Hexon Limited

# Woodlands Nursing Home

**Inspection report**

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## Ratings

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|---|---|
| **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 scheduled inspection took place over two days on 10 and 11 March 2015. It was unannounced. There were no breaches of regulations at the last inspection which took place on 25 March 2014

This is a service which provides personal and nursing care for older people some of whom are living with dementia. It is registered for 34 people, but on the day of inspection there were 22 people living at the home. The local authority had discussed with the service a voluntary suspension on funded admissions which the nominated individual had agreed to. This is because the local authority had concerns about the safety and quality of care at this service. The home had a registered manager until the end of February 2015. At the time of the inspection there was no registered manager in place although a new manager had been appointed, and was due to start in their new role on 16 March 2015. They have subsequently done so but are not yet registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

# Summary of findings

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.

On the 10 March 2015 there were two managers on duty who were registered for other establishments owned by Hexon Ltd. We have referred to these members of staff as 'the manager' throughout the report.

We walked around the premises accompanied by one of the managers. We found the premises were dirty and unhygienic. Toilets and bathrooms were dirty and the flooring was dirty in every toilet we saw. It was damaged in two toilets on the first floor. Bedrooms were dirty; windowsills were dirty and covered with dust. The laundry room was dirty; the floor was dirty and difficult to clean as it was damaged and uneven. There was no way of keeping soiled and clean laundry separate because of the lay out of the room. This was an infection control risk. Surfaces were cluttered and dirty and an infection control risk. Lounges and dining areas were dirty; furniture was dirty and soiled, there were stains and marks on walls and soft furnishings. The kitchen appeared to be clean and the latest food hygiene rating awarded in February 2015 was 4, where the highest is 5 and the lowest 1. (The food hygiene rating or inspection result given to a service reflects the standards of food hygiene found on the date of inspection or visit by the local authority.) People were not protected from the risk of infection because the environment was not maintained in a hygienic clean state. You can see what action we asked the provider to take at the back of the full version of the report.

The environment of the home was not well maintained. There were holes in some walls and ceilings. In one room a radiator had come loose from the wall and was a danger to the person whose bedroom it was. A number of light bulbs were not working in rooms and corridors which meant people were at risk of falling when they could not clearly see where they were going. The steps to the outside of the home were not well defined and were a tripping hazard. The maintenance book was missing and so there was no clear way of organising jobs which needed to be done. There were no assessments of risk for the environment in place which meant people were at risk of harm. You can see what action we asked the provider to take at the back of the full version of the report.

Staff were not effectively deployed in the home so that the lounge which specialised in caring for people with a dementia were short staffed at times, at other times the lounge for people who required nursing care was short of staff. Agency staff were sometimes on the rota at the weekends without a manager present. This meant that people with little experience of the home and the people who lived there were on duty without management support which meant there was a risk that people would not have their needs met. Skill mix and experience had not been effectively considered in drawing up rotas so that people did not benefit from a range of skills and experience at all times. This placed people at risk of not having their meets fully met.

Medicines were safely managed, although some medicines needed to be disposed of as they were out of date.

Staff were not receiving regular or effective supervision or appraisal to support them in their role. You can see what action we asked the provider to take at the back of the full version of the report.

The use of monitoring tools for nutrition and hydration was inconsistent which meant people were at risk of not having their needs met. People had not been cared for safely regarding their pressure areas. Pressure ulcers had developed and four safeguarding alerts regarding the way the home managed people's pressure care had been received by the local authority in the past two months. All of these were under investigation, however, it was clear from reviewing individual's care plans that pressure care monitoring documentation had not been consistently used to protect people. Changes in skin integrity had not been acted upon in a timely way to protect people from harm. You can see what action we asked the provider to take at the back of the full version of the report.

The nominated individual had not taken account of published best practice guidance for providing an appropriate environment which promoted the well-being of people living with a dementia related illness. There was insufficient signage to assist people to orientate themselves around the home, there were no objects of interest, rummage boxes or interesting photographs or paintings to stimulate reminiscence and wellbeing. This

# Summary of findings

meant that the environment did not support people's needs in relation to dementia. You can see what action we asked the provider to take at the back of the full version of the report.

Staff received induction and training in mandatory areas so that they had the skills to care for people effectively, however, recording of this was not up to date.

People's mental capacity had been assessed in line with the Mental Health Act (2005) and people were encouraged to make choices about their day to day care. The service had referred those people who may be deprived of their liberty for assessment by the relevant authority. This meant the service had taken people's mental capacity into consideration in planning their care.

People had access to health care professionals and the home referred to these professionals, however, they did not always do this in a timely manner to protect people.

Some staff were kind and caring, others were not skilled or confident at managing the behaviour of people who were distressed or demonstrated behaviour that challenged and they did not assist in a compassionate way. This meant that people did not always receive a kind and caring service.

Although some staff appeared to know people well, care plans emphasised clinical care and did not focus upon social, spiritual, recreational and cultural needs or aspirations. Plans contained inconsistent information about people's life histories and what was important to them. This meant that there was a risk staff would not know people well or be in a position to offer personalised care.

The service did not effectively monitor or assess the quality of care it offered. This meant that people were at risk of inappropriate or unsafe care and that their views and the views of staff did not inform practice. There was a risk that any shortfalls in care practice were not identified and acted upon. You can see what action we asked the provider to take at the back of the full version of the report.

# 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?**

Inadequate

The service was not safe.

Some people told us they felt safe living at Woodlands Nursing Home However, during our inspection we found that the service was failing to provide consistent and safe care.

People were not protected from the risks of acquiring infection because the home was dirty and unhygienic.

People were not protected because the environment was poorly maintained, it was unsafe and there were no environmental risk assessments in place.

People were not protected because staff were poorly deployed within the home. Skill mix and experience were not always considered when organising rotas for staff. Staff were safely recruited.

Medicines were safely handled. However, some out of date medicines needed to be disposed of and audits were not in place to monitor the handling of medicines to ensure they continued to be safely handled.

**Is the service effective?**

Inadequate

The service was not effective.

People told us that they were well cared for but that they sometimes had to wait for attention.

Staff were not supported in their role through supervision or appraisal and this meant people did not receive good care.

The service did not consistently meet people's health care needs including their needs in relation to nutrition, hydration and pressure care.

People did not benefit from an environment which was adapted, decorated or which had adequate signage for people with a dementia related illness.

Staff received induction and mandatory training to protect people's welfare.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA)

**Is the service caring?**

Requires Improvement

The service was sometimes caring.

People told us that staff were kind and caring.

We observed staff kindness and compassion varied according to the member of staff on duty. There were instances where staff showed a caring attitude and other instances where they were less caring and handled situations in a way which did not enhance people's well-being.

# Summary of findings

Staff were not always nearby to intervene if people became anxious or exhibited behaviour that challenged because they were in another area of the home. They were not deployed in a way which ensured people's distress could be dealt with quickly.

People had been assisted to dress in an appropriate way which protected their dignity and respected them as individuals.

The way the home handled pain relief was not always tailored to individual needs.

**Is the service responsive?**

**Inadequate**

The service was not responsive to people's needs.

People told us that they were not consulted about their care. We found that consultation was not routine and that there was no evidence that consultation lead to improvements in the service.

People were not enabled to take part in appropriate, tailored daily activities which were focused upon their preferences.

People did not benefit from care which had been planned to centre on them as individuals and meet their particular social, cultural and recreational needs.

People did not all have ready information prepared which would assist in a smooth transition to another service such as hospital.

**Is the service well-led?**

**Inadequate**

The service was not well led.

People told us that they enjoyed living at the home and that they would recommend it to others.

People did not benefit from effective assessment or monitoring of the service quality.

The management of the service was not effective. It did not protect people or support their well being. The registered manager had left the home and there was a long history of the service being reactive to requirements placed upon it rather than being proactive to improving quality. Previous improvements had not been sustained over time.

People and staff were not effectively consulted or involved in the management of the home. Lines of communication were not clear or effective.

# Woodlands Nursing 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 was an unannounced scheduled inspection over two days, the 10 and 11 March 2015. On 10 March 2015, the inspection team consisted of one adult social care inspector, a specialist nurse advisor 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 by experience who accompanied us had experience of care services for people who were living with a dementia. One adult social care inspector carried out the second visit on 11 March 2015.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority and looked at four safeguarding alerts that had been made. In addition to this, before the inspection we would usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not request the PIR. However we gathered the information we required during the inspection visit.

We made observations of care throughout the first day of inspection. We observed people in two lounges and dining areas. We spoke with fifteen people who lived at the service, eight members of staff and five visitors. We spoke with the managers who were registered for other services owned by Hexon Ltd. There was no registered manager in place. We also spoke with a visiting clinical nurse specialist, a visiting social care assessor, and, prior to the inspection, two health and social care professionals.

We looked at all areas of the home, including people's bedrooms with their permission where this was possible. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at ten care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, maintenance records, staff duty rotas and four staff recruitment files. We also observed the lunchtime experience and interactions between staff and people living at Woodlands Nursing Home.

Inadequate

# Is the service safe?

## Our findings

An infection prevention and control (IPC) visit was carried out on 02 March 2015, where significant concerns were raised about the way the home protected people from the risk of infection.

On the first day of inspection we noted that the home was in the process of receiving a deep clean to the communal areas by an external company. The home had also received a delivery of new pressure relieving cushions. This was in response to the findings of the IPC report which identified that the home was dirty and that pressure cushions were worn, damaged and dirty all of which was an infection control risk. On the second day of inspection the home had a delivery of three new reclining chairs which were to replace worn and dirty chairs earlier identified in the IPC report. An activity cupboard had been tidied following the IPC inspection and items removed from the floor which made it easier to clean. The medical room had been cleaned and tidied.

However we found numerous infection control risks. For example, four of the toilet rooms we looked at were in a poor state of repair; the floors were dirty and damaged. Toilet bowls were dirty and some toilet seats and seat raisers were marked with faeces. Two toilet and bathroom walls were also marked. Chairs in lounges dedicated to nursing and dementia care were dirty and stained. The arms of two of the chairs in the dementia specialist lounge were marked with faeces. Kylie sheets, which are designed for use on individual beds, were being used on chairs for communal use which was an infection control risk. We saw communal bathrooms with dirty and damaged floors, dirty sinks and damaged seals around the wash hand basins. En-suite bathrooms were also dirty, with dirty and damaged floors. We noted that window sills were covered in dust and that cobwebs were hanging from window frames.

People were not protected from the risk of infection because the laundry room was dirty. The ramps into the laundry were non- impervious and therefore an infection control risk. The workflow in the laundry did not prevent clean and dirty laundry from coming into contact with each other which was an infection control risk. The laundry floor was dirty and damaged. The window sills and surfaces in the laundry were cluttered with items not related to laundry. These were covered in dust and dirt and were an infection control risk. Mops in the laundry room were stored head down rather than head up as recommended for effective infection control. Cleaning equipment was not colour coded correctly to minimise the risk of cross infection. There were no separate hand washing facilities in the laundry room which meant that staff could not wash their hands within the room they were working when completing laundry tasks.

Soap dispensers in toilets were empty or refilled rather than fitted with disposable cartridges. Paper towels in some toilets were missing, in others they were piled on dirty window ledges. We found a refilled dirty alcohol hand rub in the entrance hall. There were insufficient sanitising gel dispensers throughout the home which would help minimise the risk of cross infection. Throughout the home we came across furniture and fittings which were damaged and whose surfaces were worn and permeable and therefore an infection control risk. Some bins were foot pedal operated. However, there were a number of open topped bins which posed an infection control risk as people were not protected from coming into contact with the contents. We noted that linen on some beds was stained and needed to be replaced.

We spoke with staff who carried out cleaning duties. They told us that they had a cleaning routine but that the previous manager had taken the schedules from them. They were presently working without schedules. We saw on the staff rota that one member of cleaning staff was on duty each

day of the week for six hours a day between eight am and two pm. After this time the responsibility for cleaning fell to the care staff. We did not notice care staff carrying out any cleaning after two pm on either day we were at the home. The manager told us that care staff often did not see cleaning as their job. It appeared that almost all the cleaning jobs fell to the one member of cleaning staff on duty each day. We noted that the home was a large old building which was not easy to keep clean. This meant that effective cleaning was not being carried out which meant that people were at risk of cross infection.

**The provider has failed to ensure that people were protected against identifiable risks of acquiring an infection. This is a breach or Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

Inadequate

# Is the service safe?

We did not see risk assessments for the environment. For example, there were no risk assessments for the kitchen, laundry, lounges, other communal areas, corridors, stairs or lift. We noted a number of risks to people as we toured the building. For example, many of the light bulbs were not working which meant the lighting was too low in places for people to clearly see where they were going. There was a risk that people may fall and injure themselves. The steps to the outside door were not clearly defined which meant people were at risk of falling. In one room a radiator had come loose from the wall causing a risk that it may fall on a person and injure them. We noted that hairdresser's equipment was left in a lounge where people with a dementia related illness had access. This posed a risk to people who may ingest liquids or injure themselves with equipment. There were damaged walls, doors and floors, damage to surfaces, old and tired furniture which needed attention or removal. One toilet room had a large hole in the ceiling. An upstairs landing cupboard had a hole in the back which led directly out into the roof space. Here there was a hole in the roof. This meant the back of the cupboard was open to external debris and the risk of vermin. Staff told us that the maintenance book had gone missing and that they usually would write jobs in this book. They were presently relying on word of mouth. There was no reliable system in place to ensure that maintenance tasks were identified or dealt with in a timely way to provide a pleasant, safe environment for people.

**The premises were inadequately maintained and unsafe. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

People told us that they felt safe in the home, and visitors told us that they considered their relatives and loved ones were safe. For example, one person told us "I feel safe here". A visitor told us, "My mother's very safe here". Another person told us, "The doctor keeps an eye on me. I get my tablets on time."

Some people and staff told us that the home at times felt short of staff. For example one person told us, "There's a lack of staff. They're overworked and do long shifts." Others felt that staffing levels were not a problem. Staff told us that when they needed two people to carry out personal care for one person it meant that some jobs were missed, such as putting away clean laundry.

At times during our observations staff appeared to be sitting together in one lounge with insufficient cover in the other communal areas. For example, on the first day of our inspection, three members of staff sat in a sunny, bright lounge with one person while in a cooler, less pleasant dining area there were four people with no staff. We spent time with one person who was agitated and challenging people. During an eighteen minute period there were no staff available to diffuse the situation. This put people at risk of harm.

The managers on duty told us there was always one nurse and four or five care staff on duty during each day, and one nurse and two members of care staff at night to care for twenty two

people. The staffing levels were planned in response to people's dependency. There was no registered manager in post and no deputy. However, two managers who were registered in other homes owned by the same company told us there was always one of them on duty at Woodlands Nursing Home each day. We looked at the rotas for March. Sometimes care workers were on duty with two senior members of staff, sometimes with one and sometimes with none. We asked a manager about this and they could not explain why staffing had been organised in this way. Skill mix had not been well considered in drawing up the rotas. Less experienced staff were sometimes on duty without senior staff for support and advice. This created a particular risk to people's safety when agency nurses were on duty who were not familiar with the home or people who lived there. Sometimes at weekends there may be an agency nurse on duty who had never been to the home before, with no manager on duty to guide them. Staffing was not organised to ensure people were safe.

We looked at a falls analysis of the home and found that most falls were in people's rooms. Relatively few were in communal areas and the number of falls was not more than expected. While this may suggest that staff were on hand to protect people from falls in communal areas of the home, staff deployment on the days of inspection did not effectively meet the needs of people in the home.

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to

commencing work at the home and that employment references had also been received. This provided evidence that only people considered to be suitable to work with vulnerable people had been employed.

The home had a safeguarding of adults from abuse policy and procedure. Staff told us that they had received training in safeguarding people from abuse and could correctly tell us what they would need to do if they suspected abuse was happening. This meant that staff had the training to alert the appropriate authorities if they suspected abuse so that people could be protected. However, despite this training staff had not identified when people had been at risk of harm in the home.

The home had a whistle blowing policy and procedure. Five staff told us they understood the whistle blowing policy and four told us they had confidence to raise any issues with senior staff.

However, one member of staff told us, "It depends who I was raising it with" when asked if they had confidence to raise an issue with senior staff. This means that not all staff felt comfortable raising concerns using the whistle blowing policy which meant there was a risk people may not be protected.

We saw that disciplinary procedures were in place to protect people from staff who were not suitable to care for them and we saw disciplinary procedure records which showed these were used appropriately.

We looked at the way in which medicines were managed. The home had a policy on the safe handling of medicines, a home remedies policy, and a policy for when people refused their medicines. Only nursing staff administered medicines. On each day we visited the home it was the first time that the nurse on duty had been in the home. This meant we could not speak with them about their knowledge of people's needs regarding medicines. However, we saw that medicines, including controlled drugs, were recorded on receipt, administration and disposal. Recording for a chosen sample was accurate with correct coding used, however, there were a small number of gaps in the recording.

The medication trolley was dirty with one bottle of out of date laxative which should have been disposed of. Although this bottle of laxative was not in use there was a risk that people may be administered laxative that was out of date.

There was no servicing record for the fridge. The fridge had a large build-up of ice inside which required defrosting. The draws of the fridge were broken and it needed cleaning. One medicine in the fridge was no longer in use. This medicine should have been removed to ensure people were not at risk of being administered medicines that were no longer in use.

There was a large stock of supplement drinks and yoghurt type preparations. Four of these were out of date The medicines room was unsuitable for storing these supplements.

Although the surfaces in the clinical room appeared to be clean the room remained in a poor state of repair.

A Medical Optimisation Pharmacist had last visited on 14 August 2014 and made notes on the patients Medication Administration Record ( MAR) sheet. They had sent a detailed report on 14 February 2014. It was unclear if their recommendations had been acted upon, though the records we saw were accurate. This meant there was a risk that people would not have their medicines handled in a way which reflected best practice.

The service was not carrying out medicine audits, which meant that the home did not have a system in place to identify and learn from errors or to ensure that people received their medicines as prescribed.

**We recommend that the nominated individual deploys staff to ensure they are effective in meeting people's needs.**

**We recommend that the nominated individual follows professional advice to ensure medicines are handled safely and appropriately.**

Inadequate

# Is the service effective?

## Our findings

Staff told us that they were not receiving regular or constructive supervision. The manager told us that supervision had not been taking place regularly and that they had a plan for this to be re-introduced when the new manager began their role. Staff had not received appraisals of their work. This meant that staff were not adequately supported in their role.

**This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

Staff were not using the Malnutrition Universal Screening Tool' (MUST) consistently. Of the six nursing care plans we reviewed, five did not have the MUST tool in place, though information about this was present in files. The MUST tool is recommended by the National Institute for Clinical Excellence (NICE) and is used to assess risk and therefore ensure that people receive the care they need in relation to their nutrition and hydration. Nutritional and hydration risks which were identified on people's care plans were not dealt with through the MUST tool when this would have assisted staff to give safe and appropriate care in this area. Charts for nutritional and fluid intake were inconsistently completed. This put people at risk of not having their needs met.

People had their pressure care needs assessed. Risk assessments were in place to address tissue vulnerability. All records had a Waterlow risk assessment and score which informed staff of the vulnerability of each person around their skin integrity. However, body maps were not used consistently. We found evidence of pressure ulcers where body maps had not been used, and the progress of pressure ulcers was inconsistently recorded so that it was difficult to recognise whether these were improving. Turning charts were inconsistently used. We found gaps in recording on turning charts with no explanation. The manager told us that for one person the reason for the gaps was because they were able to turn themselves at that time. We spoke to the person and saw that they were capable of turning themselves. The lack of recorded explanation however meant that there was a risk people would not be turned as they should be. This was particularly important as the home was using a number of agency nurses who would be heavily reliant on records to guide the care they gave.

Four recent safeguarding alerts had been received by the local authority with regard to pressure care of people at the home. These were in relation to the home not being proactive in their pressure area care. For example a vulnerable person had lost weight. Staff had not been proactive in referring to the tissue viability nurse, speech and language therapy team, accessing the correct pressure relieving mattresses or profiling beds to assist effective pressure care. The person had been nursed on an incorrect bed, which was pushed against the wall giving difficult access for nursing care. There was no weight record, but staff confirmed there had been a visible and significant weight loss for this person. Staff told us that they had not been able to weigh this person because of their frailty and lack of cooperation, however there was no record of staff using other methods to estimate weight loss. A visiting professional had described this person as "emaciated" when they were referred through the safeguarding process. We visited this person who as a result of the safeguarding intervention was now on a correct bed and pressure relieving mattress. They continued to appear very frail and the tissue viability nurse had given the home advice on estimating Body Mass Index so that a record could be kept of weight change in future.

**The failure to take proper steps to protect people against the risks of inappropriate or unsafe care is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

There was no evidence that people were involved in decisions about the environment. The home specialised in caring for people with a dementia, and areas of the home were protected by key pad to ensure people who would be unsafe if they left these areas were contained within them. However, the décor of the building did not lend itself to effective dementia care. There was little signage to assist people with a dementia to orientate around the home. For example, toilets did not have a picture of a toilet on the door and people's bedroom doors were not all labelled with their name or a picture they might find familiar. The corridors were badly lit, which is unhelpful for all, but particularly causes difficulty for those with a dementia or sight impairment to find their way around. In the communal areas of the home devoted to caring for people with a dementia there were no objects or rummage boxes to stimulate people's interest. Pictures on the walls were uninspiring and did not promote conversation or reminiscence. The nominated individual had not acted on

published best practice advice on creating an environment which promoted the well-being of people with a dementia. Jigsaws, dominoes and other games were shut away in a cupboard, not on display to encourage people to take an interest. This meant that the environment did not support people's needs in relation to dementia.

**The failure to provide a suitable environment to meet the needs of people with a dementia related illness is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

People told us that they had their health needs attended to. For example one person told us, "I suffer from chest infections so see the doctor a lot. If anything's the matter they ( the staff) get it sorted and usually quickly too. I also see the chiropodist every 7 weeks."

Staff told us that they had received training in all mandatory subjects and in some other areas of relevance such as behaviour which challenged, nutrition and dementia care. They told us that the company were "very good" at keeping training up to date. However, we were unable to locate previous training schedules from before the previous manager left the service in February 2015. We saw that a new training scheduled had been set up and saw certificates which showed that most staff had received training across all mandatory subjects.

We saw staff induction records on file and staff told us that they received a thorough induction which included shadowing another more experienced member of staff until they were confident to work unsupervised.

We saw that people's capacity to make decisions about their care had been assessed. Assessments included a consideration of when people were at their most able to make decisions, the type of decision they could make and how to improve communication through interpreting body language and gestures. For example, one plan stated, "{The person} does not have capacity to make life changing decisions. [The person} is able to decide what they are able to eat and drink." All plans included consideration of how to promote choice and to support people in making choices. Staff understood that people must be consulted about decisions around their care. They spoke about keeping decisions simple for people with cognitive impairment, about requesting consent to give care and involving family, advocates and others where appropriate. We saw that Independent Mental Capacity Advocates (IMCAs) had been involved in some people's decisions. We saw that a number of applications for deprivation of liberty had been made to the local authority. This was in relation to the risks associated with restrictions on people's liberty to move freely around the home. This meant that people were protected from being unlawfully deprived of their liberty.

However, we could not find any record or plan of training in the MCA. Staff told us that they had received training in their induction but had not received separate training in this area. This meant there was a risk that staff were not fully aware of best practice around the Mental Capacity Act and Deprivation of Liberty safeguards and that people would not have their capacity to make decisions sufficiently taken into account.

For seven people whose care plans we looked at there were nutritional assessments on file and referrals to external professional support had been made. For example, we saw referrals to the dietician and to the Speech and Language Therapy team (SALT). Risk assessments were in place for nutrition and hydration and we saw that these areas of the care plan had been regularly reviewed and updated where necessary. People's likes and dislikes in relation to meals were recorded and any allergies were recorded too. We observed a meal time. People appeared to enjoy their food. One person told us, "You can eat as much food as you want. I'm satisfied and it doesn't all taste the same". Another person told us "The food's excellent". The food appeared palatable and there was a choice which staff explained to people.

We had received a concern that people were not offered anything to eat after 16:00 which would have been too long a gap between this meal and breakfast. We spoke with the manager about this and they told us that people ate their main meal at lunch time then had tea which was usually cold, around 16:30. After this snacks and drinks were available on request and were also offered to people before they went to bed. There was a discrepancy between the concern raised and what the manager told us was usual practice. The manager told us that staff would offer snacks more proactively in future to ensure everyone had the opportunity to eat after the tea time meal.

Some files had pressure care plans in place with risk assessments and evidence of referrals to the tissue viability nurse.

Inadequate

# Is the service effective?

We spoke with a social care assessor who was visiting the home on the second day of inspection. They had been monitoring the care of a person who had a pressure ulcer and who had been the subject of a previous safeguarding alert. The assessor told us that staff had followed the advice of the tissue viability nurse and that the pressure area now needed monitoring only. They had spoken with the person who told them they were happy with their care.

Health care professional's visits were recorded separately so that staff could follow treatment advice more easily. Staff told us that they often accompanied people into hospital for appointments.

**We recommend that the service consults people over the choice and availability of food after the tea time meal to ensure people receive the food they prefer when they want it.**

**We recommend that the service trains staff in the MCA to ensure they have the skills and knowledge required to apply its principles.**

Requires Improvement

# Is the service caring?

## Our findings

People told us that staff were caring towards them. For example one person told us," I'm very happy. I can't find fault with it at all. The staff are all friendly …They look after you. They never let you feel uncomfortable. They're very kind. "

However, we observed that staff varied in their caring approach to people. We saw staff touch patients in a caring way, for example holding their arm and hand whilst walking with them down the corridor. We carried out observations in communal lounges and saw two members of staff hoisting a person from a wheelchair into an armchair. They were reassuring with the person and worked carefully and patiently as a team. The procedure was completed without any observable pain or discomfort to the person. We spoke with the person later about how they had felt during the move and they told us, "Fine. " A visitor told us "The staff are very nice to us. They're friendly and laugh and joke. They always make me feel welcome too. Each time I come I always get a cup of tea. "However, another visitor told us, "The staff are alright. There is one or two who get stroppy."

We observed one member of staff on their own in a communal lounge who was struggling to cope with a person's behaviour. This was exacerbated by the fact there were no other staff around at the time to assist with other people who were in the vicinity. The member of staff did not deal with the situation effectively and the situation was not de-escalated. However, we observed another member of staff at a different time speaking with this same person in a way which was kind and had a calming effect.

We observed that staff were not always nearby to offer support and reassurance to people when they needed it. The home was split into distinct areas and staff were sometimes in a different area of the home, outside the hearing of people who were distressed.

There was little evidence of personal histories, interests or what was important to people in files. However, some staff appeared to know people, their families and interests well and could use this information to speak with them in a caring way. Other staff did not seem to engage well with people and spent time talking with each other rather than people who lived at the home. This meant some people were isolated and not spoken with when there were staff on hand to do this.

We noted a complaint which had been received in December 2014 which referred to staff ignoring a person in an uncaring way who had been in distress and in need of assistance. This complaint had been upheld and an apology made by the manager. Staff involved had been disciplined. This meant people had suffered because staff had not been caring.

People appeared well dressed and smart. They had been assisted with their personal care so that their dignity was preserved. We spoke with one person who was visibly proud of the outfit, with matching jewellery, they were wearing. We noted that staff asked if they could assist people with personal care, and were polite and helpful. We noted that staff knocked on doors to preserve privacy.

Some files contained records of discussions and decisions about end of life care; these were typically brief and some records were generic forms about how to approach the care of people when they reached the end of their lives.. We saw examples of advance decisions and all Do Not Attempt Resuscitation forms were correctly completed and witnessed. Staff told us that people's relatives and friends were welcome to visit at any time and that they supported visitors when their loved one was reaching the end of their life so that they could remain with them as long as they wanted to. We spoke with a clinical nurse specialist for care homes, who was working with the care homes project which operated from the local St Catherine's Hospice. Woodlands had been identified through the accident and emergency department of the local hospital as one which would benefit from guidance and support from the project around caring for people at the end of their lives. A consultant attached to the project also visited the home to offer advice on symptom control. The clinical nurse specialist told us that they supported the staff at the home to plan effective pain relief and pressure care. They spoke with relatives about their loved one's care, to discuss options and to reassure them. Although this initiative was positive; because there was no registered manager to guide staff, there was a risk they would not effectively learn from the support and guidance of the project. There was also a risk that best practice advice would not be implemented once the project ended.

We noted that those people who would benefit from pain relief administered by syringe driver did not have this option open to them as the nurses did not all have syringe

Requires Improvement

# Is the service caring?

driver training. This meant that pain relief had to be arranged in a different way. Training was available but staff had not attended. This meant that pain relief was not tailored to individual care needs.

**We recommend that the service follows best practice guidance in end of life care particularly relating to the use of syringe drivers.**

Inadequate

# Is the service responsive?

## Our findings

Some files had information about people's lives, what was important to them and their interests, but these were not very detailed. Other files had no or insufficient details for staff to form a clear impression of each individual and their particular social, cultural or recreational needs. For example one file had no information about a person's life before a debilitating illness. The person was not in a position to tell staff and so this limited the way staff could tailor support to meet their needs. Staff told us that they knew some people, their families and other visitors well, but there were others they knew much less well, particularly those who had no visitors.

Care plans were not personalised sufficiently to give staff the information they needed to give care that was centred on each individual. For example, one care plan stated " Xxx does like to be entertained with activities." This gave no detail about what this person's interests may have been or what activities they best enjoyed.

Staff told us that there was no one member of staff who had overall responsibility for organising activities. They told us that they carried out hand care, quizzes, ball games, painted nails and sang. They also had an external entertainer, who did word games and other activities with people. The home did little to particularly engage and stimulate residents with dementia; there were no activities focused on sensory stimuli. Such activities have been shown to have a beneficial effect on people with a dementia. Another member of staff told us that they did jigsaws with people, played dominoes, looked at magazines and went for walks. We did see people going out for short walks in the grounds accompanied by staff, which they clearly enjoyed. We also observed a game of dominoes and one person being given a manicure. However, for much of the day we noted that people were sitting doing nothing, and that a number of conversations they had with staff were only initiated when they became distressed or attempted to leave a key coded area.

We saw that care plans were regularly reviewed, but that the plans in general had a clinical focus and were less well developed when it came to social needs and general wellbeing. There was little consideration of a holistic approach to care in either written records or the care we observed.

**Failing to provide personalised care is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

Most people told us that they were not consulted about their care. However, one visitor told us, "Yes they have asked my view of the home". They had made a suggestion and staff had acted upon it. People told us that there was a lack of stimulating activities. For example, one person told us, "No I don't think there are any activities provided for us." A visitor told us, "There's a lack of activities. Look around us now (in the residential lounge) people are asleep. They just sit here all day long."

There was no written evidence that the nominated individual routinely listened to people's views about their care or acted on this. The home did not conduct resident's meetings, or record any individual consultations with people about their ideas for improving the service. The general manager told us that people had been surveyed for their views, however, we did not see plans for improvements in the service as a result of these. This meant that the nominated individual could not be sure that the service met people's needs, wishes or aspirations.

The service had a complaints procedure and policy and we saw a record of a complaint with the outcome and learning actions. However, there was an empty comments box in the entrance hall and the results of consultation from 2011 and 2012. No up to date surveys had been carried out. This meant that people were not consulted about their care and that the home did not routinely listen and learn from people's experiences.

Throughout the two days of inspection visitors came and went and were welcomed by staff and offered refreshments. There were however a number of people who spent most of their days in their rooms with few visits from staff or anyone else. Staff told us they had little time to spend talking with people, and we observed that staff were too busy to do this other than when they were giving personal care. This meant that people were at risk of becoming isolated in their rooms.

Some people had hospital passports in place, which were drawn up to ensure the hospital would have an at a glance guide to people's care needs when they admitted. However, some people did not have such a passport, including one person who had severe sensory and

Inadequate

# Is the service responsive?

communication impairment. This meant that staff would need to draw up a plan at short notice should this person be admitted. This meant that important information may not always be shared if people moved between services.

Inadequate

# Is the service well-led?

## Our findings

We saw some evidence of quality assurance; for example the previous manager had carried out a falls analysis, a pressure sore audit and care plans were regularly reviewed. However, there were no audits for the safety of the environment, safety of equipment, cleaning, medicine handling or complaints. We saw an infection control audit which had been carried out on 25 February 2015 which had not identified the serious nature of the risk of infection to people due to an unhygienic environment. Problems had not been clearly identified and therefore plans had not been put in place for improvement.

There was little evidence of people's current involvement in developing the service. Surveys of visitors had been carried out in the past; however, the latest results we saw were for 2012, though the area manager informed us later that there had been a more recent survey of relatives and staff but that results had not been collated. Visitors and people who lived at the service appeared content with the service they received, though for some of the people we spoke with it was clear that their expectations were not high. One person told us, "We aren't given any surveys or questionnaires but they do ask us our views. But I'm not sure if it changed anything." Another person told us, "They're all right. They do look after us. If I want something I've only got to ask. Sometimes it takes them a minute or so to get it but I get it in the end." The nominated individual had not ensured that people were consulted and involved in their care.

The home had no registered manager in post. The previous manager left in February 2015 after a short period in post. There had been a history of changing management over the past few years. During these years the service had not been proactive in its approach to improving care. Inspectors had found shortfalls in the level of care, the maintenance and decorative presentation of the building on a number of occasions and this had resulted in improvements which had not been sustained. Management had been reactive to requirements placed upon it rather than developing a programme of work arising from a commitment to improvement. The nominated individual told us they had appointed a manager who would start work on 16 March 2015. A deputy manager had also been appointed which had the potential of providing continuity and leadership within the home.

Staff were able to tell us that it was important to support people with regard for their dignity, independence, equality and safety. However, we found that people were not consistently supported in this way. Staff gave the impression they were not empowered or inspired to work towards quality care and they told us that morale was not high.

Staff until recently had not been supported by regular meetings. The managers told us that a staff meeting had taken place on 4 March 2015 and we saw an agenda for this. Staff told us that this had been an information sharing exercise. After the inspection the area manager informed us that there had been three staff meetings between December 2014 and March 2015, however, the acting manager at the time of inspection could not locate any minutes from these.

Staff told us they felt supported by the managers and that there was an open door policy, but that they were unsettled by the change in management over the past few months. Staff were not able to express the vision and values of the service; they were not involved in developing the quality of care, consulted or made to feel part of a team working towards the best support possible for the people they cared for. Staff did not receive constructive feedback about their work as they had not received supervision or appraisal for some months.

A manager was present at the home each day however they were not in a position to begin developmental work as they were registered managers for other services and their time was committed to this.

There were no reliable lines of communication to and from the managers, staff and people living at the service. Management had not kept people informed about the voluntary suspension on admissions after discussion with the local authority or the plans they had to improve. This meant that the service was not well led and did not promote best practice.

The service had a suggestions box for people's convenience. On the day of inspection we noted that the suggestions box did not contain any suggestions. The manager at the time of inspection could not locate any plans which may have been drawn up to improve the service following any suggestions.

Inadequate

# Is the service well-led?

Notifications had been submitted to CQC as required, however, we noted that safeguarding alerts had sometimes been raised by external parties rather than being identified and referred by the home in the spirit of openness and a desire to improve.

**Failing to protect people by adequately assessing and monitoring the quality of the service is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

The managers were clear on what the key challenges were to the service. They agreed that there had been a lack of investment in the maintenance and décor of the building and that it was not a pleasant place for people to live in its current state. They understood that the organisation of cleaning needed attention to ensure people were protected from the risk of infection and had a pleasant environment to live in. They recognised that the quality of the service had not been monitored effectively. They recognised that improvements had not been sustained in the past and that planning improvements and sustaining them would be a challenge for the future

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br>**People were not protected because the premises were not safe or adequately maintained.**<br>**The environment was not suitable to support the well-being of people living with a dementia related illness.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br>**People were not protected by staff that had suitable supervision, appraisal and support in their role.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>**The registered person did not protect people against the risks of receiving care that was inappropriate or unsafe. Care was not planned or delivered to meet people's needs.** |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br>People were not protected against the risks of inappropriate or unsafe care because the service was not effectively assessed and monitored. |

**The enforcement action we took:**
Warning Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>People who use services and others were not protected against the risk of acquiring infection. |

**The enforcement action we took:**
Warning Notice