Carisbrooke Healthcare Ltd

The Woodlands Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We performed this unannounced inspection on 7, 8, 25 and 29 April 2016. Woodlands Care Home is run and managed by Carisbrooke Healthcare Ltd. The service provides accommodation and personal care for up to 40 older people. The service is provided over two floors with the upper floor supporting people living with varying stages of dementia. On the day of our inspection 37 people were using the service.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. People who lived at the service were not always protected from the risk of abuse as the registered manager had not ensured all staff working at the service had received safeguarding training and some new members of staff were unaware of how to report issues of concern. The registered manager had not followed safe practices when recruiting staff. Some staff had commenced work without going through the Disclosure and Barring Service checks and some people lacked appropriate references.
People were not always protected from risks as appropriate risk assessments had not always been completed. The risk assessments in place did not give staff enough information on how to manage the risks. Some of the information about risks in people's care plans was contradictory.
Staffing levels were insufficient to support people's needs and people did not always receive care and support when required.

Although people received their medicines as prescribed the management of medicines was not always safe.

Staff did not always receive appropriate training and supervision to assist them in their roles. The principles of the Mental Capacity Act were not always followed as people had been deprived of their liberty without the required authorisation to do so.

People were not always protected from the risks of inadequate nutrition and referrals to health care professionals were not always undertaken when needed.

Although people were treated in a caring and respectful manner, staff did not always engage with people when given the opportunity. People who used the service, or their representatives, were not always encouraged to contribute to the planning of their care.

People did not receive person centred care as the care records did not give adequate information required for individualised care. People and their relatives felt able to raise concerns or complaints to the registered manager but the issues raised were not always responded to and acted up on.

The service lacked an open culture serious incidents which had occurred had not been reported to the appropriate authority in a timely way

Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. This lack of effective governance led to some people not receiving safe and consistent care.

This resulted in us finding multiple breaches in regulations and negative outcomes for some people who used the service. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always safe as the provider had not ensured staff had the appropriate training to help them deal with abuse and had not followed safe recruiting processes when employing staff.

Risks to people were not always appropriately assessed and steps were not always taken to mitigate risks.

There was not always enough staff to meet people's needs in a timely manner.

People received their medicines as prescribed however they were not always managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received appropriate training and supervision to ensure they could perform their roles and responsibilities effectively.

People were supported to make independent decisions. However, procedures were not always in place to protect people who lacked capacity to make decisions.

People were not always supported to maintain a nutritionally balanced diet and fluid intake.

People's health was not always effectively monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

People's choices, likes and dislikes were respected however staff did not engage socially with people when they had the opportunity.

People's privacy and dignity was not always supported.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not have their care planned for consistently and this resulted in care which was not always safe or effective.

People were not always supported to undertake social activities within the home and the broader community.

Complaints and concerns made to the management team were not always responded to effectively.

Is the service well-led?

Inadequate

The service was not well led.

The service lacked appropriate governance and risk management frameworks which resulted in poor outcomes for people who used the service.

Staff did not feel supported by the management team.

People were not able to provide feedback about the quality of the service and any feedback given was not acted upon.

There was a lack of transparency and many incidents in the home. Appropriate notifications had not been made to the CQC.

The Woodlands Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 7 8 25 and 29 April 2016. The inspection team consisted of two inspectors 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with six people who were living at the service and seven people who were visiting their relations. We spoke with three visiting health professionals, six members of staff, the deputy manager and the consultant who was supporting the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of six people who used the service, five staff files and a range of records relating to the running of the service. These included audits carried out by the registered manager.

Inadequate

Is the service safe?

Our findings

People who lived in the service were not always protected from potential abuse. Although some staff were able to identify signs of abuse and understood the process for reporting concerns to their line manager or the Care Quality Commission (CQC). Some members of staff we spoke with had not received safeguarding adults training. One staff member we spoke with although able to say they would raise concerns to their immediate line manager was not aware of how they could share they concerns with external safeguarding agencies. This meant there may be times when issues regarding people's safety would not be reported and acted upon robustly.

The care records staff completed to highlight safety issues did not have the necessary information to highlight issues of concern. Body maps in people's care plan completed to record bruising, pressure ulcers and other skin marks or breaks did not give any indication of how the issues recorded had occurred. For example, one person was recorded as having a skin tear and blister on their outer arm but there was no information about how it had occurred.

The same person was recorded as having two bruises to their right arm as well as bruises to their left hand and arm. No records were available to indicate how the bruises had occurred or that any investigations were carried out. We spoke with staff about this, a number were new to the service, newer members of staff were unable to explain the injuries. However other staff members told us the person had a medical condition which caused involuntary movements and whilst they had not witnessed the injuries occurring they felt this was the cause. The person's care records also contained a letter from a local hospital which indicated they had attended the hospital following a head injury. We were not able to find any evidence of an incident form being completed or any observations being completed following the person's discharge. This meant incidents and accidents were not being reported correctly or any actions taken to prevent recurrence.

Despite this some people we spoke with who lived at the service told us they felt safe, one person told us, "Of course I do. I feel comfortable. They pop in to see you and ask if you are alright." Relatives we spoke to told us they felt their relations were safe, one relative said, "Extremely safe, absolutely. If (name) was anxious they would show it."

People who lived at the service were not always protected from individual risks to their safety. The risks to individuals were not always assessed when they were admitted to the home. In addition, the assessments which were in place, whilst identifying risks, did not give staff enough information on how to manage the risks. For example, one person who had been admitted to the home for a short period during 2015 had been readmitted in 2016. The person was living with dementia and was at risk of falling but their individual risk assessments had not been reviewed or updated since the person's previous admission. We witnessed two members of staff using an unsafe moving and handling procedure to move the person from a chair to a wheelchair. The person could not take their own weight properly in the transfer and staff prevented the person from falling only by quick manoeuvring of the wheel chair. This put the person and staff at risk of

sustaining an injury.

Some information we viewed in people's care plans was either incorrect or contradictory. We viewed a person's falls risk care plan which stated the person used a certain type of aid to assist them to the standing position from sitting but there was no mention of this in their mobility care plan. There was also an entry in the communication book from health professionals stating that the physiotherapist had advised that a different aid and full hoist was to be used for all transfers. This meant that the person was being exposed to avoidable risks because the correct equipment was not being used. Another person had a mobility assessment completed that stated the person used an aid to assist them from sitting to standing and walking frame. However their mobility care plan and falls risk assessment stated they required a full hoist at all times. This meant there was a risk that inappropriate methods of transferring people would be used, increasing their risk of falls or injury.

People were not always protected against environmental risks in the service. The registered manager did not undertake regular audits of the environment and equipment. We were unable to find any audit information prior to December 2015. We saw a person had a movement sensor mat in place when they were sitting in the lounge. When staff moved the person it did not activate and we found it was not working. Staff were unable to tell us when it was last checked. Staff found a replacement but the person had been sitting in the lounge throughout the morning. Should the person have attempted to stand when staff were occupied with other people they would not have been alerted to the person's movement increasing the risk of falls through the use of faulty equipment.

Health professionals also told us that staff did not feed back to them if equipment they had put in place was not effective. For example, one person had been using a particular type of walking frame but had struggled to use the equipment safely and had fallen as a result.

This lack of effective monitoring of people's health needs was a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient numbers of appropriately trained staff on duty to assist people. People we spoke with who lived on the ground floor of the service told us told us they felt there was enough staff. However relatives of people who lived on the first floor of the service (where the needs of people were greater) told us they felt there were not enough staff. One relative told us, "There is not enough staff, over the year we've been coming the turnover of staff is high." The relative went on to say they were worried their relation was not receiving the personal care they required. They told us they had gone into their relation's room and found they had dry food around their mouth and at 10am the person's fluid chart was showing they had not had a drink since 6am that morning. The relative said, "Staff are stressed at times as they have such a lot to do."

Staff we spoke with told they felt extra staff were required to provide the care people required. One member of staff told us, "Staff levels have been poor especially upstairs." The member of staff told us the people on the first floor were more dependant and required a lot more supervision and help. Another member of staff told us there had been occasions when they had to work alone to provide care to a person who required two people to assist them. Staff told us as a result of not having enough staff people on the first floor were getting up later than they wished. Some people who required re-positioning to prevent tissue damage were not receiving this aspect of care as often as they should and documentation relating to care was not being completed. One member of staff told us they felt the high number falls were due to a shortage of staff as they were not able to observe people.

We saw from a person's care plan they were meant to receive six hours of one to one care throughout the day. The person was living with dementia and became upset and anxious very quickly, they had limited mobility and were at risk of falling. From our observations during the inspection we saw the one to one care was not provided for this person. We requested to view staff rosters for the previous six months but these could not be located and only four weeks were provided (from mid-March 2016 to mid-April 2016). We requested staff allocation sheets to show us how staff were allocated and who had been allocated to provide one to one care for the named person. The sheets could not be located and we were told this was often arranged verbally and not recorded. As a result of the lack of records and our observation we concluded the one to one care was not being provided for this person and they were not receiving the care they required to keep them safe.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the service were not always protected from staff who may not be fit and safe to support them. We looked a five staff recruitment records and found the registered manager had not always followed safe recruitment processes. Criminal records checks had not been received from the Disclosure and Barring Service (DBS) before two members of staff started to work at the service. These checks are to assist employers in maker safer recruitment decisions. Two records showed staff had provided personal references and not those from previous employers with no notes to explain why this was. We highlighted this to the provider who told us they would address these issues.

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

People told us they received their medicine in a timely manner and in a way they could manage them. However on the 1st day of our inspection we observed the clinical room where medicines were stored was left unlocked during the medicine round. The room contained large amounts of medicines for return to the pharmacy in open boxes and an unlocked medicines refrigerator. We pointed out the unsafe practice to the deputy manager who rectified the issue.

We had also received information from a health professional regarding a medicines error that had resulted in a person being left in pain for a significant length of time. However we could not find any evidence to show the error had been investigated, which staff member had made the error and if further training had been undertaken to prevent repeat incidences.

On the day of our inspection we observed a medicines round and saw the staff member followed safe practices and ensured each person took their medicines. We saw one person had their medicine in cups on their table and the person told us they like to have the medicines this way. The person's relative told us the staff always made sure their relative took the medicine We saw medicines records relating to administration and ordering were up to date.

Inadequate

Is the service effective?

Our findings

People we spoke with did not feel they received care from sufficiently skilled and competent staff. One person told us, "I don't think they are really. I don't think they are given time to be trained. There are a lot of new ones." One person told us that some staff 'edged away' from personal care. Relatives we spoke with felt that there was a high turnover of staff and with regard to skill and knowledge one relative told us, "The ones that have been here a long time are (skilled and knowledgeable), but there are so many that come and go that I've no idea about them." The relative went on to say the biggest problem for them was the staff turnover they said, "You just get used to staff and then they are gone and you are never told anything."

Staff we spoke with who had worked at the home for a number of months told they had not received regular supervision. One member of staff told us they had received supervision in February 2016 but had none previously. Another told us they had been in post for three months and had not received any supervision. They told us they did not feel supported in their role. Two members of staff told us the organisation was not well run, they said it was disorganised. They told us a team of consultants had been brought in to assist with the running of the home were helping and training had improved.

Two members of staff we spoke with had been working in the home for over a month and had only received training in moving and handling. The two members of staff had received no other training, one of them had no prior experience of working in a care setting. The members of staff told us they had undertaken three shifts where they shadowed a more experienced member of staff and then they were considered part of the staffing numbers. Staff also told us they could be working with people on the ground floor of the home for a number of shifts and then be required to undertake a shift on the first floor. One staff member told us they had not worked on the floor they were allocated to on the day of our inspection much before. They did not know the names of the people on this floor and were not aware of their care needs. We asked staff members about the information given on handovers at shift changes and one member of staff told us the handovers were, "Weak." They said there was very little information given about people's care needs. This showed that staff were not sufficiently supported in their roles and the lack of support for staff impacted on the standard of care people who lived in the home received.

Staff training records showed a number of significant gaps in the training that had been undertaken by staff. For example, on both days of our inspection a number of staff working on the first floor, supporting people living with dementia, had not received dementia awareness training and no staff had received training in dealing with challenging behaviour. The newer members of staff had not been given training on on food handling but were assisting with meals and the training matrix lacked any record of staff undertaking managing nutrition. This impacted on the quality of care given to people as staff had not been given support to develop a set of skills to assist them give appropriate care for these people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that staff followed the principles of the Mental Capacity Act 2005 (MCA) and the

Deprivation of Liberty Safeguards. 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.

There were some mental capacity assessments and best interest decisions undertaken for some people in relation to the administration of medicines. However, we saw that some best interest decisions did not clearly show why the decision had been made. For example, a decision had been made to refrain from using bed rails for one person. The records did not explain why the bed rails were unsuitable for that person. The person was at risk of falling and other measures had been taken to reduce the risk by the use of a sensor mat by their bed but the rationale for the decision was not documented.

Another person who had a sensor mat in place to alert staff of their movements did not have any evidence of consenting to the use of the mat. A mental capacity assessment and best interest decision process had not been followed for this person. The person's care records indicated they had significant short term memory problems and could not use the call bell. This suggested they would not have capacity to make the decision, however no formal process had been followed to show why the decision for the use of the sensor mat had been made for them.

Some staff we spoke with did not show a good understanding of the MCA and their role in relation to this. The training matrix showed a large number of staff had received recent training on this subject. One member of staff told us, "We have to make decisions for some people, we would have a best interest meeting." However they told they had not been involved in this process and were not able to give an example of a person who may have had a best interest meeting to establish if particular decisions should be made for them.

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 and hospitals 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.

There were a number of people who lived in the home who were deprived of their liberty as there were key pad locks to prevent some people leaving independently to protect their safety. We were told the registered manager had made applications to the local authority for a large number of DoLS but only one record of an application could be produced. This meant the registered manager was not working within the principles of the MCA and there were a number of people who were being deprived of their liberty illegally.

This was a breach of Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We raised this with the provider who told us they would address the issue straightaway.

People we spoke with who had the capacity to make their own decisions told us their day to day decisions were respected by staff. One person told us, "Yes you can do what you want, stay in your room or get up. Go and chat to people in their rooms." Another person told us, "We can make our own mind up (when they get up) it's usually the same time but you don't have to get up." A third person told us, "I decide when I want to go to bed. There's no one deciding when I go to bed – I'm too old for that."

People's nutrition needs were not always met. Two care records we examined showed both people had

been gradually losing weight since their admission to the home. However, there was no clear information in the care plans regarding how the weight loss had been managed. One person's weight assessment record showed they had lost 3kg in weight during a one month period, however when staff had completed the person's risk assessment tool they did not record this weight loss. In the same person's care record a number of months later the service's assessment tool rated the person as high risk due to their weight loss. A GP referral had been made and food supplements had been prescribed. The documentation indicated that the person should be weighed weekly and have food and fluid intake recorded. We could find no evidence of these weight checks taking place and the only food and fluids charts we found were 8 daily records over a two month period. The person had continued to lose weight and up to the last recording of their weight (which was two months prior to the inspection) the person had lost nine kilograms in a period of a year.

The second person's care records showed the person had lost five kilograms in weight since they had arrived in the home. This weight loss was over approximately eight months, the record then showed a significant weight gain of three kilograms in one month. However there had been no record of interventions from health professionals or changes in diet and the weight gain was not questioned or checked by staff. We highlighted the issue to a senior member of staff who accepted that such an anomaly should have been checked by staff. The last recording of the person's weight was two months prior to our inspection. This lack of management of people's care records meant some people who lived at the home were at risk of receiving care that did not meet their needs
This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they enjoyed the food served to them one person told us, "It's alright, very nice. Usually there are two choices you can have one or the other." Another person said, "Plenty (of food) and it is good, well thought out. I usually eat what's there, there's no menu. They tell you what there is when you get to the dining room and I eat most things." We discussed the menu and choices with the chef who told us people were asked what they wanted to eat the evening before the following day's lunch. They told they usually cooked a small number of extra portions of each option in case people forgot what they had ordered or changed their minds.

However, some people in the home living with dementia were unlikely to remember their choices each day or some people may not understand what was being offered without the visual options being placed in front of them at mealtimes. This, coupled with a lack of information in people's nutritional assessment records of their food preferences, meant staff would not have the knowledge to meet the nutritional preferences of a large group of people they cared for.

Some relatives we spoke with had concerns over whether their relations were given enough to drink throughout the day. One relative told us told us they had viewed their relation's fluid chart that morning which showed the person, who was nursed in bed and had significant care needs, had not been offered a drink for four hours. Another relative told us, "At other places (homes) you see would see regular tea rounds with cakes, I don't see that here." Three members of staff we spoke with stated clearly there was no set drinks rounds throughout the day. Staff we spoke with told us they asked people if they wanted drinks and snacks throughout the day however we saw very few examples of this throughout the inspection. This and the lack of visual prompts for people who had difficulties making their needs known meant that some people's hydration needs were not always being met.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's health needs were not always met. One set of relatives we spoke with told us their relation had an on-going health condition and whilst staff had identified symptoms of concern and escalated this to the person's GP they had not carried out the GP's instructions in a timely way. Health professionals we spoke with told us they often had problems finding staff to assist them. When they came to give treatment to people staff were not always aware of the reason a health professional had been called in and showed poor knowledge of people's health conditions. One health professional told us that treatment plans they had put in place to assist people were not always followed. For example, staff had not supported a person with an exercise treatment plan which was designed to improve their mobility.

Requires Improvement

Is the service caring?

Our findings

The people and relatives we spoke with told us the staff were kind to them and willing to assist them when they were required. However, the majority of the interactions we saw related to tasks being undertaken for people. These interactions were positive with people and staff talking easily to each other showing people felt comfortable with staff. For example, we saw two staff members transferring a person from a wheelchair to an easy chair. The task was undertaken in caring and gentle manner with the staff members talking with and reassuring the person they were assisting. However, we also noted there were occasions when there were opportunities for staff to engage socially with people that were not acted upon. This was not solely due to demands placed on staff or staffing levels. We saw staff who told us they were new to the home standing in the lounge area and not engaging with the people in the room. This showed a lack of person centred care for the people who lived in the home.

We observed lunches being served in the ground floor dining room. The management of the meal was at times noisy and disorganised. Staff distributed meals to people from a list in front of them rather than looking at which people were sat together. As a result people sitting together were unable to eat their meals together. Staff talked over people's heads loudly to each other. At one point visiting relatives were having a loud conversation and a staff member joined them and began shouting to colleagues across the room. We saw one person in particular become very agitated by the situation. This mealtime experience lacked the air of sociability for the people in the room and had a negative impact their dining experience.

People told us they had the opportunity to develop relationships with other people who lived at the home. One person told us, "It's happy, the other residents all talk so you have a nice social bit." Relatives told us they were welcome in the home and were comfortable when they visited.
However relatives told us as the providers did not supply a role specific staff uniform. This coupled with a quick turnover of staff meant relatives were unsure of what roles staff undertook and as a result did not always know who to talk to about their relation's care.

The people we spoke with told us they were able to express their views and make day to day decisions about their care. However, we could not find any further evidence that people or their relatives were involved with planning their care. Each of the care plans we viewed contained a standard form stating that the person or their relatives were happy for staff to undertake reviews of the plan without their input. The form was photocopied and the person's name handwritten at the top. Of the forms we viewed only one was signed by a relative and the others had not been signed. As a result people's care was not reviewed by the people who knew them best.

People we spoke with told us that staff respected their privacy and dignity. One person told us, "Yes I leave my door open but they (staff) always knock and ask if they can come in." Another person we spoke with told us, "Yes, they always see that people are treated with dignity and respect." A relative we spoke with told us, "I can honestly say that the people (staff) I've seen with my (relation) are very respectful, the treatment I see is always good." The relative went on to say they had witnessed staff getting down to eye level when talking to people and talking discreetly about personal care. However, one relative we spoke to told us they felt their

relation's dignity was not always respected. They told us they had noticed the person had dirty nails after receiving the support they required with personal care. The relative told us the person's false teeth had gone missing and staff were unable to tell them where they were.

Staff we spoke with told us they closed the door and curtains when they provided personal care. One member of staff told us they would prepare things in advance so people were left uncovered as little as possible and they made sure people were able to choose their own clothes each day. Another senior member of staff said, "Yes I am a strong believer in managing people's privacy and I make sure it happens."

During our inspection whilst we saw a number of positive interactions where staff clearly maintained people's privacy and dignity, there were occasions when this was not the case. For example, we saw one member of staff call across the room to a person about plans for their personal care. This showed that people's privacy and dignity was not always maintained.

Requires Improvement

Is the service responsive?

Our findings

People did not receive person centred care because their care plans were not person centred and contained contradictory information. This meant it was difficult for staff to find the information they required to give people the appropriate care. One person's care record gave contradictory information about their mobility. A recent assessment tool indicated their mobility risk was low and that the person was cooperative. It also stated that they required little assistance and was able to walk with the aid of a stick. However, a mobility risk assessment stated the person required a walking frame and was at high risk of falls as they were uncooperative at times. The person had fallen three times in three months but no changes to their care had been recorded. We were only able to find two post-accident observation records. Following one of the falls the person had been admitted to hospital but no reason for the admission was recorded in their records. This lack of and contradictory information placed this person at risk of further falls and injury.

People's care was not planned appropriately. One person's care plan was incomplete and also showed they had been admitted to the home on two occasions. The first admission was over six months prior to our inspection and was for a period of respite care. The second admission was three months to our inspection and was for long term care. No assessment of the person's needs had been undertaken after the second admission. Their weight had only been recorded once, one month after the most recent admission. Their care plan contained some records from their previous admission but lacked up to date plans for their personal care or mobility. There was a one page tick box assessment which established they were at risk of falls with no further information on how to manage this risk. The lack of information on the person's needs placed them at risk of receiving inappropriate and unsafe care. We raised the issue with the management team who told us a consultant team had been employed to improve the information in people's plans to ensure staff could give appropriate care.

Staff we spoke with told us they could not rely on the care plans. One member of staff told us, "The care plans have been a mess." Another member of staff told us, "Sometimes I come back from days off and the paperwork is a mess and I have to try and find missing charts." Another told us the paperwork was poor. Staff who had worked in the home for some time told us they knew the needs of the people who lived in the home. But we spoke to new staff who told us they were not always allocated to a particular set of people and the lack of consistent up to date information in the care plans meant this set of staff could not give individualised care to people.

This was a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014.

There was a lack of support for people to follow their interests and take part in social activities. The people and relatives we spoke with told us there was a lack of stimulation for people. One person told us, "We've said there's not much to do. A lot of us would like a little walk in the garden sometimes. We talk about it and everybody is of the same mind." A relative we spoke with told us, "I think they (people who lived in the home) need more to do. I mean its soul destroying just sitting here." On the days of our inspection there were no organised activities and people were sat in communal areas with no meaningful activity for long

periods of time.

The home employed an activities coordinator, whose job was to coordinate a programme of events for people. The activities coordinator had no input in planning the programme and at times did not know what they were meant to do to facilitate particular activities. For example, the programme advertised a painting session, but there were no painting supplies to carry out the activity. We saw there was a poster advertising a programme of activities but the poster was showing the previous month's activities. A poster showing the current month's activities was not available when we enquired.

The activities coordinator received little support to carry out the programme. For example, the lack of staff to assist them when organising a cinema session meant the amount of people they could take to the cinema room in the service was limited. This was because a number of people required constant support and the activities coordinator could not leave people to support other people come to the room.

There was a complaints procedure on display to inform people how to raise concerns and people and their relatives told us they knew who to raise concerns with when they had them. However, one relative told us they had raised a complaint with the registered manager and, whilst they thought it had been addressed, they had received no feedback from the registered manager to let them know what they had done about the issue. A number of the relatives we spoke with told us that although their concerns and issues were listened to they were not always acted upon.

We saw one partially completed complaint record in the complaints folder. The record was not dated or signed by the person receiving the complaint and had only a first name of a service user on the form with a list of significant concerns raised around personal care of the person. The complaint form did not show who had made the complaint and contained no actions relating to how the complaint was managed. This meant that the concerns about the person's care may not have been resolved.

Staff we spoke with told us if a person wanted to make a complaint they would tell the registered manager but staff did not receive any feedback on these complaints. This meant that staff could not act on the complaints or concerns of people and alter practice to improve care.

Inadequate

Is the service well-led?

Our findings

Whilst some people we spoke with were happy with the care being delivered in the service, other people and their relatives expressed concern over the turnover of staff. One relative told us when they reported issues they weren't always sure things were passed on. They said, "But then again I am never sure if the person I raised it with is still here." Another relative told us, "The manager told us they were going to have the staff they wanted and they would pick them. Why then are they leaving?" They went on to tell us there were some care staff who they knew had enjoyed working at the service but had left and the relative was not sure why. The relative told us the staff members had been good at their jobs. Relatives told us the high turnover of staff and the lack of uniforms for staff caused confusion as there were a number of new members of staff and people were unsure of their roles.

We found the systems in the service that were meant to monitor and identify improvements were not effective and the lack of effective governance led to some people not receiving safe and consistent care. During the period between January 2015 and February 2016 there were five serious injuries resulting from people having fallen. The registered manager did not report these accidents to the Health and Safety Executive (HSE) at the time of the injuries. The registered manager has a duty to report serious accidents resulting in injury to a person as soon as possible under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Serious accidents are reported to the HSE to assist enforcing authorities such as the Care Quality Commission in deciding whether to investigate to identify where and how health and safety risks arise.

At the time of our inspection there was a registered manager in place. It is a condition of the provider's registration to have a registered manager in post to manage the service. The registered manager must be aware of their responsibility for reporting significant events to the Care Quality Commission (CQC).We found the CQC and had not been informed of a number incidents that had occurred in the service. The registered manager has a responsibility to notify the CQC of certain types of incident under Regulation 18 of the Care Quality Commission (registration) Regulations 2009 (part 4)

For example, prior to our inspection we received six notifications from the Local Authority of RIDDOR incidents that had occurred at the service. Five of these were retrospective notifications relating to the serious injuries that had occurred between August 2015 and March 2016. Of these the CQC had only been informed by the service of two serious injuries.

One person had fallen 18 times between February 2015 and 2016 and due to large gaps in the person's records we could not see whether the events around the fall had been recorded and managed effectively. We were only able to find six post-accident observation sheets for this person and as a result of the lack of records were unable to assure ourselves that the person had received safe care and treatment following their falls. Therefore the systems in place to monitor and mitigate risks to people's health and safety were not effective.

Other examples of incidences which were not reported to us were related to a serious drug error and a GP's

instructions not being followed which resulted in a person being in severe pain for a prolonged period of time. Some people at the service had developed pressure ulcers of a severity that would require the registered manager to notify the CQC which were being treated by the district nursing team but the CQC had received no notifications of these events. During our inspection we asked for records to show if investigations had been carried out following these injuries and occurrences, or if the registered manager had looked at strategies to support staff and prevent reoccurrence of these issues but no records could be produced. This indicated a lack of openness and transparency at the service.

This meant the registered manager had breached Regulation 18 of the Care Quality Commission (registration) Regulations 2009 (part 4).

People's views on the service were not considered, the home had a questionnaire that was meant to be completed by residents but there was no formal means for relatives to feedback to the management team. There were only three completed questionnaires available and people we spoke with could not recall completing any questionnaires or being asked their views. This meant the service was not able to use the views of people and their relatives to improve the quality of the service.

We found that records were not always maintained and completed in full and this posed a risk that people would receive inconsistent care. We viewed a number of charts which were meant to record a person's change of position. The person's care plan indicated they required two hourly changes of position prevent pressure damage. There was a lack of recording on some sheets indicating the person had not received this care and there were sheets missing. This person also had a fluid chart in place and over a period of three days it had been recorded the person had only drunk 140ml of fluid. Further daily care records for the person could not be located for us and as a result we could not see what action staff had taken as a result of these omissions.

The service's accident book showed between February 2015 and 2016 there had been 156 occasions when people who lived in the home had fallen. However, there was a 12 week period from the 6th June 2015 to the 30th August 2015 when one accident book had been completed and a new one started where no falls had been recorded. We saw evidence in the care records we examined to show one person had fallen twice in this period and another person had fallen four times during the 12 week period. This indicated an accident book was missing and as a result the number of falls recorded was not a true reflection of the actual number that had occurred.

We asked for staff rosters for the six months prior to our inspection and were only given records relating to the previous month. Further documentation relating to staff rosters could not be found and staff told us the roster was often hand written and changed without their knowledge. Staff records relating to recruitment were incomplete and some people had been employed without a current Disclosure and Barring check (DBS). This lack of governance put people at risk of receiving unsafe treatment as the provider could not demonstrate to us they had achieved consistently safe numbers of staff or that all the staff employed were safe to work with the people who used the service.

Care plans were not being audited to ensure they met the current needs of people who used the service. As a result, documentation in people's care plans did not always reflect the extent of people's needs or what treatments were in place for particular issues. One person had a pressure ulcer on their heel, they had limited mobility and was having their pressure ulcer treated by the district nurses. Their care plan did not contain any tissue viability, mobility or foot care assessments. We spoke with the managing director and deputy manager about this they told us they would rectify this straight away. We also spoke to a senior care

worker and a care worker about the person's treatment and were assured they were aware of the person's mobility needs, their tissue damage and the treatment in place. However, the lack of care records relating to this person needs meant that new staff were not able check on the person's treatment without the support of more experienced staff and as a result may not understand the importance of the treatment in place.

Further audits we viewed relating to tissue viability, infection prevention, medications and equipment monitoring had been undertaken inconsistently and lacked analysis to improve the quality of the service. We found information recorded in the audits did not match what we found in other records. For example the monthly falls audit for December 2015 showed there had been nine falls, however the service's accident book showed there had been 15 falls from the 8 December to the 31 December 2015. The audit did not record any trends relating to falls or whether particular people were falling more than others. The information on the audit was not only incorrect but gave no meaningful analysis that would assist to reduce falls in the service.

Although the provider and the managing director of the company came to the service regularly, this did not provide effective oversight of the service. They did not undertake any audits related to maintaining the quality of the service. They did not oversee the audits the registered manager undertook and as a result were not aware of the lack of issues that affected people's safety.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents lack of appropriate statutory notifications

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care lack of person centred care records

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment lack of up to date risk assessments, lack of checking of equipment lack appropriate applications for DoLS

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment lack of training for staff on safeguarding lack of robust recruitment processes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs weight losses lack of monitoring of diets and weights

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance lack of quality assurance audits

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing poor staff levels lack of staff training and suppport