Keslaw Limited

Woodcot Lodge Care Home

Inspection report

12 Rowner Road
Gosport
Hampshire
PO13 0EW
Tel: 02392 520085
Website: www.fshc.co.uk

Date of inspection visit: 4 5 12 March 2015
Date of publication: 22/07/2015

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

Overall summary

This announced inspection took place on the 4, 5 and 12 March 2015. Woodcot Lodge is a nursing home which offers personal and nursing care to 85 older people, some of whom live with dementia. The home has three floors, with a lift providing access to all floors. The second floor accommodates people living with dementia and the first floor accommodates people with nursing care needs. The ground floor is referred to as 'residential' and accommodates older people who do not fall into the other two categories.

On the first day of our inspection there were 58 people being accommodated. On the last day of our inspection 67 people were being accommodated.

There has been a history of non–compliance with the regulations at this service since September 2013. Following inspections in December 2013 and February 2014 we issued warning notices to the provider for a breach in regulation 22, staffing. In June 2014 we found the provider was no longer in breach with this regulation. In February and June 2014, we issued warning notices for a breach of Regulation 9, care and welfare. We found in

Summary of findings

September 2014 the provider had met the warning notices but a compliance action was made in relation to care and welfare. At the inspection in June 2014 we also identified a breach of regulation 20, records, where we served a warning notice. We found the provider had met the warning notice at our inspection in September 2014 but a compliance action was made. Outstanding compliance actions remain in relation to food and nutrition and quality assurance.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had an understanding of abuse and what action they should take if they felt someone was not receiving safe care. Risk assessments relating to people were not always completed and had not been updated as necessary. Staffing levels and the skills mix they had were not planned and organised to meet the needs of people. Staffing recruitment records did not detail all the necessary checks had been undertaken before staff started to work to ensure people were safe. The administration of medicines practices in the home were not safe.

People felt staff had the knowledge to care for them effectively. However, staff had not received training in all relevant areas to ensure they could meet people's needs. Staff had not received regular formal supervision. Staff had an awareness of and understood the Mental Capacity Act 2005 and the principles of this had been applied. Some people did not have their nutritional needs taken into account and receive adequate support at meal times. Health needs were assessed and the relevant professionals were involved in people's care provision.

The majority of staff were caring but due to being very busy they were not respectful of people's privacy and dignity at all times. People were not formally involved in discussions about their care. Care plans were not personalised and did not provide detailed information to guide staff about the support a person needed. The home had a complaints policy but this was not always being followed.

Quality assurance in the form of auditing took place on a regular basis. It was not possible to establish learning from audits took place to bring about effective change. There was a lack of transparency and openness as staff and relatives who had raised concerns did not feel they were listened or responded to. Staff did not feel able to approach the registered manager with their concerns, were unclear about the provider's values, and their views on the shortfalls of the service did not match with managers. There was lack of accurate, up to date and consistent records of people's needs which placed people at risk of receiving care and treatment that did not meet their needs.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risk assessments were not always individualised and did not detail how the risk should be minimised. Risk assessments for the environment had been completed.

Staffing levels did not meet the needs of people. Staffing recruitment practices were not thorough and did not ensure the safety of people.

The management of medicines was not safe and people were at risk of not receiving medicines safely.

Staff had been trained in the safeguarding of vulnerable adults and were able to describe the different types of abuse.

Inadequate

Is the service effective?
The service was not effective.

Staff received training but this did not ensure all staff had the skills to meet the needs of people. Staff did not receive regular supervision.

People were not protected from inadequate nutrition and hydration; it was not possible to safely assess a person's level of hydration and nutrition intake.

Staff understood the principles of the Mental Capacity Act 2005 and these were applied correctly.

Inadequate

Is the service caring?
The service was not always caring.

People were not consistently provided with opportunities to be actively involved in decisions about their care.

Some staff demonstrated a lack of understanding of how to treat people with respect privacy and dignity.

Requires Improvement

Is the service responsive?
The service was not responsive.

Care plans did not record people's individual needs and show staff how these should be met. Staff did not always meet people's individual needs.

Complaints had not been recorded in the complaints log, so we could not be assured these were responded to, investigated or learnt from.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

The service has a registered manager, but staff did not always feel able to openly discuss concerns with them and where they had raised concerns, did not feel they had been responded to.

Staff were not clear about the values of the organisation.

There were some systems in place for external auditing but these had not picked up concerns to ensure a quality service was provided to all people.

Care records were not well maintained, accurate or reflective of people's individual needs.

Woodcot Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4, 5 and 12 March 2015 and was unannounced. We visited the service between the hours of 8:00am and 11:00pm over the three days. The inspection team consisted of two inspectors, a specialist advisor in the care of frail older people, especially people living with dementia and those with end of life care needs, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for people who have dementia.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spent time talking to 15 people, five nurses, seven members of care staff, the deputy manager and the registered manager. We looked at the staffing records of nine members of staff. We saw minutes of staff meetings, residents meetings, the policies and procedures file, monthly reports by the regional manager and the complaints log and records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and free from harm. Comments included "Yes I feel safe here and they keep my room clean". People told us their medication was administered on time and that supplies did not run out. A relative told us, "The only criticism I have is that they seem to need more staff, they are rushed off their feet". Another relative told us, "The main thing is the staff don't have enough time to chat with anyone in the lounge they're always too busy". Another relative told us, "They are always short staffed and people are in the lounge and left to their own devices, people have to wait to go to the toilet."

Risk assessments had not always been completed where necessary. Where they had been completed they had not always been kept updated and therefore did not reflect people's current needs. For example, in daily notes there was information of concern about people's emotional, behavioural and nutritional needs but risk assessments had not been completed in relation to these issues. For one person the risks had meant they had been moved to another floor and required one to one support. No risk assessment had been completed to reflect the risks for this person and other people. We saw people wandering without supervision or support into situations of risk, and into other peoples bedrooms. This placed them and others at risk but risk assessments had not been completed to identify the risks or the support staff should provide. There was an environmental risk assessment, which gave information on what to do in the case of emergencies, such as flooding or a fire.

The lack of risk assessments in place to ensure the safety and welfare of people meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010) which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service used a tool called Care Home Equation Safety Staffing (CHESS) to determine the staffing levels needed to support people. We were advised this was completed monthly and included a review of each person's individual needs. The last monthly assessment had been completed on 4 December 2014 and was therefore two months out of date. Care records for people did not reflect a monthly review of their dependency levels. This meant information about people's needs was not always used to inform the staffing levels. All staff asked were unaware of how staffing levels were determined. We saw examples throughout our visits where there were not enough staff to meet the needs of people. This included lunch time in the dining room, during the day and throughout the evening. At times the staffing levels meant people did not have their needs met and were at risk. At some meal times people who needed prompting and one to one support were not given this in a consistent and dignified way as staff needed to support more than one person at a time. One person walked around the floor and picked up a pair of plastic gloves and blew their nose, no staff were around so we encouraged the person to put the gloves in the bin. We saw one person in the evening trying to get up unaided. A staff member walked past their room and rushed in. They informed us the person was at high risk of falling and should not be getting up on their own.

Relatives told us they had concerns about the staffing levels and one described how the lack of staffing meant their relative's needs were not met. Staff told us they did not have enough time to meet people's personal needs as they were too busy. They said they would regularly share staff across the floor of the home, so if one floor was 'heavy' (meaning people on that floor had higher support needs) they would send a member of staff to that floor. There was a lack of knowledge from staff as to what they were supposed to be doing. For example, we were told by the manager on one floor that two people were provided with one to one support. However staff working on this floor told us this was not possible and these people were checked every fifteen minutes. We also saw examples of where staff did not have the skills to care for people. For example, one agency worker who had spent the previous day working on a one to one basis told us they were new to care and this was their third day working in the care industry, which meant they did not have the experience to be working with people who had complex needs and people were at risk of receiving unsafe care

Appropriate steps had not been taken to ensure there was always sufficient numbers of staff with the relevant skills to meet the needs of people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Recruitment procedures in the home were not sufficient to ensure all the necessary checks were being undertaken before staff worked in the home. Two references had not been undertaken for one staff member. The provider had not completed the necessary checks with the Disclosure and Barring Service (DBS) for four staff and therefore we were not confident all staff were suitable to work with the people in the home. These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. One person had a criminal conviction which they had declared but no risk assessment had been put in place to ensure the safety of people with regard to the relevancy of the conviction.

A lack of appropriate recruitment checks before people started work in the home meant people were at risk of receiving care from people who were not suitable to work with adults at risk. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there had been an error in the ordering of people's medicines, which had resulted in medication being delivered into the home in boxes and not in the usual blister packs. The provider had not complied with safe practice in the storage of medicines that were waiting for disposal in some areas of the home. Newly ordered medicines had been put into the disposal bin by mistake.

On one floor the recording of controlled medication was not to an acceptable standard. It was being recorded in a paper based book where the start date had not always been recorded and some completed courses of medicines had not been completely scored through. We found errors with the recording of medication on the Medical Administration Records (MAR), which meant there was not an accurate record of what medication each person had taken. For example the MAR charts recorded one person had not received one of their prescribed medicines for four days. The time of one medicine to be taken had been changed by hand writing on the MAR chart for one person. This meant that people were at risk of not receiving their prescribed medicines with an impact on their health and wellbeing.

The inadequate practice in the administration, recording and storage of medicines was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on abuse and the different types of abuse. They showed knowledge of what action to take and who to contact if they had any suspicions abuse was taking place. Staff knew how to locate the provider's safeguarding policy and knew that they should report incidents quickly to the registered person when they occurred.

Inadequate

Is the service effective?

Our findings

People told us medical attention would be sought if needed, "I haven't needed the doctor but I think they would get one quickly to me". A relative told us how they felt some staff didn't always understand the needs of some people. They said "Some nurses don't seem to get on with X and others are very kind to him. It's like they don't understand him."

Staff did not have the skills and knowledge to support people with their assessed needs and preferences at all times. We saw some good examples of staff supporting people in a manner which demonstrated their understanding of people. However we also saw examples of where staff did not have the knowledge or skills to support people. This was mainly when supporting people who were living with dementia. For example one person regularly asked where their partner was, an agency staff member responded to this person and said they would help them find their partner. A permanent member of staff overheard and came and gave reassurance to the person and gave the agency worker an update of the person's family circumstances. Staff interactions with people demonstrated they had little skills of working with people with dementia and behaviour which may be considered challenging. When looking at the training matrix it was difficult to establish what training each member of staff had covered. We were told by the manager this was due to difficulties with training being recorded in different ways. From the training records given to us we could establish thirteen of approximately 80 staff members had covered face to face person centred care, which we were told related to 'dementia care'. Five staff told us they had not received training in supporting people with dementia and felt this was an area they needed. The registered manager said this was covered in person centred care training; however they told us on the third day of our inspection they had booked a course for staff about dementia. This meant that people were at risk of not receiving safe care appropriate to their individual needs.

There were no systems in place to support staff development through the use of supervision such as one to one time with their manager. Six staff told us they did not receive regular supervision and there was no formal arrangements in place for staff to receive this support. One senior member of staff told us they had not had time to arrange one to one sessions. This meant the provider was unable to confirm staff were working to an appropriate standard or receiving the support they required to perform their roles.

Staff did not receive regular formal supervision or adequate training to ensure they could meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not provide adequate support to all people to ensure they received their meal in a way to meet their individual needs. One person had their meal served to them on a plastic plate and they also had a spouted plastic cup. Several staff tried directly feeding the person but they refused. When the person was offered a cup of tea without a spout and their pudding arrived in a china dish the person drank and ate independently. There was nothing in the person's food and nutrition care plan relating to the need for a plastic plate or spouted beaker.

People's records gave very little information on people's needs and preferences relating to their food and nutrition and support needed at meal times. Food and fluid charts were either not completed or did not include adequate information to ensure people's nutrition was recorded and monitored. Fluid charts did not include target intake amounts of fluids and they were not totalled. This meant it would not have been possible to assess the person's level of hydration over a number of days. Peoples' food charts showed poor intake that had not been transferred to people's care plans. People had their weight monitored although not always as often as described in the care plan. We saw for some people weight records identified they had lost weight. Care plans had not always been amended to ensure staff knew how to support these people with their nutritional needs. Relevant professionals were contacted regarding this but care plans and relevant risk assessments were not updated to reflect people's changing needs regarding nutrition and hydration.

People were not protected from the risks of inadequate nutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They knew if a person lacked capacity, relevant people needed to be involved and meetings held to help ensure decisions were made in the person's best interests. Staff asked people for their consent before carrying out any activity with them. People's care plans contained a mental capacity assessment, but these were not all decision specific. The manager had made Deprivation of Liberty safeguarding applications appropriately where people were being deprived in some way of their liberty for their safety. These had been put into people's care plans to ensure staff were aware of them.

The home had good links with the local GP practice. People had access to a chiropodist, optician and community psychiatric nurse. A member of the speech and language therapist (SALT) team told us the staff followed their guidance and they were called in appropriately.

Requires Improvement

Is the service caring?

Our findings

People gave us positive feedback regarding the caring nature of staff. One person said "They are very respectful and polite" and another said "I'm quite happy here, they're very kind to me I have no trouble with any of them". One person told us "I have my meals where I like depending on how I feel".

We found staff were kind when interacting with people on a one to one basis. However, on occasions, staff lacked the time and skills of understanding how to interact with people with privacy, dignity and respect. For example, one person's footrests on their wheelchair had not been positioned and after a while a staff member asked the person what was wrong "My legs are dangling and it's uncomfortable". This was then addressed. During one lunch time, on two occasions, two different people were supported to eat their meal by staff who were standing over them and putting food in their mouth, with little communication. On both occasions the staff talked over the people they were supporting, to other people in the dining room demonstrating a lack of respect for people.

During our inspection we saw examples of where people were supported to make choices, however this was not consistent. For example staff said, "Shall we go to the dining room for dinner". Those who wished to went and for others who wanted to stay in the lounge or their bedroom, their choice was respected. People who were independent could choose where they wanted to sit. However, those using wheelchairs were not afforded the same level of choice and were positioned where the care staff left them. It was noted throughout the lunch period the only drink offered to people was orange juice. We noted on three occasions staff mixed all the individual pureed food up without consultation with people. On one day the choice was gammon or quiche, but the quiche was covered in gravy which people had not been consulted about. People were not always treated in a respectful and dignified manner, where choice was promoted.

We saw some examples of where people were supported to be independent and their privacy was respected. For example, some people were encouraged to walk around the home and help with serving teas and coffee. At other times it was clear people's privacy and dignity was not considered. We saw one person asleep on their bed for over four hours during the day, they had no sheet on the bed and no duvet cover for this time, which was undignified and did not respect their privacy. One person was prompted to move and when they did, it was noted their trousers were loose fitting and falling down. This exposed their underwear and continence support items. This was not acknowledged by staff and a few minutes later the person fell. The support the person received following the fall was not well organised and did not ensure the person was supported by the staff they knew best. This demonstrated a lack of care, dignity and privacy for this person. On another occasion a person came out of the toilet and they had not dressed themselves properly leaving all their underwear and continence aids on show. This was only acknowledged by staff when they entered the populated lounge.

One person was sat in a dining chair away from the table at an angle. A care staff member without any communication to the person pulled the chair from the front legs of the chair towards the table. A second staff member came over and communicated with the person and told them what they were doing. A clothing protector was attempted to be put on one person who resisted and became agitated as the staff member continued to encourage the person to put it on. On one occasion a carer shouted across the dining room "(name) come and sit down".

People were not always supported by staff who recognised their needs and demonstrated respect for people's privacy, choice and dignity. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's written records included little information on people's life histories or preferences in relation to their choices. Care staff did not have access to care folders but had access to the records in people's rooms. Care folders were kept in locked areas on each floor of the home and staff were aware of the need to keep these locked to ensure confidentiality. Care records in people's rooms included much less personal information and were more task based on what support the person needed in relation to day to day tasks. There was no evidence people were involved in any decisions outside of daily tasks. There was little evidence in daily notes that families had been informed when there had been major changes involving the planning or reviewing of their family members care provision.

Requires Improvement

Is the service caring?

We recommend the service seeks advice and guidance from a reputable source, about supporting people with dementia to express their views and in actively involving them in decisions about their care and support.

Inadequate

Is the service responsive?

Our findings

People told us they had freedom of movement and could spend their time as they wished. "I like it here I've no complaints I wouldn't be here otherwise". "I can sort myself out; I only ask them to help me when I need to".

People did not receive personalised care which was responsive to their needs. Assessments had been completed before and when people moved into the home. Care plans were developed from the assessment in thirteen main areas of need including, capacity, medication, mobility, nutrition, continence, hygiene, skin tissue viability, psychological, infection, communication, human behaviour, cognition and breathing. We found care plans were not reflective of people's current needs; they had not been updated and included conflicting information in each section. We found entries in daily notes or in the communication record which had not been followed up or added to the care plan. Sometimes this had been added in the wrong place. For example an update to one person's care plan in 2015 had been added to the 2013 care plan, making it doubtful any member of staff would have seen this updated information.

Throughout our inspection we saw examples of where staff were too busy to offer personalised care to people. People were left to sit without stimulation in communal lounges or in their bedroom. More mobile people were left to roam the floor, sometimes into places where they put themselves at risk or into other people's bedrooms.

People who had behaviours which challenged staff were not managed well. On one day of our inspection one person was very vocal using language and sounds which could have been distressing to others. We were told by staff at lunchtime this person had been taken in to the dining room but had thrown their food and shouted at people. When tea time came staff followed the same routine and the person behaved in the same way. Two people left the dining room telling us they did not like the noise. The person was taken to their room and a staff member sat with the person in their room. However other staff kept coming into the room and each time the person would start being vocal again. When the staff member left the room they were upset. Staff told us they had been hit, spat and pinched by the person and some staff showed us scars which they said were a result of this person's behaviour. One member of staff told us they were scared of this person. The information in the care plan identified the person may be physically and verbally aggressive; however there was little information about how staff should manage the person's behaviour in these circumstances. In the 'personal hygiene and dressing and sexuality' care plan a note had been recently added stating 'sometimes three carers are needed'. There was no detail as to when and why and what each member of staff would be doing. This person was therefore at risk of receiving inappropriate and unsafe care and support.

In another person's care plan it was recorded the person had moved into the home onto one floor, they had then moved onto another floor but then moved back onto the original floor. Staff were able to tell us the reasons for these moves. However there was very little documentation in the person's care plan detailing this information. We found no detail of any discussion or involvement with the person.

We heard one person in a lounge calling out for twenty minutes. When we went into the lounge we observed a staff member sitting close to the person calling out, writing up notes and ignoring the person who was also banging on the chair arm. One person asked us what was happening whilst another said, "Don't bloody shout, stop it" and another said "Keep it quiet …what do you want". When we entered the lounge the staff put away the file and said to the person calling out, "What do you want X, what's the matter" and went to sit with the person who then calmed a little.

The lack of care planning and information did not support people to receive personalised care to meet their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy and a complaints log book was maintained. The home also kept copies of compliment cards and letters. In the staff meeting minutes of November 2014 there were two comments regarding complaints. One was from staff regarding the staffing ratios which were not considered sufficient and the second was from a relative who had complained about staff complaining about each other. At the nurses meeting in November 2014 it recorded a relative had complained about how long it had taken to get access to the building. When speaking to a relative they told us they had made a complaint about the lack of care their relative had received when they had visited one

Inadequate

Is the service responsive?

morning. None of these complaints were detailed in the complaints log, which made it impossible to know if they had been investigated, responded to or learnt from. This was also not in line with the homes complaints policy which defined a complaint as, 'Expression of dissatisfaction from a person, their family or carer, person acting as their representative or and person who is affected or likely to be affected by the action, omission or decision of the Company."

The lack of recording and investigating complaints was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010) which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us they felt staff were approachable and visitors told us they were always made to feel welcome and there was a friendly atmosphere. We were told by relatives that relatives and residents meetings were held but one relative told us, "Nothing ever changes".

The home had a programme of audits which were completed weekly, monthly and every quarter. The audits were also completed at different times of the day to ensure the home was functional at all times. We could see these were completed but were concerned some of the areas of concern we found had not been picked up in the homes own audit programme. For example shortfalls in training, accidents and incidents responsiveness, staffing levels and suitability for employment, and medication issues had not been identified. These shortfalls were significant enough that they constituted breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2010. The regional manager completed a quarterly audit, and it was noted the last audit had identified that not all staff were receiving regular supervision.

A customer satisfaction survey had taken place in September 2014. 24 of 56 surveys had been returned and the information from these had been collated. Some of the results showed people were not happy with the service they were receiving. For example only 60% thought the food was either good or very good, only 55% thought activities were good or very good and only 61% thought the care was good or very good. An action plan had been developed to address the areas with the lowest scores. For example a cook from another home run by the provider had been brought in to improve the meals to ensure people received a well presented and nutritious diet.

Incidents and accidents were noted and recorded on the homes computer system. This was to provide an on-going picture of individual concerns or incidents. However incidents and accidents had not always been recorded on the system. This meant the recordings were not an accurate reflection of people's needs. Night staff did not have access to this system to ensure they knew people's needs in relation to any incidents or accidents. The recordings had not been summarised and so there could be no analysis or learning from this information. For example when we asked how many falls there had been over a month on each floor, this information was not available. This meant the lack of analysis prevented staff learning from these incidents to see if there were any emerging patterns.

The lack of a robust quality assurance system was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 Regulations which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not possible to establish if people were directly involved in the development of the service. In some areas we found there was a mismatch of information from what the management told us and what staff told us. For example the registered manager told us the staffing levels were good. However staff told us they had concerns over the staffing levels, the high turnover of staff, and the supervision of staff. Some staff told us they had reported their concerns to the manager about staffing levels but felt they had not been listened to. A staff member told us they and other staff were 'scared' to talk to the registered manager and the clinical lead. The manager also told us all staff could access the computerised system, however when asked, the staff on duty in the evening told us they were not able to access this information.

Staff told us they had their own values but were not sure what the values of the organisation were. Staff felt supported but this tended to be by their peers and by the person in charge of the floor. There had been recent changes in the leadership to bring about improvements in the quality of the service provided. Staff were aware of these changes but felt some of the issues of staff not performing were not addressed by the management of the home.

The handover of information on people's needs was handed over at the start of each shift from nurse to nurse or on the ground floor from the senior carer to the next senior or the most senior carer on duty. When there was time this information was passed onto the other care staff. For example, we listened to two handovers on one floor, and the basic needs of each person were handed over verbally from nurse to nurse. However, the care staff were already engaged in providing care to people, which did not stop, so we were unsure when they caught up with the handover of information.

Inadequate

Is the service well-led?

Care records were not accurate, up to date and did not give staff adequate information to care for people. For one person we noted they had been prescribed a medicine for oral thrush. However the records showed their last oral assessment had been five months previously. Care records did not detail information on what staff should do if someone fell and we noted care records were not updated when people had a fall. For example a person fell in connection with their poor fitting clothes. The care plan was not updated to remind staff to check the person's clothing to try and prevent further falls. The care records relating to people's behaviour and the monitoring of their behaviour were not accurate or updated to reflect incidents. For one person there was four recordings of physical contact in a two month period, however the behaviour risk record was not clear on how to support this service user. Inconsistent records placed people at risk of receiving care and treatment that does not meet their needs.

This lack of accurate record keeping was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (2)(d)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.