Woodlands Retirement Residence Limited

Woodlands Retirement Residence

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 unannounced comprehensive inspection took place on the 12 and 13 June 2018. Woodlands Retirement Residence is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Woodlands Retirement Residence accommodates up to 19 people across two adapted buildings. At the time of our inspection 16 people were living at the home.

At the last unannounced comprehensive inspection in February 2018, we judged that improvements were required in delivering a safe, effective, caring, responsive and well-led service. We found the provider continued to be in breach of the regulation related to governance. This was because the registered provider had failed to establish and operate effective systems to ensure compliance with the regulations, or to monitor the quality and safety of the service. In addition the registered provider was failing to comply with Regulations 9 (Person centred care), 10 (Dignity and respect), 11 (Need for consent), 13 (Safeguarding service users from abuse and improper treatment) and 18 (Staffing) . After our inspection in February 2018 we served Warning Notices to the registered provider which required them to be compliant with these regulations by 6 April 2018. A Warning Notice is one of our enforcement powers. Following the last inspection, we asked the registered provider to complete an action plan to show what they would do and by when to improve the key questions 'is the service safe, effective, caring, responsive and well-led service' to at least good.

At this inspection we found the required improvements had not all been made since February 2018. Some of the improvements we had identified as required at our previous comprehensive inspection in February 2018 were on-going or had not been made and the provider remained in breach of several regulations. Despite previous inspections identifying shortfalls in governance systems, we found that insufficient progress or improvement had not been made to the systems and processes to audit and improve the quality of care provided at Woodlands Retirement Residence and to meet the Regulations. We are considering what further action to take.

There was a registered manager in post who was present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Risks had not always been assessed to keep people safe and protected. There was insufficient guidance available for staff to ensure that people's conditions were managed appropriately to protect people from potential risks. Most staff knew how to protect people from abuse. Staff recruitment was not robust. People received their medicines as prescribed but the management of medicines was not effective.

People's capacity was not always assessed and considered when decisions needed to be made to ensure their rights were protected in line with legislation. The registered provider had not ensured that the staff team knew which people were subject to a Deprivation of Liberty Safeguards (DoLS). People had access to a variety of food and drink to maintain good health. People were supported when necessary to access a range of health care professionals. Health care records did not contain sufficient information and guidance for staff to follow. People felt staff had the skills and experience to care for and support them, but staff did not always receive the training they needed to support people effectively and in-line with current guidance.

People were supported by staff who they described as kind and caring. However, we saw instances when people's privacy, dignity and confidentiality were compromised.

People told us they were given choices about some aspects of their care. However, it was not always clear how people were involved in planning and reviewing their care. People's care records did not always contain an accurate and up to date account of their needs and how these were being met. People were provided with activities they enjoyed but had limited opportunities to access the outside or local amenities. People knew how to raise concerns but information was not available in different formats.

The management of the service was inadequate as the provider did not carry out robust checks to ensure that care was being delivered safely and effectively. The provider had not taken sufficient action to address many of the concerns we highlighted in our previous report. The delivery of high quality care is not assured by the leadership and governance in place.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew how to recognise and report any safeguarding concerns internally. However, staff were not always clear how to report to external agencies.

Potential risks to people's safety and welfare were not kept under review and where changes were identified documentation was not updated to promote their safety and welfare.

Medicines were administered in line with people's prescriptions. However, improvements were required in the safe management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care was obtained by staff, but the provider did not always consider people's rights and freedom.

Care plans did not include sufficient guidance for staff to support people effectively.

People felt staff had the skills and experience to care for and support them, but staff did not always receive the training they needed to support people effectively.

The dining environment was pleasant and people enjoyed their food. People were supported to have access to on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they were supported by staff who were caring; however people's privacy and dignity was not always supported and maintained.

People's confidential information was not kept or shared

securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always contain an accurate and up to date account of people's individual needs and how these were being met.

People were provided with activities that they enjoyed but had limited opportunities to access the outside or local amenities.

People, their relatives and representatives knew how to complain and told us they felt comfortable doing so.

Is the service well-led?

Inadequate

The service was not well-led.

There were no effective systems or processes in place to ensure that the service was safe, effective, caring, responsive or well led.

The provider did not have robust processes for monitoring and improving the quality of the care people received.

There was a lack of effective oversight by the provider to ensure that improvements were identified and acted upon.

Woodlands Retirement Residence

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 unannounced comprehensive inspection took place on the 12 and 13 June 2018. The inspection team consisted of two inspectors on the first day and one inspector on the second day.

We had already asked the provider to complete a Provider Information Return (PIR) earlier in 2017, so we did not ask them to complete this again. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account when we made the judgements in this report. We also reviewed the information we held about the service. We looked at information received from the local authority commissioners, Healthwatch and the statutory notifications the manager had sent us. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit, we met and spoke with five of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time. We spoke with two relatives of people and one visiting care professional to get their views. In addition we spoke at length with the registered provider, three senior care assistants, five care assistants and the cook.

We reviewed four people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for seven people. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2018 we rated the registered provider as 'Requires improvement' in this key question. We found that people were placed at risk by insufficient numbers of staff to maintain people's safety. Potential safeguarding issues had not been recognised and responded to. Risks to people had been assessed but actions taken to reduce risks were restricting people's freedom. At this inspection we found that the issues had not all been addressed and we had further concerns about the safety of the service. We identified that the service was now in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, Safe care and treatment. The registered provider had failed to ensure people received consistently good, safe care that was compliant with the legal regulations.

We looked to see how risks to people were assessed so they were supported to stay safe. Staff we spoke with told us that one person who lived at the home required the support of two staff and equipment in order to move them safely. A member of staff told us, "[name of person] needs two staff to move them, we use a slide sheet but it is difficult." We reviewed the risk assessment for this person and found they had been assessed as requiring minimum support with moving and handling. We found there were no written individual risk management plan to identify the required equipment needed to or how staff should transfer the person safely. We observed most staff supporting people to transfer safely or move around the home and saw they considered people's comfort and safety during these procedures. However, we also observed on two occasions when staff supported people to stand up or transfer by holding the person under their arms and lifting. This inappropriate technique of supporting people increases the risk of injuries such as skin tears, dislocation or fracture. This was brought to the registered provider's attention who advised us that staff had all received moving and handling training and they would address this particular transfer method with all staff.

Most of the staff we spoke with had a good knowledge of individual people's health needs. However, when speaking with staff about the needs of one person who lived with diabetes we received conflicting information about what action they would take if the person had a medical emergency. We looked at the person's care records and found that these had not been completed with enough detail to guide staff. The lack of recording could have impacted on the monitoring of people's healthcare needs and may have delayed appropriate action to be taken in a medical emergency. We brought our findings to the attention of the registered provider who advised us that care plans would be updated to ensure staff knew how to support health conditions.

Some people were at risk from aspects of the environment. For example, we identified flammable objects such as cardboard and a mattress stored under the stairwell directly above people's bedrooms. This presented a potential fire risk. Most staff described what they would do in the event of an emergency. Although each person had an individual emergency evacuation plan (PEEP), staff told us that they did not participate in regular fire drills and there were no records to show when a fire drill was completed. The registered provider advised us that fire drills did not take place on a regular basis and they had no oversite to assure them which staff had participated in fire drills. We requested to see the provider's fire risk assessment of the home to identify what the procedure was in relation to fire safety. The registered provider

advised there was no fire risk assessment in place. This placed people at increased risk of harm in the event of a fire because staff did not have guidance to support them with the safe evacuation of the building in an emergency.

We asked people if they received the right support to take their medicines. One person we spoke with told us, "I always have my medicine…the staff are very good..they order it for me and I don't run out." We observed the administration of medicines by staff wearing tabards stating that they should not be disturbed whilst administering medicines. However, we observed a staff member was disturbed to complete the handover. We observed the medicine trolley left open and unsupervised during a medicine round. Although the time the trolley was unattended was brief, it was in a place where people could have taken medicines from it. This meant medicines were not always kept secure and safe. In addition we noted the medicine trollies were not secured to a wall when not in use. The provider told us this was due to be done following our inspection. We saw that staff who supported people with their medicines had received training and had been observed to check their competence to administer medicines.

We found there was no stock control system in place so the staff and provider could monitor medicines kept in the home and assure themselves that people's medicines were available and used as prescribed. In particular, staff were not using the 'carried forward' box on the medicines administration record charts (MAR charts) to provide a full record of the quantity of medicines available for each person. We found excessive stock of 523 co-codamol for one person. We found discontinued medicines in the current stock box rather than in the returns box. In addition, the systems for managing controlled drugs were not robust. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We looked at the controlled drugs administration records and found that there were outstanding balances for a number of medicines. Without complete and up to date balances in the controlled drugs book it was not possible to assure ourselves that these medicines were being safely returned to a pharmacy when no longer needed.

We looked at the records of one person who was administering some of their medicines independently. We found a risk assessment had been completed, but there was no system for staff or the provider to monitor this. We also found the person did not have secure storage for their medicines in their bedroom.

The registered provider had failed to ensure people were protected from the risks associated with their conditions and were not ensuring the safe care and treatment of people through appropriate management of medicines. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We checked how people who lived at the home were protected from other risks associated with the premises. We found that appropriate maintenance were completed in relation to areas such as water, passenger lifts, gas and electrical safety. We spoke with the cook who advised that they had daily and weekly cleaning schedules in place. The service had achieved a '5' star rating by the environmental health agency which meant they regarded the service as having good food hygiene standards.

People's safety was compromised because the registered provider did not have a robust recruitment process for staff. Although the provider used a checklist to help them obtain the required information about new staff, we found examples where they had signed these as completed although they had not obtained all the information listed. We looked at the recruitment records for three staff. One staff member's recruitment records included an application form which they had not fully completed. The sections for previous employment history, education, and the names of referees were blank. Two staff records contained Disclosure and Barring Service (DBS) checks from previous employment. The records did not show the

registered provider had checked whether anything had changed which may make the person unsuitable for their current role. On the second day of our inspection the registered provider showed us evidence these staff had applied for up to date DBS certificates but the provider had not seen them to assure themselves regarding the content of the checks.

At our last inspection in February 2018 we found people were being supported to remain safe by unnecessary restrictions on their freedom. We found the provider to be in breach of Regulation 13, Safeguarding people from abuse and improper treatment. We identified that when people sustained an injury in the home, no formal investigations had been conducted or referral to the appropriate safeguarding agencies team completed. On this inspection we found some improvements had been made and the provider was no longer in breach of this regulation. We saw when unexplained injuries had occurred; systems were now in place to follow safeguarding procedures. One relative we spoke with told us, "I've not seen staff do anything wrong." Most of the staff we spoke with demonstrated an understanding of how to recognise signs and symptoms of abuse and were aware of whistle-blowing procedures. However, the registered provider had not ensured all staff were up to date in safeguarding training and practice. One member of staff we spoke with was not aware of who to contact outside of the organisation should they witness any safeguarding concerns. The registered provider acknowledged this and consequently arranged safeguarding training for staff following our inspection.

At our last inspection in February 2018 we found the provider to be in breach of Regulation 18, Staffing. The registered provider had no system in place to calculate staffing levels. We saw the numbers and deployment of staff at times had potential to put people at risk. During our inspection of June 2018 we found some improvements had been made and further were planned. The service was no longer in breach of this regulation. We sought the views of people who lived at the home about staffing levels and whether they received support and care in a timely manner. We received mixed responses from people about whether they thought there were enough staff available to support them. One person told us, "Staff are extremely busy in a morning…very rushed [and] have no time. It gets better throughout the day." A relative told us, "There seems to be enough staff about when I visit." Most staff we spoke with told us there were times when there were not enough of them to provide care and support in a timely manner. One member of staff said, "There is not enough staff and time in a morning." We observed staff deployed within the home during both days of our inspection. One person told us that staff responded quickly when they used the call bell. We observed people were supported in a timely manner and we saw call bells were answered within reasonable times when people used them. The registered provider advised us they now used a dependency tool to assess the numbers of staff required to ensure they had sufficient staffing levels and that there was an active recruitment campaign in progress to recruit further staff.

People were protected from the risk of infection. We saw the home was clean and the décor was well maintained. One person told us, "This place is spotless." We observed care staff wore personal protective clothing when they supported people with their care. We did note, however, that there were hand towels and bars of soap in some communal bathrooms. Whilst the towels appeared clean and were laundered regularly this is not good practice in line with infection prevention guidance.

Following our last inspection in February 2018 the service had put systems in place to record accident and incidents. Whilst staff understood their responsibilities to record safety incidents and concerns, there was no evidence to demonstrate that the learning from the incidents had been used to reduce the likelihood of re-occurrence.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2018 we rated the registered provider as 'Requires improvement' in this key question. We found the Mental Capacity Act (MCA) (2005) was not being consistently implemented to ensure people were not restricted unlawfully. After our inspection in February 2018 we served Warning Notices to the registered provider which required them achieve compliance. At this inspection we found some improvements had been made in relation to MCA. However the quality and consistency of these assessments continued to be varied across the service and the provider remained in breach of this regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and explored staff's understanding of the principles of the Mental Capacity Act (2005). One person told us, "Staff ask my permission before they come into my room." Staff were able to describe the basic principles of the MCA and understood the importance of obtaining consent. We observed staff gaining consent from people before supporting them with their needs. For example, asking people if they had finished their meals before removing plates and asking people their permission before removing their glasses to clean them. However, some people's capacity assessments had conflicting information relating to whether or not people lacked capacity. On one person's care plan we found a medical appointment which had been cancelled by a relative on behalf of the person. The capacity assessment identified that the person had capacity to make decisions themselves. Additionally, records showed the relative did not have the relevant powers to make these types of decisions on behalf of their relative. The registered provider advised us that the relative had made the decision and they had not consulted with the person. This meant the provider was not always following the principles of the MCA and ensuring people's rights were protected.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered provider advised us that a number of applications for DoLS had been made to the authorising authority. We reviewed one person's care plan and saw that they had a Deprivation of Liberty (DoLS) application to restrict their liberty which was waiting to be agreed by the authorising authority. However, the person had been assessed by the provider as having capacity to make all decisions. The registered provider explained that it was unsafe for the person to leave the home on their own. When restrictions had been placed upon people, for example, the use of sensor mats, these areas had not been considered or assessed under the MCA. The registered provider told us and records showed that people's capacity to make decisions about the care and support they received had not been assessed when appropriate in relation to decisions around the use of equipment such as sensor mats. We also found no record of consent from people to this type of monitoring. In addition, we saw people were restricted from accessing the garden as

all the doors were locked and could only be opened by staff. We explored this further with the registered provider who advised us that some people may fall if they went out on their own. Specific decisions about people not being able to access the gardens freely and independently had not been considered in the assessment process for people who lacked capacity to make this decision. For people who had got the ability to consent to freely accessing the gardens this had not been considered. This meant the provider had failed to identify that practices in the home were not always in accordance with principles of MCA and had not considered this to be potentially restrictive practice.

Some of the staff we spoke with did not always know which people were subject to authorised DoLS and three staff had no knowledge of what DoLS meant for people living at the home. One member of staff said, "[I] don't understand DoLS and I don't know who is on one." The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.

The registered provider was not ensuring that people's rights were protected and this was a continued breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Need for consent.

People told us that in their opinion staff had the skills and right experience to deliver effective care and meet their needs. One person told us, "I think staff have the right skills and training." Most staff told us they had the skills or knowledge required to support people safely and promote their wellbeing. However, a staff member told us they needed some up to date moving and handling and food safety training. We reviewed the registered providers training matrix to corroborate this and identified a number of staff who had not received refresher training in safeguarding, food safety, moving and handling, fire safety and MCA. This meant that people may have received support from staff that had not got the appropriate up to date knowledge and skills.

Staff told us they had a period of induction, which included working alongside more experienced members of staff. One staff told us, "During my induction I observed other staff and was introduced to people." The registered provider had ensured their induction processes were in-line with the principles of the Care Certificate. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life.

People identified as being at risk of malnutrition were not always supported appropriately. We found that food and fluid monitoring charts had not always been completed fully. The fluid target that people had to meet to ensure good hydration had not been assessed or recorded. For example, on one person's food and fluid chart we found their individual nutritional intake was not quantified and their fluid intake was not calculated on a daily basis to ensure their nutrition and fluid intake was adequate to maintain their health. We found that the failure to monitor, whilst at the time had no direct impact on people possible risks would not be easily identified.

People had a choice of meals and where to eat. People were positive about the food and told us that in general they like the food that was offered. One person told us, "I love the food here, plenty of choice." There was a set menu in place but people told us they could have an alternative choice if they preferred. We observed drinks and snacks were offered between meals and people had access to fresh fruit and snacks independently.

People told us they had the opportunity to see healthcare professionals such as their GP, dentist and optician to maintain their health and receive ongoing healthcare support. A relative told us, "Any problems

at all with health and they [the staff] ring us." A visiting health professional told us that staff followed all health care advice given.

The premises had been adapted and decorated to support most people to move from their own bedroom and around the communal areas of the home. There were several communal rooms where people could sit and read rest or watch what was going on around them. Although people's rooms were personalised with their own furnishing there was no evidence of best practice design for people living with dementia. For example, the use of handrails, colour coding or memory boxes, which could support people to navigate the building independently.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2018 we rated the registered provider as 'Requires improvement' in this key question. We found that people were not always treated with dignity and respect and their rights to privacy was not always upheld. After our inspection in February 2018 we served Warning Notices to the registered provider which required them to be compliant with this regulation. At this inspection we found the registered provider had not made sufficient improvements and remained in breach of this regulation.

People's privacy and dignity was not consistently respected and promoted. Although staff we spoke with were aware of how to promote people's dignity, this had not been consistently practiced. Staff told us and we saw that privacy screens in one double occupied room were not available or being used to maintain people's dignity and privacy. Staff told us that they supported both people with personal care in their bedrooms. This was unacceptable practice and staff and the provider had failed to recognise the need to protect people's dignity and privacy.

Whilst staff told us they respected people's right to confidentiality this did not consistently happen in practice. We saw confidential and personal information pertaining to people who lived at Woodlands Retirement Residence on display in a communal corridor. For example, all care plans could be seen and were accessible by anyone who lived at the home and, or who visited. We saw people's dietary requirements and one person's end of life wishes were displayed in the communal corridor. We saw the staff handover being undertaken within the communal corridor. Confidential and personal information pertaining to people was discussed and could be overheard by anyone who lived at the home and, or who visited.

We observed two people being supported by staff to eat their meals. We observed staff standing up to support people with eating who were sitting down. There was limited interaction between the staff and people when supporting them with this task. Whilst we did not see anyone distressed by this, for some people living at the home this failed to ensure that they had been treated with respect.

Failing to treat people with dignity and respect is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 10. Dignity and respect. This is a continued breach of this Regulation.

People spoke positively about the standard of care provided and spoke warmly about the staff who supported them. One person we spoke with told us, "Staff and kind and respectful to me." A relative described the staff as "Angels." During our inspection we spent time in the communal areas and saw that people were relaxed about asking staff for assistance. Most of the staff had worked at the home for several years, and some, including the registered provider, had worked there for a number of years, which gave people continuity and familiarity with the staff. Most people chose to spend their time in the communal areas, which showed they were comfortable with the people they shared their home with.

People told us they were given choices and supported to be involved in their care. One person told us, "I like the comfort of my own room." People we spoke with felt they were involved in decisions about their care

such as when to get up and go to bed. However, one person told us they were not always asked their opinions on the food they would like to eat. The registered provider acknowledged that they had not consistently asked people to feedback about their experiences of living at the home. Whilst we observed staff promoting people's independence with tasks such as allowing people to walk with their walking frame and promoting people's independence at meal times; we did not observe many opportunities for some people to take part in everyday living skills, for example, helping to set a table for lunch if they wanted.

Visitors were welcome at the home and could visit when they chose to. One person's relatives told us they were made to feel welcome by the provider and staff. People could spend time with their relatives in their rooms or within the communal areas of the home.

At the time of our inspection there was no-one living at the home who required advocacy support. Advocates are trained professionals who support, enable and empower people to speak up. Information was on display within the home which informed people about local advocacy services available to them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2018 we rated the registered provider as 'Requires improvement' in this key question. We found that people were not all receiving care that was person centred and met their individual preferences. After our inspection in February 2018 we served Warning Notices to the registered provider which required them to be compliant with the regulation. At this inspection we found whilst some improvements had been made further were needed. The service remained in breach.

People we spoke with told us they were supported to express their views and wishes about daily lives. One person told us, "I like to get up at 7.15 every morning. It's what I like." Another person told us, "I'm very independent and able to make my own decisions and choices about my life." However a number of staff told us that some people weren't consistently given choices in relation to what time they got up in a morning. Comments from staff included, "We never get people up against their will, but we are expected to get a number of people up due to staffing levels in a morning." We explored this with the registered provider who advised us this was not common practice and they would address this with staff as a matter of concern.

People did not consistently contribute to the planning of their care. One person we spoke with told us, "I've never been involved in my care plan review." Not all people had attended care plan reviews to share their opinions of experiences of living at the home and to review if the care and support provided was still appropriate to meet their individual needs. Some care plans we reviewed contained conflicting guidance for staff to follow. For example, frequency of re-positioning people, frequency of weight monitoring and inconsistencies in capacity assessments. The care and treatment for some people did not reflect their preferences or meet their individual needs.

People we spoke with told us that staff knew them well. One person told us, "Staff know I like a lie in on mornings." However people had not consistently been supported to follow their interests and take part in activities that were socially appropriate to them, including the wider community. For example, one person told us, "I would like to go shopping more." Another person we spoke with told us of their interest in a particular sport and how they missed it. Although most staff we spoke with displayed a good understanding of people's likes, dislikes and daily routines they had not fully understood people's emotional and social needs or used information contained within people's care plans as an opportunity to engage with the person about their interests. Whilst there had been some work to develop people's care plans in relation to obtaining information about people's previous lives and interests not all staff used this information in practice to ensure individual care and support was provided to people.

We found that staff did not always have the skills or time to work effectively with people living with dementia. People we met were at differing stages of their dementia and there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. Staff had limited knowledge and understanding of how dementia affected people in their day to day living. For example, staff did not explore alternative ways to enable people to make informed choices and did know how to make a positive impact on the lives of the people who lived with

dementia.

There was some information recorded in people's care plans about people's wishes and expectations for being supported at the end of their life. However, more work was needed to ensure end of life plans were person-centred to ensure people were supported to be comfortable, pain free and dignified at the end of their life.

The registered provider was not ensuring that the care and support provided was consistently person-centred and this was a continued breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014, Person centred-care.

There had been no attempt to design care plans in a way that meant people who lived at the home would be able to understand and comment on their contents. This meant the registered provider was not meeting the Accessible Information Standard (AIS). The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand to enable them to communicate effectively. It is now the law for the NHS and adult social care services to comply with the AIS.

People we spoke with told us that staff were responsive to their needs and supported them in the way they preferred. One person said, "I prefer to stay in my room. I really love it. Staff pop in and see me all the while." Relatives we spoke with described that they felt their relations needs were met by the staff. A relative told us, "Staff are marvellous; mum is more than looked after." We observed staff supported a person who lived with a visual impairment with their meal and communication was effective. Staff explained what the meal was and where the contents were situated on the plate using the clock face.

People had the opportunity to participate in activities they enjoyed. One person told us, "There's plenty to do. We had a party for the royal wedding and sat outside." We saw that daily newspapers and magazines were available for people to read within the home. We saw digital clocks with the right time and day displayed all around the home. People independently accessed the television remote control and chose the channel they preferred to watch. We observed staff talking to people about the royal family, history and special events. We saw some people tapping and singing to age appropriate music. During our inspection people had the opportunity to be involved in arts and crafts sea themed painting sessions, music mobility session and a religious service. One person told us, "There are no outside trips, I miss that." Another person told us how they would like to go shopping but needed staff to support them. We did not see any evidence that people were supported to make links with the local community and access activities outside of the home.

People we spoke with told us their religious needs were respected. One person told us, "We have church services coming in, I'm not religious but I always attend because I do like hymns." We spoke with staff about what the Equality Act meant for people who lived at the home and if people's needs based on their protected equality characteristics or their values and beliefs were recognised and met. One member of staff told us, "It's important to treat people individually. We have to respect and accept people's religions and sexual orientation, they are still people."

People we spoke with knew how to raise a concern or make a complaint and staff knew how to guide people if they wished to formally complain or raise any issues. One person said, "Any concerns, I would go straight to [name of registered provider] she would sort it." The registered provider had a formal procedure for receiving and handling concerns. Whilst a copy of the complaints procedure was clearly displayed in the home it was not in a format that met everyone's communication needs.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2018 we rated the registered provider as 'Inadequate in this key question. We found that the registered provider did not have effective auditing systems in place to monitor and improve the quality and safety of the service. After our inspection in February 2018 we served Warning Notices to the registered provider which required them to be compliant. On this inspection of June 2018 we found there was a continuing breach of this Regulation and a further four breaches of regulations.

Despite previous inspections identifying shortfalls in governance systems, we found that insufficient progress or improvement had been made to the systems and processes to audit and improve the quality of care provided at Woodlands Retirement Residence and to meet the requirements of regulations. As a result there continued to be systematic shortfalls in the monitoring and oversight of the service to ensure people's safety and well-being.

We asked to see how the provider monitored the service for patterns and trends in the event of any accidents and incidents. Although information in relation to these types of incidents was recorded, there were no robust and effective systems in place. For example, the provider did not maintain oversight of such incidents, and take appropriate action, evaluate and use lessons learnt to reduce the likelihood of re-occurrence.

Safeguarding concerns were not consistently dealt with in an open and transparent way. We found one incident which could constitute a safeguarding concern which had not been reported to the appropriate safeguarding agencies or to the Care Quality Commission (CQC for their consideration. In response to our concern the registered provider advised that the incident had retrospectively been reported to the appropriate safeguarding agencies and to CQC. In addition, we did not see information and procedures for safeguarding or whistleblowing on display to enable people, visitors or staff to follow should they have any concerns.

The provider's governance and oversight systems were ineffective to ensure medicines were managed safely and people were protected. We found there were no stock control systems in place to ensure staff and the provider could monitor medicines kept in the home and assure themselves that people's medicines were available and used as prescribed. The audits had failed to identify the shortfalls we found and as a result the correct handling of controlled drugs, storage and disposal of medicines were not followed safely. The systems of audit were limited in their scope. For example, a medicine audit dated 05 May 2018 states, "Audit. No concerns." Without an effective system to check and monitor stock levels it is difficult for providers to ensure service users medicines have been given as prescribed or identify when any potential medicine errors had occurred.

The provider's systems in place to protect people from potential harm were not adequate because they did not have a robust recruitment for staff. Governance and audit systems that were in place had had failed to identify that recruitment systems were not adequate to ensure service users were kept safe and protected from the risk of harm.

Systems for identifying, capturing and managing risks are ineffective. The provider's audits of care plans, including risk assessments had failed to identify they lacked specific details about service users' conditions and how staff were to mitigate against associated risks. The provider had not monitored whether staff were using moving and handling equipment safely. The provider had failed to ensure that accurate, complete and contemporaneous records were kept in respect of each service user. Whilst care plans had been audited it had not been identified that some care plans were not accurate, up to date and reflected people's current needs. Failure to identify that care records did not have clear information and guidance for staff meant that the provider was unable to check if service users were receiving care in a way which met their needs and kept them safe. The provider's systems in place to audit the environment to ensure it was safe this was ineffective as had not identified several issues in relation to fire safety.

The provider's governance and oversight systems were ineffective to ensure they were working in line with the principles of the Mental Capacity Act (2005). The staff we spoke with did not always know which people were subject to authorised DoLS and some staff had no knowledge of what DoLS meant for people living at Woodlands Retirement Residence. This meant people were at risk of staff applying restrictions to people's care and treatment which they were not legally entitled to do.

The provider's governance systems to ensure that people using the service were treated with respect and dignity at all times while they are receiving care and treatment was ineffective. Some people who shared bedrooms were supported with personal care without the use of privacy screens. Records were not stored securely. People's personal care files were stored in a communal area and unlocked; people and any visitors were freely able to access these. We also saw confidential information about people's dietary requirements and end of life wishes displayed in a communal corridor. Failure to have effective governance in place resulted in people's dignity and respect being compromised.

We looked at how the registered provider gathered people's views and how they promoted a positive and open culture. People and staff were not formally asked about their views and experiences about the home. There were no effective systems in place to capture and respond to feedback. The provider had not been proactive at obtaining people's views to enable them to participate in improving the service. For example, one person told us, "I would really like something else on the breakfast menu." There was no evidence that that people were involved in planning meals or that their views were sought about the quality of food drinks and the dining experience. Failure to have effective governance in place resulted in an inability to drive improvements in the quality and safety of the services provided including the quality of the experience for service users.

Roles, responsibilities and accountability arrangements are not clear. The registered provider had led the service for many years and was also the registered manager. They had not kept their knowledge and understanding regarding best practice, or the changes in fundamental standards and regulations up to date. In addition, the registered provider was not aware of The Accessible Information Standard which was introduced by the government in 2016.

Systems had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. This constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Some people and relatives told us they were mostly happy with the management of the home. One person told us, "[name of registered provider] comes to see us most days." A relative said, "[name of registered provider] is very supportive."

Some staff did not feel listened to, respected or supported. There was limited evidence of communication with staff to ensure consistent processes. Whilst the provider had implemented formal supervisions with staff, staff told us staff meetings were infrequent. We saw some brief records from staff meetings which demonstrated that the sharing of best practice and the opportunity to reflect on performance was limited and not used to promote good practice. For example, notes that we saw for a staff meeting held on 28 March 2018 stated 'infection control and new personal care- person centred' but there was no content of what was discussed and no evidence of what was expected of staff. We received mixed responses from staff in relation to the approachability and support from the management team. One staff member said, "[name of registered provider] is lovely on good days and unapproachable on others." Another staff member said, "I do feel supported by [name of registered provider]."

It is a legal requirement that providers current CQC inspection report is displayed at the service where a rating has been given. This is to enable people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall of the home. The provider currently had no website.

The registered provider had worked in partnership with the local commissioning team and other agencies to support care provision and development. The registered provider told us how they shared appropriate information with other health professionals for the benefit of people who use the service.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider was not ensuring that the care and support provided was consistently person-centred. Regulation 9 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and people's confidentiality was not respected or upheld. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people using the service. Regulation 11 (10 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to inadequate risk management processes within the service. Regulation 12 (2) (a) (h)

People were not protected from harm by the safe management of medicines. Regulation 12 (2) (g)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2)(a)(b)

The enforcement action we took:

We imposed a condition on the providers registration.