Anchor Trust

Woodland Grove

Inspection report

Weston Park
Weston Village
Bath
Somerset
BA1 4AS

Tel: 01225464004
Website: www.anchor.org.uk

Date of inspection visit:
09 November 2016
10 November 2016
11 November 2016

Date of publication:
13 February 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 9, 10 and 11 November 2016 and was unannounced. The last comprehensive inspection took place in April 2015 and at that time, five breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to person centred care, need for consent, nutrition, safe care and treatment and good governance. A warning notice was also issued in relation to medicines not being managed safely.

We returned to the service in April 2016 to undertake a focused inspection to check that it was compliant with the warning notice for medicines; we found they were now compliant. There were however continued breaches in relation to safe care and treatment and good governance

At this inspection we found nine breaches of regulations. All five of the previous breaches from the last comprehensive inspection in April 2015 had been repeated. We also found four new breaches in relation to safeguarding people from abuse and improper treatment, dignity and respect, staffing arrangements and statutory notifications.

Woodland Grove provides accommodation and personal care to up to 50 older people. Each person has a room which contains an en-suite shower room and small kitchenette. There are also four flats which have two bedrooms, which enable couples to be accommodated.

At this inspection the overall rating for the service is 'Inadequate' it will therefore be placed into special measures. The commission is now considering the appropriate regulatory response to resolve the problems we found.

There was a registered manager in place at the time of our inspection; 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.

There were widespread and systemic failings identified during the inspection. Overall we found that quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service and ensuring the quality of service provision.

The registered manager had failed to make appropriate statutory notifications; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

The registered manager had made applications for Deprivation of Liberty Safeguards (DoLS) where they had been assessed as being required. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the

mental capacity to make certain decisions and there is no other way of supporting the person safely. However we also found that the registered manager and other senior staff within the provider management team had authorised the locking of an internal door and had failed to recognise that they were restraining people without authorisation and had seen this as an appropriate restriction.

Staff we spoke with had a variable understanding of the Mental Capacity Act 2005 and DoLS.

The registered manager had failed to report and take prompt action as required regarding adverse incidents appropriately.

Staff had not received regular meaningful supervision; the provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views. Staff training did not meet peoples' needs.

Care plans were not person centred. Peoples' risk assessments were incomplete and not reviewed as expected by the provider. Records used to monitor peoples' health including nutrition and skin integrity records were not always completed. This exposed people to risks of neglect and unsafe or inappropriate care or treatment.

People had access to healthcare professionals however records demonstrated that the service had failed to make appropriate referrals when there were concerns.

The administration of people's medicines was not in line with best practice.

We received some positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised.

Recruitment procedures were not followed appropriately.

There were enough staff to meet peoples' basic personal care needs.

The provider had a complaints procedure and people told us they could approach staff if they had concerns.

We found nine breaches of regulations at this inspection and will be asking the provider to send us a report of the improvements they will make.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not

enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a failure to safeguard people. Abusive incidents were not always reported appropriately. The provider had also failed to recognise the inappropriate restraint of people.

Risk assessments did not always reflect actions required to reduce risks to people.

The administration of people's medicines was not in line with best practice.

There were enough staff to meet people's basic needs promptly.

Is the service effective?

Inadequate

The service was not effective.

Staff supervision and training was not effective in ensuring staff were supported, suitably skilled and competent in their roles.

Records relating to peoples' care and treatment were not fully completed to protect people from the risks of unsafe care.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005. DoLS applications had not been made for all people that required them.

Risks relating to people's nutritional needs were not managed effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

We received a positive response from people about staff, however we observed occasions where peoples' care and dignity were compromised.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not personalised and did not contain unique individual information and references to people's daily lives.

Sufficient action had not been taken to ensure people's care and monitoring records were fully completed or analysed to prevent deterioration in their health.

People were supported to use healthcare services, however appropriate referrals were not always raised when there were concerns

People did not receive person centred activities.

There were systems in place to respond to complaints.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

Statutory notifications had not been made to the Commission for notifiable incidents.

Woodland Grove

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 9, 10 and 11 November 2016. This was an unannounced inspection, and was carried out by one inspector a specialist advisor (SPA) and one expert by experience. Specialist advisors are senior clinicians and professionals who assist us with inspections. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

As part of our inspection, we spoke with 15 people, the registered manager and other senior management staff, four relatives, seven members of staff and a visiting health professional. We tracked the care and support provided to people and reviewed eleven care plans relating to this. We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports. We also made observations of the care that people received.

Inadequate

Is the service safe?

Our findings

Staff said they had all received training on safeguarding people from abuse and all knew how to report incidents and any concerns. We found however that staff had failed to report incidences that were abusive.

On the first day of inspection staff reported to the inspection team that people in the dementia wing were locked in the corridor from 6pm to prevent them 'wandering' into other peoples' rooms in other areas of the home. We found people locked in this part of the home and unable to leave independently when we returned at 6:50pm. There were conflicting accounts provided by staff and senior management for the reasons for locking the door and how peoples' rights were managed.

There was no risk assessment in place with regards to locking the door, no best interests considerations or any Deprivation of Liberty Safeguards (DoLS) applications with regard to these restrictions placed on people. We were concerned that senior management staff had failed to recognise that they were potentially restraining people without authorisation and had seen this as an appropriate restriction.

People were not always protected from avoidable harm or abuse because staff did not always report incidents when they occurred. For example, in one person's daily record, it had been documented by staff that the person had told a member of staff about an alleged theft. The staff member had documented "Told him if he has any money it will be in the safe". There was nothing to indicate if the incident had been reported formally, or if the person was satisfied and understood the staff response. We informed the registered manager about the entry in the person's record and they were unaware of the incident and it had not been reported to the local safeguarding authority or to the commission.

These failings amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were not undertaken effectively. We looked at four staff recruitment records, a Disclosure and Barring Service (DBS) check had been completed for staff which ensures that people barred from working with certain groups such as vulnerable adults are identified.

Two of the recruitment records were not completed fully. In one record interview competency scores had not been calculated and the person made a negative statement about their former employment. This statement required further investigation to assess the candidate's suitability. There was not any further information recorded in relation to this or any risk assessment. We raised this as a concern with the registered manager and they agreed that information had not been recorded as required however they believed they had reviewed the information and contacted the person's previous employer but had failed to record this.

The other staff recruitment record that was incomplete was in relation to the competency assessment. This included literacy and numeracy tests which were not recorded as having been undertaken as required by the provider's recruitment process.

There was a lack of assurance that safe recruitment processes were completed before new staff were appointed.

We recommend that the provider ensures that recruitment procedures are undertaken and recorded in line with the provider's recruitment policy.

Staff did not have the correct guidance to manage the risks to people safely and people were put at risk of receiving inappropriate care. Risk assessments were not completed effectively citing a plan to meet the risk or were reviewed as required i.e. when the level of risk changed or as required by care plan reviews. For example in one person's care plan it had been documented that they had been assessed as high risk of pressure ulcers. However, there was no associated care plan in place to inform staff how to reduce the risk of this happening.

Another risk assessment was in relation to a person who smoked. The assessment had not been correctly completed, the risk rating had not been filled in and no review date had been set. In addition, the same person had been assessed as being at high risk of skin breakdown. The risk assessment informed staff that a Skin Integrity Plan should be completed for people who were high risk, but no plan was in place.

Falls were not always recorded effectively or relevant action undertaken. Records identified that the provider's falls recording and observation tools were not being used effectively to mitigate the risk of falls and falls guidance for staff was limited. The reverse of the provider's falls tool record had an observation record which was meant to be used to observe people following a fall. The guidance within the record advised that if the person had not been assessed post fall by a health professional, then general wellbeing observations should be conducted for 72 hours. One person's care plan showed they had fallen on 23/10/2016. The follow up observation record for this person had been completed by staff and showed the person had been observed hourly for the first 24 hours, and then observed five times during the following 24 hours and seven times in the final 24 hours. This meant that following a fall, people were being inconsistently monitored, and not always being monitored in accordance with the provider's guidance.

We also saw that referrals to the falls prevention team had not been considered or recorded and that some falls were not recorded by staff at all. There was also a failure to identify preventative measures in relation to falls.

When people had been prescribed topical medicines, there were body maps in place which showed clearly where the creams and lotions should be applied, how often and why. However, the associated charts had not always been completed by staff to indicate that the creams and lotions had been consistently applied as prescribed. For example, one person had been prescribed a cream twice daily, but staff had documented "got herself into bed before I could apply" on 05/11/2016 and "none applied" on 06/11/2016 twice. The same person was prescribed a cream to be applied four times a day but nothing had been documented for 07/11/2016 or 08/11/2016. Another person had been prescribed a cream twice daily. On 05/11/2016 nothing had been documented, on 06/11/2016, staff had applied it twice, on 07/11/2016 staff had applied it once and on 08/11/2016 they had applied it twice.

Although there were photographs in place at the front of MAR charts, not all of these had been dated and so it was unclear how staff would know when they needed updating to reflect peoples' changing appearances. This was noted in the latest external Pharmacist Advice visit which had been completed on 13/09/2016 and as an ongoing action in the provider's recent internal audit on 26/10/16.

Some handwritten entries on the MAR charts had been not been countersigned. For example, we saw three

people had handwritten charts that had not been countersigned. This was one of the audit criteria of the provider's internal audit. The external Pharmacist Advice visit had also picked up on this issue. This meant the service had failed to act on actions in respect of countersigning and dating MAR photographs despite two audits requiring the same actions.

When medicines were destroyed we observed the process which was safe and in line with the provider's procedure. However, this procedure was not consistently followed because we also noted an issue in relation to a box of injections. The log for these injections showed that there were three ampules signed in on 27/08/2016 to be used for one person. These were not in the relevant medicine cupboard when we looked. We were informed the person had since died and the medicines had been returned to the pharmacy, but this had not been written or witnessed in the log book. The drugs for destruction books were checked and on day two of our inspection the registered manager showed us the entry in the returned medicine book to show that the medicines had been returned to pharmacy. However, the date recorded for the returns was 29/10/2016. The provider's Medication Policy stated that this type of injection 'need to be audited on each day and the audit recorded'. Although staff told us they did check these medicines daily, the discrepancy that we noted was not highlighted during these checks, which meant that for ten days the daily checks were inaccurate.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines as prescribed. The staff who administered the medicines took their time with people and didn't rush them. They offered people drinks and checked they had taken all of their tablets before signing the medicine administration record (MAR) chart, the MAR charts had been signed in full and there were no gaps noted.

There was a medicines fridge in place and the temperature was being monitored by staff.
Stock checks of boxed medicines were undertaken and the results recorded by staff.

The staff rota was planned and took into account when additional support was needed. Staffing was sufficient to meet peoples' basic personal care needs. Staff told us that on occasion when there was a shortage of staff that this was covered by the regular staff at the service. The majority of the staff we spoke with said they were aware that staffing levels had increased. Comments included "Our staffing levels have improved lately", "They've taken on a few new staff, we don't use agency any more" and "Staffing has improved, turnover is not as bad as it was". A visiting health professional said "Staffing is better than it was. It's easier to find a member of staff now, and it does feel as though there are more on duty than before".

People made variable comments about the level of staffing. "It is safe, nothing bothers me, there are enough staff who come quickly if they are not busy", "I am safe enough but I am sometimes left until last because staff know I am safe" and I feel safe enough, there are always people around, and I am not afraid to ask when I need something. Visitors we spoke with also felt there were sufficient staff on duty.

Inadequate

Is the service effective?

Our findings

Care plan guidance for people who had been risk assessed for malnutrition and dehydration was not always clear and did not always provide staff with enough information.

Food and fluid records for people who had been risk assessed for malnutrition and dehydration were poor. There was no daily intake or output targets recorded on fluid charts. There was nothing documented within daily records to show that staff had recognised below average food and fluid intake or whether they had escalated their concerns to a senior member of staff when a person had eaten or drank a small amount. There was no accountability for checking and acting on the food and fluid information that was recorded. In addition to this MUST tool records were incomplete and weight checks had not been undertaken as directed. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan.

Staff did not understand why they were recording food and fluids. A member of staff told us a person was having their food intake monitored "Because the family complained so we have to prove we've offered food."

One person's care plan showed that following a GP review in June 2016 they were to be weighed monthly as they were very low in weight. This person was not weighed from that point onwards and related documentation was not completed despite care plan reviews that stated '[Person's name] needs to be weighed.' In October 2016 the GP stated that 'no longer able to weigh as cannot sit on scales.'

In another person's plan it stated on 20/09/16 'in view of weight loss staff to weigh 2 weekly for supplement and fortified diet'. This person was not weighed from that point onwards until 21/10/2016 and not again since. Related MUST documentation was also incomplete.

The failure to adequately monitor people who had been risk assessed for malnutrition and dehydration meant there was a significant risk of further deterioration in peoples' health by neglect.

These failings amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave varying comments on the quality of the training and induction they had received. One member of staff said "The induction was rubbish" and another said "I shadowed another member of staff for two weeks, but even though I didn't feel I knew everything I needed to know I was needed on the floor". Other staff spoke positively about the induction experience. We looked at induction booklets and found that review meetings had not always taken place and staff were signed off to work without their induction booklets being completed.

Training was not effective because staff did not understand why they were required to undertake some aspects of their role. For example, when we asked staff why peoples' food or fluid intake was monitored,

some were able to explain why, but others weren't. We also observed staff using unsuitable moving and handling techniques; we saw two staff using a hoist to move a person from an armchair on to their bed. This was done in a clumsy awkward way. The person was not given any instruction or reassurance throughout the process and did not appear to be comfortable; one of the care staff was new and had only done this procedure once before and was receiving instruction from the other member of staff. When we checked with the registered manager we were told that the new staff member had been deemed competent at moving and handling people following their training.

One person told us staff did not understand their needs and could do with training on how to care for residents with their medical condition and another person said "Staff do not come quickly when I call, I do not know who is going to come through the door, and staff shout at me, when I use the hoist I am frightened."

Staff supervisions recorded on the provider matrix were not as frequent as directed by the providers' policy. Although most staff said they had received regular supervision sessions they were unsure how frequently these should take place.

Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. We looked at a number of staff supervision records and not all staff had a development plan in place. We also found that some supervisions were not a meaningful source of support for staff. We looked at supervision records that clearly indicated that staff felt under pressure to complete records and did not feel suitably skilled in particular areas (care planning). The supervision response from the 'supervisor' did not provide further guidance or support for the staff. We also saw supervision records that consisted of a few sentences with no meaningful record of what had been discussed, any actions or support required.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005. Mental capacity assessments had not been completed for all people who lacked the mental capacity to make certain decisions, or give consent. We were told by senior staff that a number of people lacked mental capacity. The care plans of these people did not have any mental capacity assessments in place to determine their level of capacity to make decisions. There were also no examples of best interest decision making on behalf of people who lacked capacity to agree to the delivery of their care.

The provider had not met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA).

Staff had a variable understanding of the Mental Capacity Act 2005 and 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. There were some appropriate DoLS in place however a lack of formal capacity assessments, together with a lack of staff understanding of the MCA and DoLS resulted in some people being inadvertently deprived of their liberty and their human rights. We found that there were peoples' who did not have capacity to make decisions and who had not been appropriately assessed in respect of DoLS applications.

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People made variable comments about their views of staff competence; "Staff are very competent, some better than others, I have never had a problem with them", "Staff are jolly and well meaning, I am not sure about their qualifications, but they have the expertise and competence, so I assume they have them" and "All staff are extremely good, recently we have had new young staff who are more respectful, and ask, can I help you? Or do you want me to? Whereas the older staff just get on with it, however, they are all absolutely fantastic."

We asked people about their views on the food, these were mixed, their comments included "Food is good some days, not so good others, but usually manage one of the choices", "Food is perhaps ok, but I eat rather a lot of omelettes, I would like to have more salad and fresh vegetables", "Plenty to eat and drink, but not enough choice and "Food is good, plenty of choice: I get a good healthy diet."

People had access to healthcare professionals however as demonstrated in other sections of this report appropriate referrals were not always raised when there were concerns.

Requires Improvement

Is the service caring?

Our findings

People were at risk of neglect of their personal care. We observed that some people were unkempt, had dirty fingernails, wore stained clothing and had food debris on their faces. We saw a person sitting in stained clothing, three hours after spilling food on it at lunchtime. Two people were in their nightwear all day; one of them was still in the same pyjamas at 4pm on the second day of our visit, as were seen during the morning of the previous day. This person, usually clean shaven, had several days' growth of beard. Staff had attempted to shave it on the second day, but the electric shaver could not cope with it. The person still had food stains on their mouth as seen the previous day.

A visitor told us family members had commented on the state of their relative's teeth, which were dirty and stained. They thought they did not get prompted to clean them, they also said they were bothered about the length of their hair, which needed cutting, and how important this had always been to their relative.

Due to the significant recording gaps in personal care notes we asked the service to carry out a personal care audit for the previous 4 weeks and submit to us. The personal care audit under taken by the service reflected that staff often missed recording personal care on some days (blank on audit) and many people were being washed regularly rather than receiving showers or baths. People were frequently reported as having declined personal care. A wash did not indicate a full body wash which were also less frequent. There was a lack of assurance that people received the appropriate assistance with their personal care.

The personal care audit reflected a correlation between the people that require the assistance of a hoist and the lack of showers and baths. This presented a risk of skin breakdown, neglect and a failure to preserve people's dignity.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' dignity and respect were not always protected. We observed several examples of peoples' dignity being compromised within the home.

Whilst in the home we heard staff talking loudly about people in corridors and public areas. We saw people being ignored and responded to tersely and in a negative way. We also saw staff argue with people about what they had said disregarding the fact that the people living with dementia may not necessarily remember everything. We saw that on occasion people were treated as a 'task' and not asked before care or moving and handling was undertaken.

We undertook a SOFI observation at lunchtime. SOFI is a way of observing care to help us understand the needs of people who could not talk with us. We saw that when a person said their food was cold they were told the food could not be cold as it had just been cooked and then ignored when they repeated that their food was cold on a further two occasions. We also saw this person being ignored as they as they asked questions about how long it was taking for their food to be cooked. Staff also rolled their eyes and made

faces at one another in response to the person's questions.

People who did not like what was on the lunch menu were given the choice of sandwiches, a jacket potato or an omelette but no one asked them what fillings they would like. A visitor present was seen to get a better result for their relative who said they did not want anything offered (including omelette) by speaking directly with the chef and being provided with an omelette with an unusual filling of the person's choice. By giving the person a little encouragement towards a particular filling they liked the relative had ensured the person would receive a main meal. Had the relative not been there the person would not have eaten a main course at lunchtime.

One person was presented with a ham omelette and told the staff that they had not asked for ham in their omelette, this person was told "You asked for a ham omelette." We observed they had said yes to being offered an omelette but were not asked what they wanted in it. They were not offered a replacement and as the person had waited nearly half an hour for their omelette they decided to eat it and pick out the ham.

Another person who struggled to cut up their meal was not recognised as requiring assistance despite still having a full plate of food whilst other people served at the same time had finished all of their food.

When hot drinks were served during the lunch time service staff went to pour fresh drinks on top of leftover drink left in peoples' cups. One person asked the staff member to "Throw away the slops first". This had not been considered by the staff member and they went to the kitchen to throw away the 'slops'. They did not do this for anybody else.

We observed a member of staff inspecting a person's wound whilst they were sat at the dining table and making a comment on it. They did not first ask the person before lifting the wound dressing, respect their privacy or consider the effect on other people sat at the dining table. Some people also had clothes protectors put on them without being asked.

These failings amounted to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe some instances of a caring approach from staff that smiled and gave gentle encouragement to people; it was noteworthy that these were staff who had very recently been employed.

People said they were treated with dignity and respect during personal care as this was done with doors closed and curtains drawn. We witnessed staff knocking on peoples' doors and seeking consent prior to entering their rooms and people confirmed this was usual practice. People said they were not however given a choice about the sex of the staff providing their personal care.

People made variable comments about their relationship with staff; "I have a good relationship with staff, most are kind and caring, but some staff have been snappy recently", "Staff here are very good, they are kind and caring and watchful" and "People are all nice to me, some are bossy, but all kind." Relatives made more positive comments; "Staff are very good, they are kind and caring, they have a good relationship with my loved one" and "Staff are kind to everybody, even the people who are trying, they treat everybody with courtesy and patience."

Inadequate

Is the service responsive?

Our findings

Information gathered at pre-admission assessments and placement reviews were not included within care plans. This information included personal preferences for a same gender member of staff for personal care and peoples' emotional and social needs. For example one person had moved into the service recently. It was documented in their care plan that they had no preference in relation to the gender of care staff. This person's pre-admission assessment documented that the person (female) preferred female staff to assist with their personal hygiene needs. It had also been documented that the person preferred a shower every day. The daily records for this person showed they had a wash every other day since moving in. There was nothing documented to indicate if a shower had been offered and it was not clear from the daily records what the gender of staff were who had assisted the person. Care planning and support had not been provided in a person centred way

Care plans were not personalised and did not take into account people's individual needs. For example, the care plan of a person living with learning disabilities did not describe the learning disability and how the person may be affected. The registered manager did not know what the person's learning disabilities were and staff were also not aware. The service had produced a care plan without taking into account what the person's support needs were and therefore they may not receive the care and support required or in their preferred way.

Care plans also lacked life histories and detailed information about peoples' preferences. This is significant in a service for peoples' living with dementia as the information can aid staff in communicating and assisting reminiscence with people. This information is of particular relevance when new staff are employed at the service to aid these staff in knowing and understanding There was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for.

There was a lack of planning and availability of meaningful activities which people could take part in. Peoples' wellbeing was not promoted due to a lack of activities to meet their social, mental and emotional needs. There was a daily timetable of activities on display within the home. Activities listed included: Quizzes, musical bingo, pampering sessions, ball games, film shows and musical sessions with an outside entertainer as well as a church service on Sundays. However people who required individual person centred activities on a one to one basis with staff did not receive them.

We looked at the records of one person who had a placement review in November 2015. Actions to be taken to ensure the wellbeing in relation to going out of the home had not been completed in November 2015 following the previous review of the placement in August 2015 and there were actions still not completed to date. These actions related to the person going out into the local community to maintain their emotional wellbeing.

The section of the person's care plan which related to social activities was last updated in December 2015 and did not mention them going out into the community. Daily records showed that the person had not

been out for a number of months other than when a relative took them out. There was no record of the person being offered person centred 'outings'. We looked at the daily notes for the person from 22/12/2015 until 04/10/2016. We found that the person had received one person centred outing activity; going to the shops with a member of staff to purchase a birthday card. The only other trips organised by the service for the person was when they visited the hairdresser and two group trips with other people. The service was not complying with the requirements related to the person's placement review.

We looked at the activities records for people who were unable to leave their bedrooms. We found that very little had been recorded in respect of activities or social stimulation for these people. For example we looked at the activities records for a person who was 'bed bound'. There were no activities recorded in their daily records for the last month and activities coordinators when asked about the person said "I don't think he's had any activities in his room for months." This was despite the person's care plan stating how the person wished to have activities undertaken with them in their room.

We also observed that staff did not spend time with people unless they were providing care. People commented "Staff only spend time with me when I need it because they are so busy another person said "Nobody comes to take me out, I just sit and cry."

We found that activities were not monitored by the provider for their suitability or for their provision particularly for people who stayed in their rooms or in bed. Service user's emotional and social needs were not being met.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care was not responsive to peoples' needs. For example where a person's behaviour indicated a change in their mental health the behaviour had been noted but no further action taken. A person had voiced delusional and suicidal thoughts and there was no follow up action recorded by staff. The registered manager was also unaware the person had expressed these thoughts.

In relation to another person we asked staff why the person was on a fluid chart. They said "They don't like to drink so we keep an eye on it". They did not mention the person's catheter until we prompted them or that they were a high risk of urine infections. The staff member said they would look at the colour of the urine to ascertain if the person was drinking enough. There was nothing documented to indicate if staff had identified the poor urine output, or when they had concerns if these had been escalated.

In addition, entries of 'bag full' on the fluid chart meant that it was not possible for staff to accurately monitor the person's urine output. We saw three entries of 'bag full' on three separate days and yet this had not been addressed with the member of staff who was recording the output. When we discussed this with a senior member of staff, they said the new member of staff had not been trained properly.

There was a significant risk of deterioration in the peoples' physical and mental health because staff were not responsive to their individual needs.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints procedure and people and their representatives said they knew how to complain. We looked at the complaints log. Four complaints had been received since May 2016. Three of

these had been investigated and satisfactorily resolved. However, one complaint had been received on 26/05/2016. When we asked to see the investigation and outcome of this complaint, we were unable to because the person who had dealt with it had since left the business. There was no centrally held record of the investigation process and therefore we were unable to assess whether the complaint had been resolved and closed satisfactorily. This also meant the provider was unable to use the detail of the complaint to assess for any trends or improvements.

We also saw some thank you cards that had been received. Comments included "My brother was full of praise for all you did for him" and "Thank you very much for the care you took to make his life at Woodland Grove as comfortable and easy as possible".

Inadequate

Is the service well-led?

Our findings

The provider had not demonstrated good leadership in respect of the support provided to the registered manager. During the inspection it was clear that on a number of occasions the registered manager was unaware of all of the responsibilities associated with their role. We found that the registered manager had not received support from the provider that was commensurate to the registered manager's level of experience. There had also been vacancies amongst the senior staff which had affected the registered manager's ability to manage the service. When the registered manager began their employment in April 2016 there were two care managers (deputies) in post; one part time at 24.5 hours a week and one full time 37.5 hours a week. The part time care manager left in June 2016 and was not replaced. The full time care manager left in October 2016. This combination of staffing issues at a senior level had contributed to the poor supervision of the service. A new full time care manager started working at the service two weeks prior to the inspection; the provider has decided not to replace the part time post.

This meant that the registered manager had less protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. The provider had failed to provide sufficient time and structured support to enable the registered manager to undertake their role effectively and to a good standard.

The provider's quality assurance systems and processes did not ensure that they were able to assess, monitor quality provision and mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service.

The quality assurance systems used by the provider and the service were ineffective in assessing where the service required improvement and implementing and sustaining improvement effectively within a reasonable timescale. There were widespread and systemic failings identified during the inspection. Since our last comprehensive inspection there had been no improvement in the level of service provided and some areas had deteriorated. Our findings from previous inspections have shown a history of non-compliance with the regulations. This has covered a range of areas, and when improvements had been made, these had not always been sustained. At this inspection we identified nine breaches of regulations, five of which were continuing breaches from our last comprehensive inspection. This demonstrated the provider had failed to take sufficient action in response to shortfalls previously identified.

As at other inspections, a number of the shortfalls related to matters which had been brought to the provider's attention on previous occasions. These related to key aspects of the service, such as safe care and treatment, records and good governance.

The registered manager had been in post since April 2016 and could not provide evidence of any structured provider quality assurance visits for the service as a whole other than one district manager provider report for October 2016 (the district manager post had only recently been filled) and monthly care plan audits by the provider's dementia care advisor.

The registered manager was required to complete the provider's excellence tool (computer spreadsheet) with any actions that were pre-populated within the tool or assessed as requiring completion by herself, the dementia care advisor, the district manager and the visiting regional service manager. The regional service manager did not produce any report after visiting they added actions to the excellence tool which the registered manager was to complete. The actions from any local authority reviews were also added into the tool. When the regional service manager next visited they checked the tool to see what had been completed and validated those actions.

Care plan audits were undertaken by the provider's dementia care advisor on a monthly basis; these had been ineffective as these had not led to reviews and improvements and the care plans were of a poor quality.

The registered manager told us that they and other senior staff undertook audits in relation to different aspects of the home. These audits were ineffective because they were not carried out in a way that improved upon the service. For example senior staff had completed infection control audits; we looked at the last two audits. The most recent audit raised two of the same actions which had been required for completion from the previous audit. Action had not been taken within three months of the first audit.

There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was also a failure to identify recording errors and omissions in the care records and to analyse concerns. We saw records which were undated, unsigned, incomplete and incorrect. The majority of care plans we saw (11 out of 39) had an element of this with some being significantly worse.

The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to safeguarding including allegations of abuse and neglect. The provider had failed to report incidents that the local authority safeguarding team had investigated, as statutory notifications to the Commission. For example we saw an incident recorded in one person's daily notes that they had struck another person. This incident had been recorded in the service's accident and incident management system and reported to the local safeguarding authority but not to the commission. This meant that the Commission had been unable to monitor the concerns and consider any follow up action that may have been required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Annual customer satisfaction surveys were sent out to people and their family and representatives. The last survey had been sent out in February 2016. At the time of our inspection the survey was in the process of being reviewed. We saw that the last survey from 2015 was mostly positive and issues highlighted in relation to improvement were around food choice and quality. We found that action had been taken to address these issues by the service.

Residents meetings were held every month for people living in the home and relatives meetings were held bi- monthly. The surveys and meetings were to provide people and their relatives with an opportunity to discuss their concerns and raise issues. The meetings had received a good response and a number of issues had been raised. We looked at meeting minutes; we found that action plans were not produced following the meeting. Instead actions were added to the provider excellence tool. This meant that it was not easy for people or relatives to track if actions were being completed within a timescale. The registered manager said however that they reviewed actions with people and relatives at the next meeting. This was not however always clear from the meeting minutes. We found that actions were not recorded as part of a formal auditable action plan, which meant we were unable to check that all actions had been completed.

When asked about the management of the service, people made variable comments including "There is a new manager just started, she is extremely nice, lovely, she has had a long chat with me and "I do not see the managers, I would not know them". Relatives were positive about the registered manager and said "I like the new manager's approach, she has been here a very short time but I think she will get things done", "Communication is good, I feel free to say what I think" and "[Registered manager's name] the manager, has got common sense and handles things sensibly, does things straight away, she is happy to listen, her dealings with staff are good."

There was also a yearly survey for staff. We looked at the last one analysed in May 2016. Staff meetings were held monthly we also looked at the minutes from those meetings. It was not clear from the survey report or from staff meeting minutes that actions were recorded as part of a formal auditable action plan this meant we were unable to check that all actions had been completed.

Staff made variable comments about the management and culture within the service. Staff said morale was "up and down", and "Morale has been low". One staff member said "The team leaders support each other, and the care staff come to the team leaders for their support. I don't feel supported by the manager". Another said "We could do with more support from the manager on the floor sometimes". One said "Everybody feels very unsure at the moment". However, staff also commented "We've got the basis now for a really good team with the new manager" and "There's a great team vibe here".

In relation to developing the service, staff said "I feel I am part of the changes taking place" and "It's improving, it's definitely improved". However, staff also commented "Communication between staff and management needs to get better" and "We weren't really told about the last inspection report, just told to write the care plans properly".

We found that there was a divide within the staff team; we were told that some staff were reluctant to change to improved ways of working and staff who did not like each other would not assist each other whilst working to the detriment of people. Comments about the culture and atmosphere had been recorded within staff supervision meeting notes however there was no structured approach to dealing with these issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to make appropriate statutory notifications.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Peoples' dignity and respect were not always protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to report incidences that were abusive to the local safeguarding authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a failure to adequately monitor people who had been risk assessed for malnutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Staff had not received regular meaningful supervision; the provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views. Staff training did not meet peoples' needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's personal care needs were not met. Care plans were not personalised and did not take into account people's individual needs. The provider failed to deliver care and support which met peoples' preferences.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not have the correct guidance to manage the risks to peoples' safely and people were put at risk of receiving inappropriate care. Records used to monitor peoples' health were not always completed and staff were not responsive to changes in peoples needs.

Medicines were not managed safely.

The enforcement action we took:

Imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were restrained without necessary authorisation

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service and ensuring the quality of service provision. There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people.

The enforcement action we took:

Imposed additional conditions on the provider's registration.