us, "I do all my shopping on line and I can go out whenever", saying that they often went out with friends. They told us that a musician came to the home once a month and added, "Not my cup of tea" and, in their view, not necessarily what other people wanted either. This person said that an activities co-ordinator visited on a couple of days a week, but that they were not very reliable. We asked staff about the activities on offer. One staff member said, "We usually do outings. We do a BBQ every couple of weeks and have a film night once a month. There's enough for people to do". When we were shown around the home at the start of our inspection, the area manager told us that the room that films could be shown in was rarely used, so it was unclear whether film nights did take place or not. One person told us there was no transport available from the home for people at weekends, so they could not go out. They said, "It would be useful to have access to transport". They also told us they preferred to be looked after by female staff and said, "That can be a problem sometimes when only one full-time female carer is on duty and two male staff".

We observed people having their lunchtime meal in the dining room. One person required assistance with their meal and this was done at an appropriate pace with the member of staff sat next to them. However, there was no communication or social interaction between the staff member and the person; it was task focused. The interactions we observed were limited and little eye contact was made. The staff member said, "Hello" to the person when they sat down and then said, "Open your mouth". Once the meal had been finished, the staff member said to the person, "Well done, good lady". Whilst assisting the person with their meal, the staff member had their attention diverted and was watching the television. After assisting the person with their meal, the staff member cleared the plates and tables and sat with them for five minutes. During these five minutes, we observed the staff member touched the person's hand. The person then shouted and looked as though they were annoyed. The member of staff noticed the person's response, but continued to touch their hand on four or five further occasions. Each time the person shouted and looked annoyed about this physical contact, but this was ignored by the member of staff.

The above evidence shows that people did not receive care that reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we provided feedback about the inspection to senior managers of the provider, they told us that staff may have felt pressure to provide some form of activities for people because of the inspection. They added that staff may have been unsure on the best way to meet people's social needs. One of the managers stated they might arrange training with staff from another of the provider's homes to give staff the knowledge and skills they needed to meet people's specific needs.

Some effort had been made to provide care documentation in accessible formats in line with the Accessible Information Standard. From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

Care plans were detailed in content and provided comprehensive guidance and information to staff about people's care and support needs. Care plans also included information about people's personal histories and their lives before they came to Woodhurst Lodge. People were encouraged to maintain contact with relatives or friends through social media such as Skype or by emails. Care plans provided staff with information relating to people's mental wellbeing, nutrition, spiritual care, mobility, working and playing,

challenging behaviour, communication, expressing sexuality, communication and activities of daily living. For example, one person might display challenging behaviour when asked to take their medicines. If this occurred, a best interest decision was in place so that staff could administer this person's medicines covertly, thus preventing them from becoming needlessly upset and agitated. People's care needs, including clinical interventions, were managed well. Care plans were reviewed monthly and a relative confirmed they were involved in this.

We asked staff how they get to know people when they moved into the home. One staff member said they read the life history about people and their care plan. They said they would also speak with family and friends and said, "To me, communication is everything. We get a lot of feedback from families". We asked the same staff member how they involved people in their care. They said if people were unable to communicate verbally then, "Through body language. You can tell a lot from people's body language". However, as written earlier in this section, staff did not always take account of people's body language or facial expressions to ensure people's views were listened to.

We looked at how the service managed complaints and that two complaints had been logged in 2017. These had been dealt with to the satisfaction of the complainant. We asked one person whether they would raise a complaint if they had any concerns and they told us they would see the manager. When we asked this person if they felt their complaint would be listened to and acted upon they said, "It's difficult, because everything is very close-knit here".

Requires Improvement

Is the service well-led?

Our findings

It was unclear how people and their relatives were involved in developing the service. A staff member told us that service user/family meetings were held every two to three months. However, a relative we spoke with told us that they had not heard of any such meetings. We looked at records of 'service user meetings' which had taken place in 2017. People were asked for their views individually. One person talked about the management of the home and gave her views. They told us, "The manager has moved now and we have a temporary manager, who's on annual leave currently". This person felt that the previous manager did not listen or communicate well and this had impacted on staff. They said, "There's no teamwork. We had residents' meetings and she'd just talk. I don't think she was a manager. It's not really a meeting. Staff come round and ask you individually what you think". They said there were no formal questionnaires or surveys to obtain people's feedback.

At the time of our inspection, the previous registered manager had recently left and been relocated at one of the provider's other homes. Until a new manager could be recruited, an acting manager was in place, supported by one of the area managers. After the inspection, we were told that a new manager had been recruited and would take up their post in September. We asked staff what it was like working at Woodhurst Lodge. One staff member was very positive about working at the home and the care people received. They said, "It's brilliant, that's why I've been here for years. I love helping people; I enjoy giving something back". We asked this staff member about the current management arrangements and they spoke positively about one of the area managers, saying, "She's really supportive". Another staff member also spoke positively about working at the home and said, "It's been nice, they are good staff and I feel supported". A relative told us they had not yet met the new acting manager but said they were happy with the care their family member received.

The previous registered manager had completed weekly reports for the provider and records confirmed this. The last report, dated 13 July 2017, provided information in relation to the premises, accidents and incidents, complaints, staffing, supervision and training and care plans being audited. Information was recorded in relation to people's health and welfare, wound care, nutrition and hospital admissions. It was noted that the activities co-ordinator vacancy had been an issue for several months. An area manager told us they were struggling to recruit to this post.

At this inspection, we found ineffective monitoring of the quality of the service provided. Systems were in place to assess, monitor and improve the service, but these were not being operated effectively as they had not prevented the breaches of regulation we identified from occurring. When we gave feedback at the end of our inspection on our findings and discussed our evidence, members of the senior leadership team present demonstrated they had limited oversight and insight into the concerns we had identified during our inspection. We found that this had an impact on the service, in terms of governance and ensuring quality was sustained.

In the Provider Information Return (PIR) which the previous registered manager had submitted to CQC on 8 June 2017, it stated, 'The home managers meet regularly with their area managers and other senior

managements of Sussex Health Care, who provide guidance and expertise advice where needed. External and internal quality assurance monitoring and audits will continue to take place regularly'. There was a section of the PIR entitled, 'What improvements do you plan to introduce in the next 12 months that will make your service better led and how will these be introduced?' We read, 'We will continue to be responsive to each service user by ensuring we are meeting all their needs and personal choices … strive to maintain and constantly improve quality delivery of care to each individual service user'. In our view, and from our findings at this inspection, further improvements were required to ensure the audits are robust and identify areas for improvement.

The above evidence shows that effective systems were not in place to assess, monitor and improve the quality of the services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.