Woodlands Manor Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 18 and 19 October 2018. When we inspected the service in January 2018 we rated the service as overall Requires Improvement despite recognising that improvements had been made. There was one breach of the legal requirements. Previous to that inspection the service had been rated as Inadequate, was placed the service in special measures and enforcement action was taken.

Woodlands Manor is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and nursing care for up to 40 people, however two bedrooms that were registered as shared rooms were only used by one person. At the time of this inspection there were 30 people in residence and two people were in hospital. There were two vacant rooms and four rooms were out of use because of the building works.

An extension was being built to the right side of the building. To the left of the building the area behind the car park was being used to store pile of rubbish, empty barrels and building materials. The area was not cordoned off and was unsightly. Although we have reported on this in the last three inspection reports , the provider has not taken any action to tidy and make safe, this area. We asked an inspector from the Health and Safety Executive to visit the site and check on building site safety. Relatives who had been asked to provide feedback about Woodlands Manor had commented about the rubbish and the appalling mess.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was also the registered provider.

Why we have rated the service as Inadequate.

The management of medicines was not safe. We found gaps on the medicine administration records for several people and two people who needed pain relieving medicine had not received their medicine as prescribed. The records to show that topical creams and ointments had been applied as prescribed were poor with no staff signatures and for one this meant they had sustained pressure damage because barrier cream had not been applied. We found that the auditing of medicines was not effective.

Risk management procedures did not take a holistic view of each person and we found that where two people had serious risks to their health and well-being, the risks were not being managed to ensure the risk was eliminated or reduced.

Improvements were still required with infection control and prevention procedures. The infection control audits were ineffective and did not cover all aspects, for example bed mattresses were not checked to

ensure the covers were undamaged and the foam inserts were clean. Slings and slide sheets, moving and handling equipment was still being shared between people because there was not enough to go round. We observed laundry staff not following best practice when collecting washing for laundering. Workman from the building site were seen to be accessing the kitchen area and not putting on personal protective clothing.

The provider could not demonstrate training and supervision as we were told there had been computer failure and the records had been lost. The service had changed their training provider since the last inspection and all staff were expected to complete every module of the on-line training programme. The registered manager had not arranged specific training that was talked about at the previous inspection in January 2018 and had not shared learning with the rest of the staff team following a 'resident for the day' exercise. This was a missed opportunity to improve staff approach, communication and attitudes.

People were not always looked after with respect and some staff did not speak nicely to them. On two occasions it was senior members of the staff team who did not talk respectfully about people and this does not demonstrate a good 'leading by example' means of improving staff attitudes. People's dignity was not always maintained and we have referred to an example in the main body of the report where improvements were needed.

People may not receive person centred care which is responsive to their particular care and support needs. Concerns have been raised regarding the standard of care given to five people and this was being investigated by the safeguarding adults team in South Gloucestershire Council.

The registered manager had introduced a new quality assurance system in order to check on the quality and safety of the service. The audits we saw were did not identify any shortfalls and did not cover all aspects of the service. Many of the audits were tick-box responses and where shortfalls has been identified, there was no action plan to address the issue. The audits had not picked up the breaches of regulations we have found in this inspection.

We found that improvements were required with care records and other records related to the running of the service. This included the room folders where staff were expected to monitor food and fluid intake, repositiong and topical medicines administration where applicable. The records were not maintained accurately or consistently. Medicine records were also not accurate or complete. Incorrect forms were used to report on any accidents, falls or incidents that had occurred.

On a more positive note we received favourable comments about the meals and drinks people were served with and the activities they were able to participate in. Each person was registered with a GP and arrangements were made for them to see the GP and other healthcare professionals as and when they needed to do so.

The number of nurses and care staff on duty each shift was calculated based upon the level of care and support needs for each person who lived at Woodlands Manor at that time. This was reviewed on at least a monthly basis or whenever any changes were identified. The recruitment of new staff to the service followed safe recruitment procedures to ensure unsuitable staff were not employed.

Staff were aware of the need to gain consent from people before offering care and support. The service worked within the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted to the local authority where people were unable to consent to live at Woodlands Manor. The procedures in place for assessing people's care and support needs prior to admission to Woodlands Manor ensured any placement in the service was appropriate.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can what actions we told the provider to take in the full version of the report.

The service has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve.
•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

On Thursday 15 November Woodlands Manor Care Home entered administration. Since that date CQC have been working with the administrator and the care management team employed by them to manage Woodlands Manor Care Home.

CQC are assured by the steps taken to ensure that people living in the home are safe and that the shortfalls identified in this inspection report are being addressed. The new care management team are voluntarily providing CQC with weekly updates on their progress in addressing the shortfalls, ensuring people are safe and how they are improving the quality of care provided at Woodlands Manor Care Home.

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.

Medicines were not managed safely and infection control procedures were not robust. This places people at risk of harm

Important risks to people's health and welfare were assessed but had not always been mitigated. Plans to reduce or eliminate those risk and protect people from harm were either not in place or not followed.

The staff team received safeguarding training and knew what to do to protect people from harm. There were safe staff recruitment procedures in place and staffing levels for each shift were reviewed and adjusted as and when required.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

Improvements were required to ensure the service could demonstrate that the staff team were well trained and well supported.

Some people were provided with sufficient food and drink but where there was risk of malnutrition or dehydration, the staff did not accurately record how much people had eaten and drunk. Where people were at risk of choking people may not be provided with the right food types.

Peoples care and support needs were identified but they may not receive the level of care they need. Staff ensured the GPs and other healthcare professionals were involved in people's care when needed.

People were asked to consent to care and support. The service worked within the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), making applications to the local authority where necessary.

Is the service caring?

Requires Improvement

The service not always caring.

People were not always treated with respect and some staff did not speak kindly to them. People's dignity was not always maintained.

Some staff provided kind and caring assistance and ensured people had a say in how they were looked after.

People who were able to were encouraged to have a say regarding what activities took place, the meals provided and were involved in care reviews.

Is the service responsive?

Requires Improvement

The service was not always responsive to each person's needs.

Changes to people's health care status were not always acted upon in a timely manner

The assessment and care planning processes did not ensure each person received the care and support they needed.

People were able to participate in a range of different social activities.

Any complaints were handled according to the provider's complaints policy but issues raised were not used as a means of driving forward with improvements.

Is the service well-led?

Inadequate

The service was not well-led.

The leadership and management oversight of the service and their quality assurance measures were inadequate.

Records were not compete and accurate.

The provider did not learn from incidents, complaints or concerns raised in order to reduce or eliminate the chances of the event reoccurring again.

Woodlands Manor Care Home Limited

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 follow up on the actions we asked the provider to make following the last inspection. We also checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of three adult social care inspectors, two of whom were familiar with the service and their inspection history.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to the CQC. A notification is information about important events which the service is required to send us by law. We also looked at information which had been shared with us regarding Woodlands Manor Care Home. We received information from three health or social care professionals prior to our inspection. We used the information they provided to guide our inspection. Since June 2018 organisational safeguarding monitoring by the local authority had ceased because sufficient improvements had been made by the service.

During the inspection we spoke with 11 people who lived at Woodlands Manor and four visitors who were with their relatives. Some people were not able to talk with us about their care, because they were living with a degree of cognitive impairment or were physically frail. Therefore, we spent periods of time during the inspection when we observed care being delivered and watched the interactions between people and the staff. This helped us to understand the experience of people who could not talk with us.

We spoke with the registered manager, the clinical lead nurse, plus seven other members of staff (qualified nurses, care staff, activities staff, catering and housekeeping staff).

We looked at five people's care records in full and other care records in order to check out specific details. We looked at three staff recruitment files, staff duty rotas and other records relating to the management of the home. These included audits to check on the quality and safety of the service, some key policies and procedures and feedback received from people living in the home and relatives.

Inadequate

Is the service safe?

Our findings

Medicines were not managed safely. The service has a history of poor management of medicines. A warning notice was issued after the June 2017 inspection. When we inspected the service in January 2018 we found that staff had made improvements to address the issues raised in the warning notice, so people's medicines were managed safely. At this inspection we have found that again the management of medicines was unsafe.

We looked at the medicines administration records (MARs) for each person living in the home. In several places we found there were gaps in recordings which meant people may not have received their medicines as prescribed. We discussed these with the clinical lead nurse. We were told the omissions had been discussed with the relevant qualified nurses. For one person, one specific medicine had not been signed as administered on four consecutive days, although the tablets were missing from the blister pack. This meant the provider could not be sure these medicines had been given to the person. From checking the MARs we identified two people who were prescribed pain relief medicine in a patch, had the patch changed two days later than prescribed. There was no explanation as to why this had happened. For these two people this meant their pain control had not been managed correctly.

We also found that prescribed daily food supplement drinks were not being signed as given, for one person there were only four signatures for the month of September 2018. Some MARs had been handwritten by the qualified nurses. Whilst these had been checked by another member of staff to ensure instructions had been transcribed correctly, there was no stock number recorded. Records showed the clinical lead nurse had identified omissions in the medicines fridge and clinical room temperature recordings. In October 2018 eight days had been missed up until 18 October. This shortfall increased the potential for medicines to become ineffective by being stored at the incorrect temperature.

Care staff tended to apply topical ointments and creams when they were assisting with personal care tasks. A health care professional had raised concerns with us, that topical barrier creams was not being applied to one person's sacrum and this had resulted in pressure damage. We saw records to show that topical administration competency checks had been signed off for 16 out of 37 care staff in December 2017 or January 2018. The other 21 care staff had not been observed and this was discussed with the registered manager and the clinical lead nurse. No explanation for this was given. At this inspection we looked at topical medicine administration charts and found many gaps in recordings. This meant the provider could not be sure these creams had been applied to the person. We found a prescribed topical cream in the fridge for one person, dated 4 October but this was not written on the MAR or being applied and their skin condition was not being treated. The clinical lead nurse was unable to explain why this was so.

The provider and registered manager had not ensured effective medicines audits were undertaken. As part of the providers quality audit systems the medicines records were supposed to be checked on a monthly basis. The last MAR audit we saw had been completed in March 2018. The registered manager and clinical lead nurse said that further audits had been completed however these were not located for us or provided post inspection. Medicine audits were not completed robustly, ensuring that checks covered all medical

items and expiry dates.

This is a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Serious risks to people's health and well-being had not always been assessed and mitigated. For one person who was at risk of choking, the guidance information provided by the speech and language therapy team (SALT), was ignored and at meal times they were being given food items that had to be avoided. For another person (recently moved away from the home), although there was a past history of attempted suicide, there was no risk assessment in place. Over a seven day period between 7-13 October 2018 they had been found with the call bell cord around their neck on four occasions. The staff had not identified this as a risk and taken appropriate action These failures to manage risk appropriately could potential cause serious harm to people or even death. Staff completed a routine set of risk assessments for each person (use of bed rails, falls, nutrition, moving and handling tasks, continence and skin integrity). A moving and handling plan was written for those who needed assistance to move from one place to another. These plans included information about what type of equipment was to be used, the type of sling and number of care staff required. Three members of staff had completed a train the trainer course to enable them to assess people's moving and handling needs and write safe moving and handling plans.

This is a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control and prevention measures had been insufficient when we inspected in June 2017 but in January 2018, although some improvements had been made there were still areas which needed to be addressed. At this inspection we found that moving and handling hoist and slide sheets were still being shared between several people because there was not enough of them. The registered manager said they had purchased some additional equipment but had not achieved their aim to provide individual slings for people. On one occasion during this inspection, we observed care staff using the same sling to transfer three people, one after another from wheelchairs to lounge chairs. This increasing the risk of cross infection from one person to another. We also observed a member of the laundry staff de-canting used items from one laundry basket to another, wearing gloves but no protective apron over their clothes.

During the inspection we observed three workman using the kitchen door to enter and exit the building. We also saw the workman entering the kitchen from the doorway inside, leading off from the corridor. They were not wearing personal protective equipment (PPE). There was a sign on the door saying "Do not enter without PPE".

Prior to this inspection a healthcare professional advised us of poor infection control practice. Syringes that were used to flush though gastric feeding tubes had been left uncovered in the person's bedroom. At the time of the inspection no person had a gastric feeding tube, so we were unable to check whether this practice continued.

This is a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection organisational safeguarding monitoring by South Gloucestershire Council had ceased in June 2018. However, recently, four safeguarding concerns had been raised by health and social care professionals. These concerns were in the process of being investigated and were in respect of the standard and quality of care. The service was not ensuring that care and support was planned and

delivered in a way that enabled all a person's needs to be met. Because the care staff and nurses were not following agreed care plans and completing monitoring forms correctly, people could be at risk of harm.

Infrared sensors were fitted in people's rooms and on their door frames in order to alert staff should they get out of bed. The registered manager stated these were only in use for people who were at risk of falling and where consent had been sought.

Personal emergency evacuation plans (PEEP's) were prepared for each person. These detailed the support people required if the building needing to be evacuated in the event of fire or other emergency. The plans contained a sufficient level of detail. These documents were kept in the red grab box located in the office and available to the staff member in charge.

There was a regular programme of checks of the premises, facilities and equipment. These were either completed on a weekly, monthly, quarterly or six monthly basis. Records evidenced that all the necessary checks had taken place in respect of fire safety, hot and cold water, equipment and emergency lighting. Since the last inspection a new maintenance person had been recruited. Not all the checks had been signed by the maintenance person but the registered manager could not tell us whose signature it was. The maintenance person was not available at the time of the inspection to check this out.

A review of the fire risk assessment had been carried out in December 2017 and will be fully reviewed for the whole of the premises when the new extension is ready for occupation.

At the time of this inspection there were 30 people living in Woodlands Manor. Staffing levels were adjusted depending on the number of people in residence and the collective dependency needs of people. At the time of this inspection there were two qualified nurses and six care staff during the morning shift; four or five care staff and one nurse during the afternoon and evening; and two care staff and one nurse overnight. Staff rotas for the last four weeks confirmed these arrangements. The clinical lead nurse used a dependency tool to determine safe staffing levels. We received a mixed response from staff about whether they felt the staffing levels were adequate with comments such as, "It would be great if we had more time to spend with people" and "it would be lovely if we could take part in the activities and have fun".

In addition to the care team there were housekeeping, maintenance, catering and activities staff employed to meet the daily living needs of people living in Woodlands Manor. The registered manager worked their hours from Monday to Friday. The clinical lead nurse was also supernumerary to the staffing numbers, however would cover shifts if necessary.

We checked the recruitment files of three new staff who had started working at the home since the last inspection. Safe recruitment procedures were followed - an application form, an interview assessment and pre-employment checks had been completed, including a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for convictions that may prevent them from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Individual staff training records were not available. The service was unable to share the staff training matrix with the inspection team because this had been lost when a computer failed which meant the provider could not demonstrate all staff had received the mandatory training and updates. Staff we spoke confirmed they had received training and this included moving and handling, safeguarding vulnerable adults, fire safety and first aid.

When we inspected in January 2018 the service had changed their training provider because of concerns regarding the training package they had been using. The registered manager told us when we arrived to start this inspection they had changed their training provider again and all staff were expected to work through the new training modules. The staff were aware there was a new set of on-line learning modules they needed to complete. There was an induction training programme for new staff which met the requirements of the Care Certificate (a minimum set of standards that all health and social care workers should meet). The completion of the Care Certificate was overseen by the care supervisor and clinical lead nurse. At the inspection in January 2018 we were told that face to face training was being organised in respect of dementia awareness and sepsis, but this had not happened. These frequent changes and lack of a training matrix have increased the risk of confusion about who had done what or if they'd done anything at all.

Care staff were encouraged to complete recognised qualifications in health and social care. At the last inspection 85% of the care staff team had either achieved a level two or three award or were working towards this. The registered manager was working towards the level five award in leadership and management.

Prior to the inspection in January 2018 one of the staff had completed a 'resident for the day' exercise in order to experience what it felt like to be 'looked after at Woodlands Manor. Following the exercise the member of staff had reflected on how the care she received made her feel. They talked about being welcomed on admission, being offered refreshments and noticed the smiley staff. The negative feelings they had were in respect of being scared about the stand aid, the plain plastic beakers, feeling a nuisance when wanting the toilet and a feeling of being abandoned when left alone sat at the table after lunch. They also said they felt they had waited at the table for half an hour but it was only five minutes. The staff member said the registered manager was going to be using this reflective report as a training exercise with the rest of the staff team. It was very disappointing to find that these experiences had not been shared with the staff team and was a missed opportunity to improve staff approach, communication and attitudes.

In order to check on the quality of care people received at night, the registered manager had made a number of unannounced night-time visits to the home. These had been carried out on a monthly basis but out of nine visits this year, only one had been undertaken during the early hours of the morning (1.30am until 2.45am). Five had been undertaken not long after the night staff had started working and one had been carried out at 6.30am in the morning. The report detailed the findings in respect of safety, observations made on entering the home, staff dress and records inspected. These checks had failed to pick

up any concerns including that room charts were not being checked by the nurses at the end of their shift.

Since the last inspection there had been a change in the programme of staff supervision. This was now shared between the registered manager, clinical lead nurse and the care supervisor. Supervision is where a member of staff meets one to one with their line manager and is able to discuss their performance and any training needs. Staff confirmed they had received supervision but not regularly. Whilst the majority of staff said there was a good staff team a number of staff said there were some who "did not pull their weight".

People were on the whole positive about the care and support they received and were content with life at Woodlands Manor. One person said they had lived there for four years and had "got used to the routines and the staff". Another said, "I like some staff more than others. Some can be a bit surly. I like the friendly staff who like to have fun. They all have a hard job to do and it is just some do it better than others". Those relatives we spoke with also commented that the care staff worked hard and generally their family member was well looked after.

Pre-admission assessments were carried out by the registered manager or the clinical lead nurse prior to people moving in to Woodlands Manor. These assessments covered all aspects of the person's daily life and identified specific care and support needs. These measures should ensure Woodlands Manor was the right place for the person and the staff team had the necessary skills and experience to meet the person's care and support needs.

People made positive comments about the meals and the drinks they were offered. The registered manager told us there had been some changes with the catering team and they had a new second chef in post now. Feedback from people regarding the previous second chef had not been so good, and the registered manager had taken appropriate action. Risks regarding malnutrition and dehydration were identified during the assessment process, reviewed on a monthly basis but increasing risk was not always acted upon (see safe section). Body weights were generally re-checked on a monthly basis but where people had lost weight, they would be weighed weekly. The risk of choking was not always assessed and staff were not always adhering to guidance provided by the speech and language therapy team (SALT) (see safe section)

Where there were concerns regarding the food and fluid intake with an individual person, monitoring charts were put in place. For one person who was at risk of weight loss and dehydration, their prescribed food supplement drinks were not being given. The records we looked need to be improved and we have referred to this in the well led section of the report (breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. It was evident the nurses were not checking the correct completion of these charts at the end of their shifts. When we inspected in January 2018 we had also found inconsistent practice which required improvement.

People said, "The food is very nice, lovely", "Lunch was excellent. I always looked forward to my meals", "We get plenty of food and drinks and you can always ask for another cup of tea" and "I like the homemade cakes in the afternoon. I have a sweet tooth". During our observations of the lunchtime experience we saw that the meals came out of the kitchen ready plated, the staff encouraged people to be as self-managing as possible, but were attentive to the needs of people who required assistance. Some people were served their meals in their bedroom. One person in their bedroom was sat in the comfy chair and their meal was balanced on the arm. The person was twisted round and eating her meal. We also saw one other person who was sat on the bed and their plate was on a low bedside table. They both told us it was not comfortable but they always had their meals served this way. Neither of these people had a good meal time experience. The staff had not identified or considered this was an issue where they could make improvements.

Since the last inspection there has been a further change in the allocated GP contracted to provide health care support to Woodlands Manor. The GP told us they had no concerns regarding the care their patients received and that any instructions they left were acted upon. The GP told us they visited Woodlands Manor each Thursday for a 'ward round' and relatives were able to make appointments via the registered manager if they wanted to discuss their family members' care. The GP said they were always asked to see people in a timely manner and could visit people at other times as well, as and when needed.

Other healthcare professionals that were involved in people's care included continuing healthcare nurses (CHC), occupational therapist and physiotherapists, speech and language therapists and foot care specialists. The service made appropriate referrals to other services as and when these were required.

Woodlands Manor is a purpose built care home, registered to accommodate up to 40 people. All bedrooms rooms were furnished with nursing profile beds but we noted that a significant number of the integral bed rails were worn and shabby. Comments made by health and social care professionals prior to the inspection also referred to worn and rusty bed tables and commodes. Members of the inspection team noted these as well. This was discussed with the registered manager during the inspection who advised there would be a refurbishment programme once the new extension was completed. The majority of bedrooms had en-suite facilities of a toilet and wash hand basin. Bedrooms were fitted with a telephone socket, TV point and a nurse call bell system. There were sufficient assisted bathroom facilities to meet people's needs and toilets were sited near the lounge areas. We pointed out to the registered manager that the flooring in bathroom three was damaged with a raised joined area that could be a trip hazard. There were two lounges and two conservatories. The main conservatory looked out over a large pond filled with koi, and the landscaped rear gardens.

In the last inspection report we wrote this. At the last two inspections, June 2016 and June 2017 building works were in progress. On those occasions we found that unsafe areas of the grounds had not been cordoned off and the building site storage area was unsightly and accessible. Whilst we have recognised that some improvements have been made to the grounds at the front and right hand side of the property, the registered provider must consider complete improvements when the building work is completed at the end of the Spring 2018.

There is a small car parking area to the left of the home. Areas leading off from the back garden which were unsafe for people to access were cordoned off. However, access to an area to the left of the building from the car park was open and unsightly. This area was full of rubbish, building materials and stacked wooden pallets. Relatives who had recently responded on a survey form said the area was, "an appalling mess" and "the car park is too small and the rubbish is unsightly". To the front and sides of the property, the grounds were undergoing building works and an extension was being built on the right hand side. The registered manager said everything would be smartened up when the new extension had been completed. We asked an inspector from the Health and Safety Executive to visit the service following our inspection because we were concerned about building site safety.

The home had their food hygiene rating reduced to two stars in October 2017 following a visit by the Environmental Health food safety team. The kitchen had been inspected by the team and they had found that the flooring in the kitchen was inadequate. The registered manager told us the recommended improvements had been made and the team had revisited but they were unable to locate the paperwork to evidence this. At this inspection we found there was no floor covering around the dishwasher and the flooring by the back door was damaged and had been taped down. The registered manager told us they had planning permission to extend the kitchen area but this would not be started until the extension was completed. The registered manager was not able to give any indication of dates at this point in time.

The service had a policy and procedure in relation to the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Key staff had received more in-depth training in this key area whilst others received basic training. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care and support. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised. At the time of this inspection one DoLS authorisation was in place and the registered manager had submitted a further 11 referrals to South Gloucestershire Council. These had not yet been processed.

During the course of the inspection we heard the care staff asking people to consent before they provided care and support. We heard the staff offering people choices. Examples included being asked what they wanted to eat or drink, where they wanted to sit, whether they wanted to go back to their bedroom and whether they wanted to participate in social activities. As part of the care assessment and planning process a person's capacity to make decisions was recorded. Where the person lacked capacity a record of best interest decisions made on their behalf were recorded.

Requires Improvement

Is the service caring?

Our findings

During this inspection we found that people were not always treated in a kind and caring manner. When we visited in June 2017 we found that people were not always treated with respect and some staff had been unkind and lacked compassion. In January 2018 we only received positive feedback from people and their relatives and we rated this area as good. However, this improvement had not been sustained.

One person came to speak with us and was very agitated about their medicines. One of the inspectors asked a staff member if they could come and reassure her and received a very unsatisfactory response. They said "She is on one today" and "I will go and sort her out". When this staff member approached this person they continued with a disrespectful and uncaring attitude which did nothing to allay that person's anxiety.

Another person told an inspector, "I wish that lot (referring to the care staff) would speak to me nicely". Although the person could not expand on this statement, it does indicate they were not happy with the way they were spoken to.

During the inspection we observed care staff using hoisting equipment to move three people from their wheelchairs in to comfy armchairs. On one occasion whilst being hoisted a person's upper leg and underwear was exposed to the others in the lounge room. The two staff members were oblivious to this happening. One of the two staff members who was carrying out this task was only half concentrating on the task and was being distracted by other activities in the room. They had not interacted with the person at all during the procedure however the other two staff members had chatted to the person they were assisting.

We advised the registered manager and two other staff members at the end of the inspection that one person told us they had eaten their breakfast without their dentures. The answer we received was, "Well they could have asked for them". This response from the management team was disappointing and does not demonstrate a 'leading by example' approach .

Prior to the inspection a social care professional told us that one person had been "told off" by the night staff and was told not to use his call bell. We were unable to ascertain whether this did happen or not.

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

People made the following comments when we asked them about the way they were looked after. They said, "Some staff ask me what I would like to do, but it is a bit hit and miss", "I think I am happy with the care", "The staff are very good but we don't get to see the nurses much except when they bring me my tablets" and "We sometimes have to wait a long time when you call. They come eventually though". Relatives also made comments about the length of time care staff can take to respond to call bells. They told us they were generally satisfied with their family member's care and stated they were able to visit at any reasonable time and invited in for parties for example.

We also observed some very positive interactions between staff and people. We watched one member of staff trying to gently coax a person to have a drink. They were knelt down at the person's eye-level and was speaking to them with a caring tone of voice. On another occasion we heard care staff asking a person if they were comfortable and then assisting them to change their position.

Visitors were warmly welcomed to the home and it was evident good relationships had formed.

The registered manager kept a log of complimentary letters and cards received. Comments included, "Our heartfelt thanks for all your help. You have looked after us (family) and you have brought him back to good health", "The care you gave to mum was second to none" and "Thank you for all your help, support and friendship".

The staff team knew the importance of finding out about people's individual preferences. People were encouraged to make decisions about the activities they would like to do. People had also been asked to have a say about the meals they were offered. In September 2018, 20 people had responded to questions they were asked about the current menu plan. They all said they were happy with the current menu, but wanted more fruit and vegetables, meals to be hotter and smaller portions. The findings had already been discussed with the catering staff and changes made. Where possible, people were involved in making decisions about their care and support.

Requires Improvement

Is the service responsive?

Our findings

People said, "It is very nice and the staff are very helpful to me. They do what I want", "I believe I am looked after properly", "I get enough to eat and drink and they keep me clean and entertained. No complaints from me" and "I am allowed to walk around whenever I want". Relatives also said they felt the service was responsive to their family members care and support needs but did make comments about call bell response times and a lack of activities for people confined to their room or bed. They told us, "My husband has not been here long so at the moment I am visiting every day. It all seems OK at the moment but it is early days" and "The activity staff do their best to include everybody but it is not possible for them to take a lot of residents out on trips because they are too unwell".

Despite the positive comments we received from people and relatives regarding the care and support they received, the service has recently failed to respond appropriately to individual people's specific care needs. One person had recently been admitted to hospital and was very unwell. Concerns were raised by the ward staff regarding the way this person's diabetes condition had been managed. On this occasion, the person had presented with symptoms related to very high blood-glucose levels for an 11 day period before admission. The registered manager had explained to the investigating team this had been brought about because agency nurses had been covering shifts and had not responded appropriately to changes in the person's health care needs. This explanation was unacceptable and further indicates a lack of oversight by the senior members of the management team.

We were made aware by social care professionals of two people who had until recently, lived at Woodlands Manor. Neither were happy with the way they had been looked after and did not think the staff responded to their specific needs. One person had been moved to another care home and the other was admitted to hospital and then stated they did not want to return to this service. Health care professionals had also made us aware of two other people where there were concerns about the way they were looked after.

This is a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

People's care and support needs were assessed and a care plan written detailing how their needs were to be met. Care plans were being written by the registered manager, clinical lead nurse or nursing staff. The plans we looked at included people's likes and dislikes and what was important to that person. They also provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, managing continence and wound care management (where required) for instance. Some minor updating was required with some aspects of the care plans and we fed this back to the registered manager and clinical lead nurse at the end of the inspection.

Some care records were kept in people's bedrooms and improvements were required with the quality of some of these records. We have reported on these in the well led section of the report when referring to other records, where improvements were needed. Feedback from health and social care professionals show they continue to have concerns regarding the quality of these care records in particular food and fluid intake

charts and the staff being slow to respond to weight loss.

There was a programme of meaningful social activities arranged throughout the week which people could choose to participate in. There were three activity organisers (AO) and care staff helped out when they had time to be able to support people. People were asked about their hobbies, interests and what they liked to do. Where possible these were incorporated in to the activity programme. The activity programme consisted of a mixture of in-house activities and external entertainers. On the first day of our inspection there was an armchair exercise session and approximately 12 people took part. Also on day one, two people visited a garden centre and then went to the pub with activity staff. One of the activity staff told us they had taken one person on a personal shopping trip because they wanted to buy a new jacket. The activities staff arranged for one resident who was a very big fan of a well known singer, and two others to go to the cinema and see a live streaming of a concert. These were two examples of a person centred approach to meeting people's social needs.

In August eight people had visited Avon Valley Railway and in September, 11 people had gone to Slimbridge Bird Centre. One person, despite being quite poorly had been very keen to visit Slimbridge and extra staff support had been arranged to enable this to be achievable. Photographs were always taken of any activities and shared with people and relatives.

The previous week, friends and families had been invited in to the home to attend a breakfast event. We were told that 'supportive families' had attended and money was raised for the resident's fund by a raffle. On day two of the inspection the service had a charity fund raising day, staff were encouraged to wear something pink and iced cupcakes were on sale.

People and relatives said they felt able to raise any concerns they may have and thought they would be listened to. One person who no longer lived in the home had told their social care professional they had made 'many complaints', but their care records did not refer to any concerns or unhappiness (it was acknowledged they had not wanted to be at Woodlands Manor and had already moved from two other care homes). This was discussed with the registered manager who assured us no complaints were received from this person.

The registered manager kept a complaints log and had recorded 12 complaints since the last inspection in January 2018. We looked at the records that were kept for each of the complaints which showed that each of them had been handled correctly. Five of these complaints had been raised with CQC and been passed to the registered manager for investigation and response. A copy of the complaints procedure was included in the homes brochure and a copy was displayed in the reception area. The registered manager had not used the information from these complaints to look for any trends to identify where improvements to the service could be made.

At the time of this inspection the service was not looking after any person who was at the end of their lives. The clinical commissioning group and continuing health care (CHC) team have continued to not use the service because of their concerns regarding the standard of care for very poorly people. Where the health status of people already living in Woodlands Manor deteriorated and they required end of life or palliative care, the CHC team would visit and assess for health funding. The CHC nurses continued to have concerns regarding the staff teams ability to provide good end of life care.

Where decisions had been made regarding a person's wishes in the event of a sudden collapse, a do not resuscitate form was placed in their care file. The service used the formal nationally recognised Resuscitation Council forms approved for use across all care settings. We looked at a sample of these and

found they had been completed correctly. Where people had appointed a member of the family to have power of attorney, this was recorded in their care notes, and the registered manager had a copy of the document on file.

Inadequate

Is the service well-led?

Our findings

The provider had failed to make sustained improvements in the safety, management and leadership of the service. When we inspected this service in January 2018 we found that improvements had been made in the leadership and management of the service but improvements were still required. We rated the service as Requires Improvement in this area. This was because there was a repeated breach of regulation 17 of the Health and Social Care Act (2008) Regulated Activities 2014: Good governance.

In order to check that the service had made improvements in respect their governance arrangments we looked a number of different records and their quality assurance systems. We also checked to see that the nurses were leading shifts and checking care documentation at the end of their duty. At this inspection we found the provider had continued to breach regulation 17 for the third inspection.

There was inconsistent clinical leadership due to turnover in nurses employed at the service. In January 2018 the clinical lead nurse had been in post for approximately six months, four qualified nurses had been employed and one other nurse was completing orientation shifts before joining as a bank nurse. We had talked with those nurses about leading their shifts and monitoring the care staff to ensure people received the care and support they needed. It was evident from our findings that this had not been happening.

At this inspection we found there had again been changes within the nursing staff team. Three of the four nurses had left Woodlands Manor but six nurses had joined the team. The service was using agency nurses to cover night duties and generally the agency provided the same nurses for continuity. However, the work performance of the agency nurses was not being monitored by the registered manager or deputy/clinical lead nurse. The provider/registered manager was no longer using a healthcare consultant to help them make improvements in the service, apart from occasional calls for advice.

The registered manager was continuing to work towards a level five health and social care qualification in leadership and management. Their assessor told us the registered manager was about half way through the course but the clinical lead nurse was taking a 'three month' break from the course. The clinical lead nurse was a qualified nurse and worked 40 hours per week, mainly supernumerary hours but did cover shifts as a nurse. Concerns had been identified regarding the night staff (nurses and care staff) therefore the clinical nurse was going to be covering some nights with those staff. The registered manager had failed to act on these concerns until now because of the ineffectiveness of their night time checks This was to assess work performance and then make improvements. The registered manager worked in excess of 40 hours per week in the service. Qualified nurses covered the full 24 hour period.

We found that not all records were maintained accurately, were complete or fit for purpose. For example accident or incident records were incomplete. We looked at six accident records that had been completed in the previous four weeks. Accidents that had happened in September 2018 had not been followed up at 12, 24 and 36 hours as per procedure or been checked and signed by the registered manager. One form did not have the name of the person recorded on it and another only had their first name. Two forms where an accident had happened had been recorded on an 'untowards incident form', one of them by a qualified

nurse. 'Untowards incident' had been crossed out and 'Accident Form' written as a heading.

In the controlled medicines register we found incorrect recordings on page 40. This was in respect of medicines received in to the home from the supplying pharmacy. One medicine patch had been received on 29 September 2018 but then the balance recorded on the same day was nil. However, the MAR for the relevant person did not have a signature to state the patch had been applied, but it did show the patch should have been changed three days before. The clinical lead nurse had not picked up this discrepancy nor was able to provide an explanation.

We looked at care records kept in people's bedrooms. At the start of the inspection the registered manager advised us there was still concerns with the completion of these and they were trialling a new form. Monitoring forms were put in place where there were concerns regarding food and fluid intake, skin integrity for people who were less mobile (repositioning charts), bowel charts and topical medicine administration charts. With food charts there was inconsistent recordings in respect of food eaten, fluid charts were not totalled up at the end of a 24 hours period and repositioning records did not state the frequency this should happen and were not consistently completed. It was evident the nurses were not checking care documentation at the end of their duty, which may mean people were not receiving the care and support they needed.

This is a breach of regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had purchased a quality assurance system since the last inspection and we looked at this. There was no plan in place to state how often each of the audits should be completed and there had been no consideration as to whether the audits were robust enough to identify any shortfalls. We looked at these audits and found they had not identified the shortfalls found at this inspection.

One example was the infection control audits which were completed in two parts. Part one had been completed on a monthly basis since June 2018 and on each occasion scored 97.45% with no evidence of actions being taken. Part two of the infection control audit was also repeated on a monthly basis, and scored 100% each time. Neither part one or two of the audit had included a check of the bed mattresses and visual checks of all items of nursing equipment. The audit had also not identified there were insufficient slings and slide sheets, and the damaged kitchen flooring.

We looked at the 'bedside folder's audits, where six folders had been audited at a time. In February 2018 the audit had scored 80% and in March 2018, 77%. There was an action plan after the February audit and the shortfall had been addressed. There was no action plan following the March audit and no records of any further audits.

A dietary care and nutrition audit had been completed on a two monthly basis up until June 2018. The audit had been completed by the registered manager and the care supervisor and neither the chef or kitchen staff had been involved. The written text in the June 2018 audit was word-for-word the same as the previous audit. The audit tool did not make any reference to adherence in meeting people's specific dietary requirements, that food supplements were not being given or some people's poor dining experience.

Other audits were completed in respect of call bell response times, menus, medicine charts, staff files, care files and health and safety. The health and safety audit completed in June 2018, completed by the registered manager had not covered the external areas of the home.

The quality assurance systems did not effectively identify shortfalls in the quality and effectiveness of care provision and the various audits were undertaken in a perfunctory manner. This meant the registered manager was not able to drive forwards with making improvements or sustain the improvements that had been made at the last inspection.

This is a repeated breach of regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had an open door policy and both people living at Woodlands Manor and their friends and relatives, plus the staff team can request to see them at any time. They said they encouraged relatives to discuss any concerns they may have to try to avoid an official complaint.

Woodlands Manor liaised with professionals in the local community for example GP's, the local hospice service, the dietician and the speech and language therapy team (SALT) and the care home liaison team. The registered manager and clinical lead nurse had attended the care home providers forum hosted by South Gloucestershire Council in the past to ensure they kept up to date with best practice.

The registered manager was aware when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. The CQC use information sent to us via the notification process to monitor the service and to check how any events had been handled.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider must ensure that people are treated with respect and dignity at all times. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider must ensure risk assessments processes are robust and all steps have been taken to mitigate any risks that have been identified. Regulation 12 (2) (b). The registered provider must ensure the proper and safe management of medicines Regulation 12 (2) (g). The registered provider must ensure there are measures in place to prevent and control the risk of infection. Regulation 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider must ensure there is an

effective system of processes in place to monitor the quality and safety of their service. This is a repeated breach of the regulation.

Regulation 17 (2) (a).

The registered provider must ensure records are maintained securely, are accurate, complete and contemporaneous for each person. These are to include a record of the care and support to each person.

Regulation 17 (2) (c).