Pages Homes Limited

Woodville Rest 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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 21 and 24 July 2015. It was unannounced. There were 20 people living at Woodville Rest Home when we inspected. People cared for were all older people who were living with dementia, some of whom could show behaviours which may challenge others. People were living with a range of care needs, including arthritis, stroke and heart conditions. Many people needed support with all of their personal care, eating and drinking and mobility needs. The registered manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

Woodville Rest Home is a large domestic-style house which has been extended. People's bedrooms were provided over three floors, with a passenger lift in-between. Single story accommodation was provided in an extension to the rear. There were sitting/dining rooms on the ground and third floors. The sitting/dining room on the third floor was not being used because the home was not up to capacity. There was a wheelchair accessible enclosed patio/garden area to the rear.

Summary of findings

Woodville was situated in a residential street in Bexhill on Sea. The provider for the service was Pages Homes Limited who also owned another care home in the vicinity.

Woodville Rest Home had a recently appointed a registered manager. The previous registered manager left Woodville Rest Home in the Spring of 2015. The new registered manager had previously been the registered manager for Pages Homes Limited's sister home. 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.

Woodville Rest Home was last inspected on 30 December 2014 and 2 January 2015. They were rated as inadequate at that inspection. The Care Quality Commission (CQC) issued two Warning Notices after the inspection in respect of care and welfare of people and assessing and monitoring of the quality of the services. The provider sent us an action plan which detailed when different areas would be addressed. This stated all matters would be addressed by 27 May 2015.

We found the provider had not met the Warning Notices or addressed their action plans by their due dates.

As at the last inspection, the provider was not consistently ensuring people's care needs were assessed or met, including supporting people who were living with dementia, people who were at risk of pressure wounds and people who had continence needs. The provision of activities had increased but activities provided did not take account people's individual diverse care and support needs.

We continued to find some people showed weight loss and were at risk of dehydration, but relevant care plans were not in place or relevant external professionals contacted. Also where people had seating and mobility needs, relevant healthcare professionals were again not contacted so people received the support and equipment they needed.

People's privacy and dignity was not consistently respected to ensure their basic needs were met, in an appropriate way. Communal use of certain clothes continued.

As at the last inspection the provider did not have safe systems to ensure a hygienic environment to prevent risk of spread of infection. There continued to be a lack of hand washing and drying facilities in some areas. Some equipment and furnishings were not clean, including people's easy chairs and shower seats.

People were still not protected by the provider's systems for administration of medicines. There were unsafe systems for the storage of prescribed skin creams and a lack of information about their use. There continued to be administration of some prescribed medicines which were out of date.

At the last inspection we saw staff had not been trained in a range of areas, including the safe moving and handling of people and principals of infection control. At this inspection staff were not all trained in infection control and although staff had been trained in the safe moving and handling of people, this had not been embedded and again we observed unsafe ways of supporting people to move.

Although we had issued a Warning Notice after the last inspection about assessing and monitoring the quality of services, the provider had not identified a range of areas to ensure people were safe and areas for action were not identified and acted on. This included where people may be at risk from others or from the home environment. Differences between what people's care plans stated and how care workers carried out care had not been identified. There was a lack of auditing of the systems for monitoring of the external cleaning contractors.

The provider did not have systems for the monitoring of informal concerns raised by people, so was not aware of some issues. However there were effective systems for formal complaints, which were being followed.

Some of the past recruitment systems had not ensured all relevant checks on prospective staff were undertaken to verify they were safe to provide care to people. The registered manager reported they would take action to ensure these matters were addressed.

However, the provider had taken action since the last inspection in a range of areas. They had invested in more equipment to support people with moving, which care workers were positive about. Plans were being developed to make the home environment more supportive for

Summary of findings

people who were living with dementia. The provider had identified many of their policies and procedures needed up-dating and development, they had contracted with an external company to do the necessary work.

The new registered manager had reviewed staff training needs and was working to ensure all staff were appropriately trained. This included making sure all staff were trained in awareness of how to support people who may be at risk of abuse, and their responsibilities under the Mental Capacity Act (MCA). Staff knew about actions to take if they thought a person was at risk of abuse and were aware of the plans to ensure they were trained in the MCA.

People and staff felt staffing levels had improved. This was partly because the provider had kept staffing at the same levels for when the home was full.

Some people were supported in the way they needed in their daily lives, including during mealtimes and when involving them in activities. Staff were consistently polite and friendly to people when they supported them.

Staff reported on the improvements in the service. They said the training provided had supported them more in their role. They felt the new registered manager was involving them more and providing an open atmosphere in which they could work to support people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

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

CQC are taking enforcement action to ensure that Pages Homes Limited provide safe and effective care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe

People's safety in the environment and from others was not always ensured.

The systems for management of medicines were not consistently safe.

Systems for hygiene did not ensure people were protected from risk of infection.

Methods of staff employment were being improved.

Staffing levels were safe for the number of people in the home. Staff were aware of their own responsibilities for supporting people from risk of abuse.

Is the service effective?

Inadequate

The service was not always effective.

Action was not always taken where people were at risk of malnutrition and dehydration.

People were not consistently referred to relevant external healthcare professionals when needed.

Although training and supervision systems were now being developed, these had not always been embedded to ensure effective care was provided.

There were systems to ensure the requirements of the Mental Capacity Act and Deprivation of Liberties Safeguards were followed.

Is the service caring?

Inadequate

The service was not consistently caring.

People who were living with continence needs did not have their dignity ensured. Communal use of some people's personal items was not prevented.

Staff were not aware of, and did not take people's diverse needs into account, to ensure they were treated as individuals.

People were involved in decisions about some aspects of their care and were supported in making some choices.

Is the service responsive?

Inadequate

The service was not always responsive.

People who had needs relating to pressure wounds, continence and dementia did not have their needs assessed and met. Some people's care plans were not followed.

There were some systems to meet people's recreational and activities needs, but these were not based on people's diverse preferences and individual needs.

Systems had not been developed so people's individual concerns were acted on. However, formal complaints were investigated and the complaints policy followed.

Summary of findings

Is the service well-led?

The service was not consistently well-led

A range of areas had not been identified by the provider's audits and action taken to ensure people's health, safety and welfare.

The provider had identified some matters and was in the process of taking action.

People spoke positively about improvements made by the new registered manager. Staff appreciated the more open, inclusive management style of the new registered manager.

Inadequate

Woodville Rest 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.

The inspection took place on 21 and 24 July 2015 and was unannounced. The inspection was undertaken by 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.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We reviewed the provider information return (PIR) and used this information when planning and undertaking the inspection. The provider also sent us some information immediately after the inspection.

We met with 12 people who lived at Woodville Rest Home and observed their care, including the lunchtime meal, medicines administration and activities. We spoke with four people's relatives. As some people had difficulties in verbal communication, 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 inspected the home, including the laundry, bathrooms and some people's bedrooms. We spoke with seven of the care workers, the cook, the handyman, the registered manager and the provider.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for two other people.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

We talked with people about if they felt safe at Woodville Rest Home. One person told us "I worry a bit" when we asked them if they felt safe. Most other people responded to say they felt safe, one person saying "I'm safe enough with the staff."

At the last inspection on 30 November 2014 and 2 January 2015, we reported on a range of areas where people's safety in Woodville Rest Home was not ensured. The provider had acted on the specific areas we included in our report but had not considered wider areas to ensure the safety of people.

One person told us "Things go missing." Another person told us "Small bits of money can go." We observed two people frequently walked about throughout all of the building. This included walking into other people's rooms, handling objects and on occasion taking objects away with them. On both days of the inspection cupboards which contained items which could have put these people at risk were not locked. This included a cupboard under the stairs containing electrical meters and other equipment, and the lift motor cupboard, which contained electrical cabling. The appearance of one of the unlocked cupboards showed they had been accessed by one of these people. We looked at the care plan for one of these people, they did not have any risk assessment about their behaviours or guidance about how to support either themselves or other people from their behaviours. Staff had also not reduced risk to people by routinely ensuring all areas in the building, which would present risk to people living with dementia, were kept secure. There were no environmental risk assessments to ensure people living in the home were safe while continuing to access the areas they needed, when they wanted to.

One of the people who remained in bed all of the time had recently rolled out of bed and sustained some bruising. Their bed was at its lowest position, so it was close to the floor but there was no protection to the floor by their bed, such as a crash mat, so their risk of harm was reduced should they roll out of bed again. We looked at the person's risk assessment and it had not considered the use of such equipment. Two of the care workers we spoke with were not aware such equipment could reduce risks to a person who might roll out of bed.

At the last inspection, we identified issues relating to safe management of medicines. The provider sent us an action plan in which they stated they would have met the breach by 27 May 2015. We found a wide range of areas where the provider continued not to ensure the safety of people in relation to medicines.

People's prescribed creams were not being managed appropriately. All of the creams for people were inappropriately stored together, in an open laundry basket on top of a cupboard in the dining area. A number of these creams had dispensing labels which instructed 'Apply twice a day' but there was no information such as body maps in those people's care files to show where these particular creams should be applied. Care workers confirmed they would not know to which parts of the body they should be applied except "By knowing it in their heads". A person's steroid cream had been prescribed for application three times per day but their medication administration record (MAR) showed that the cream was applied at morning and teatime, and on eight occasions the person's MAR showed their teatime application had not been made, despite the prescriber's direction that it should be administered three times a day. The care worker we spoke with did not have information on why the person had not been administered their skin cream as prescribed by the doctor.

A review of MAR found six separate incidences where care workers had omitted to sign to denote that medicines had been administered. There was no evidence that these omissions had been identified before the inspection visit or that care workers administering medicines had checked to ensure that people had actually received their medicines. It was not possible in retrospect to confirm whether people had received their medicines as prescribed to them.

As at the last inspection, we found some medicines were being used after they had expired. A box of Paracetamol in the medicines trolley, which a care worker confirmed was in current use for a person had expired in May 2014. One person's eye drops had been opened on 18 April 2015. The directions on the box stated they should be used within a maximum of 28 days after opening. The MAR for this person showed these eye drops had continued to be administered, two months after the medicines' expiry date. The use of out of date medicines may mean they do not work in the way they were meant to and may impede a person's recovery.

As at the last inspection, we found the provider did not have safe systems to ensure a hygienic premises and

Is the service safe?

prevent risk of cross infection to people and others. On both days of the inspection we found communally used toilets which had unclean light pull cords, and did not have paper towels, liquid soap or any other method to ensure people could wash and dry their hands. This meant people continued not to be able to adequately cleanse and dry their hands after using the toilet and could also be at risk of hand contamination from using unclean light pull cords. The service was not following guidelines to ensure all areas were clean, to reduce risk of cross infection. This included shower chairs in two of the communally used showers, which were unclean on the under surface, showing brown and green deposits. The laundry also had deposits of dust and debris beside the machines. Such unclean areas can harbour microorganisms so debris and need to be removed and areas fully cleaned, to reduce risk of cross infection.

Many of the chairs in the sitting room showed signs of staining and stuck-on debris, including on arm-rests. Some of the staining and debris looked like food debris and could present risk to people when they rested their hands on arm rests. When inspectors sat down on easy chairs in the lounge, there was a smell of urine from the chair cushions. We looked at many of the easy chairs in people's rooms. Nearly all of them showed debris on their under surfaces and several of them also smelt of urine. Where standards of hygiene were not being fully maintained, people can be put at risk from cross infection. Elderly people who are frail and already living with a range of medical conditions may be at particular risk of infection, therefore to reduce risk of infection to people, full standards of hygiene need to be maintained.

The lack of effective systems to ensure the safety of people, management of medicines and infection control are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a medicines round. The care worker carried out the round safely and ensured people had swallowed their medicines before signing them off as administered on the MAR.

At the last inspection, we noted one newly appointed member of staff did not have all relevant documents retained on file to demonstrate they were suitable to work in a care setting. At this inspection, we looked at eight staff recruitment files. We saw two different staff files showed matters which should have been taken into account during the recruitment process and probed further, to ensure the prospective members of staff were safe to work with people. The registered manager reported these members of staff had been employed by the previous registered manager, prior to April 2015, when he took up post. After the inspection, the registered manager sent us an action plan in which they outlined that they would identify deficits in the previous recruitment processes and would take relevant action to verify all of the staff were safe to work with people

We saw from one staff file that the registered manager had instigated the disciplinary procedure about a matter relating to people and their safety. He had followed appropriate procedures when he did this, to ensure people were safe and the member of staff treated fairly.

At the last inspection, we identified issues relating to a lack of staff to meet people's needs. At this inspection, people said they did not feel this was an issue. One person's relative said "I was concerned about staffing before but it's better now." A person told us "I have a bell in my room I can ring and they usually come quickly." At the time of this inspection, the home had several empty rooms, however, the provider had maintained staffing levels at levels for when the home was at full capacity, to ensure people's needs were met. We saw care workers were readily available in the sitting room to support people when they needed assistance.

We spoke with staff about their understanding of safeguarding people from the risk of abuse. Three of the care workers we spoke with said they knew how to identify and report abuse. They said they felt confident that the registered manager would deal with any issues raised. All of the staff said they had been trained in the area.

All of the aids for moving people and the chair weighing scales had been maintenance checked annually and were labelled to confirm this. The provider had developed policies and procedures relating to unforeseen events such as a power failure, since the last inspection. The new registered manager had set up a small emergency room which included relevant items like torches, blankets and fans for staff to use in the event of a service failure, to ensure people could continue to be safe at such times.

Inadequate

Is the service effective?

Our findings

People said they felt their needs were effectively met at Woodville Rest Home. One person told us they felt "Well cared for". People's relatives commented on the improvements since the last inspection. A person's relative told us "I think the staff seem knowledgeable and it's much better here now." Another person's relative said "They have got more knowledge about dementia" and another "The staff seem much more enthusiastic and interacting."

People gave us mixed comments about the meals. One person told us "I didn't like it much" about the lunchtime meal. Another person told us "Food, up and down." A person said "The meals are very good you get a choice at lunchtime. The sandwiches at teatime get a bit monotonous but there's always enough." Another person told us "The food's good, always two choices."

At the last inspection, we identified a range of issues relating to supporting people with their nutrition and hydration. After the inspection, the provider sent us an action plan in which they stated, among other areas that nutritional risk assessments would be carried out monthly and where risks were high, people would be referred to relevant healthcare professionals. They also stated where necessary charts would be put in place to monitor people's food and fluid intake. All areas in their action plan would be completed by 7 May 2015.

The provider had not taken action to complete their action plan. We saw a person had lost a total of almost 10 kilos in a year. The person's nutritional assessment had not been completed. They had not been referred to their GP or a dietician about their weight loss. Care workers we asked said they had "No worries" about this person's dietary intake. The person's care plan stated 'extra snacks should be given through the day to boost their weight'. We saw no snacks were offered to this person outside of mealtimes The person did not have a food intake chart to monitor if they were eating sufficient nutrients or their care plan being followed.

Another person's care file stated 'Weight loss-staff to monitor and observe'. There had been no further weight recording since their last recording seven weeks previously although they had been losing weight before that. One care worker told us "We would just know if they weren't eating enough", another that the person ate quite well and another did not know if there were any concerns around the person's weight or diet. There were no food charts to monitor the person's nutritional intake. We made safeguarding referrals about these people after the inspection.

As at the last inspection, we also saw people were not protected against risk of dehydration. The inspection rook place on a very hot summer's day. The Department of Health had issued heat wave guidance in relation to older people. One of the key areas in this guidance related to ensuring older people have a sufficient fluid intake during hot weather. None of the care workers we spoke with were aware of this or other guidance on risks to older people of dehydration during periods of hot weather. Three of the people remained in bed in their rooms all or most of the time. They were not able to give themselves drinks independently. None of them had fluids available in their rooms, so care workers could support them by giving them a drink each time they went by. These people had food and fluid intake records in their room, however none of them had their fluid intake totalled, so risks of low hydration levels could be assessed. When we totalled these people's fluid intake, all showed they had taken in very low levels of fluids over the 24 hour period, despite the hot weather and risk to them of dehydration. We made safeguarding referrals in relation to these people after the inspection.

The lack of effective systems to ensure people's nutrition and hydration needs were met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we identified staff did not always call in relevant professional to support people when needed. After the inspection, the provider sent us an action plan in which they stated external professional support would be sought where necessary. This would take place by 30 March 2015. In the PIR they stated staff would contact the GP when needed and earlier intervention from therapist such as the occupational therapist would be sought where people needed it. A person's relative said "They do get the GP in promptly."

However, we found the provider had not ensured they had taken relevant action to ensure external healthcare professional support was obtained when people needed it. As well as the examples above where support had not been requested for people who were losing weight, support from other external healthcare professionals was not sought. We

Is the service effective?

asked care workers why a person who askedus to get out of bed to use the commode was unable to do so. Care workers told us the person was not able to use a commode as they could not sit straight, so were at risk of falling off their commode chair. There were no assessments in the person's records relating to this need. None of the care workers were aware of whether the person had been referred to a therapist to ensure they had an appropriate commode to meet their seating needs. A different person was assisted to walk by care workers. When they did this, a care worker walked backwards holding the person's hands so they were outstretched at shoulder level, which could affect their balance and their shoulder joints. We asked care workers if they had been advised by a physiotherapist that this was an appropriate means of supporting the person when they were walking. They said a referral had not been made to a physiotherapist to ensure the person was assisted to walk in a safe and comfortable way.

Three of the people we met with were supported by care workers to eat all of their meals. Their records all stated they could be at swallowing risk and so were given a soft diet. None of them had been referred to a specialist like a speech and language therapist or dietician to assess their swallowing difficulties and dietary needs.

The lack of effective systems to ensure timely care planning was taking place for people, with other relevant health care professionals is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we identified issues relating to the unsafe moving and handling of people. We found training in a range of areas, including safe moving and handling of people was not up to date. Care workers were also not supervised when they moved people, to ensure they did this in a safe way. Records showed, and care workers confirmed, they had received training in moving and handling of people, since the last inspection. This training had not been effective in ensuring people were moved in a safe way and there continued to be limited systems to supervise care workers to ensure they did move people safely.

We were told by a person's relative that the person required two care workers to move them. This was done by "Gently supporting under [the person's] arms." The relative said care workers had used a handling belt in the past but this didn't happen anymore. Moving people by lifting them under their arms can cause damage to a person's shoulders. It also had the potential to injure the back of the care worker moving the person because this type of lift puts a strain on the care worker's back. We observed unsafe moving and handling of people. For example, two care workers assisted a person to move using a handling belt. The belt was not placed correctly on the person, so it rode up under their arm pits. If a handling belt is placed like this, it can cause pressure under people's arms which is uncomfortable for them and can put the person at risk of injury to their shoulders. The person called out when they were moved as if they were in discomfort. This took place in the lounge in full view of other staff but they did not supervise the two care workers to ensure the person was moved in a safe way. On a different occasion we again saw two care workers supporting a person to move in an unsafe way when using a handling belt. One of the care workers said they had been trained in using a handling belt but may have forgotten their training. Training and supervision systems had not been effective to ensure the safe moving and handling of people.

At the last inspection, we found care workers were not following safe principals in infection control and had not been trained in this area. Despite issues being identified at the last inspection in relation to infection control, only five of the 21 staff had received infection control refresher training since the last inspection. The lack of training meant staff were not aware of matters where people could have been placed at risk. This included unclean tablets of soap and wet cloth towels in a shower room which was used by the people who had their rooms on that floor of the home. Staff were therefore not following guidelines on safe hand cleansing for themselves and people living in the home, as outlined in guidance from National Institute for Health and Care Excellence (NICE) (2012). Additionally several of the pedal bins did not have liners in them and others did not have any inner bin at all, so used hand towels were placed on the internal foot pedal mechanism for lifting up the lid of the bin. This meant there was a risk of contamination to the inner surfaces of the bin. Staff had not identified such areas during the course of their normal duties and taken action to reduce risk of cross infection.

Staff not had received appropriate training and support to ensure people were moved in a safe way and risk of infection control was reduced. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

At the last inspection, we identified the provider needed to take action to ensure people who did not have capacity were protected under the Mental Capacity Act 2005 (MCA) to ensure they took appropriate action to safeguard people who were at risk of being deprived of their liberties. The registered manager reported that since they came into post they had ensured all relevant referrals were made to the local authority under the Deprivation of Liberties Safeguards (DoLS). They had performed brief mental capacity assessments on all of the people and would be developing these assessments further, once care workers had received relevant raining. We looked in people's records and saw brief mental capacity assessments had been completed for all of the people. Records showed training for staff in their responsibilities under the MCA was ongoing. This was reflected in what staff told us, with some staff showing an understanding of the area and others who showed limited knowledge, reporting they had a training date booked.

The registered manager had performed a review of staff training needs and had started a programme to ensure all staff were regularly trained in areas such as first aid, fire safety and supporting people who were living with dementia. The training plan identified where staff had not been trained and were due up-dated refresher training. Care workers reported they enjoyed the current training because it was led by a trainer and was more interactive than e-learning. Some care workers felt more training was needed so they fully understood their role and appropriate ways of supporting people. They said the new registered manager was supportive of training and prepared to listen to what they felt was needed in relation to their training.

The registered manager had set up individual supervision meetings for staff and had ensured all staff had received at least one supervision meeting, and some more. We looked at a sample of supervision meeting records. They showed the new registered manager had started by trying to establish a working relationship with each member of staff, identify their strengths and areas which needed to be developed. A care worker reported they were pleased to now receive supervision. They said they felt listened to when they brought up issues. Another care worker said the supervision systems now "Work two ways," and felt it was helpful to them.

We observed a lunchtime and saw people being supported by care workers. The meal took place in the dining room with people being seated at one of the three dining tables. People could also choose to remain in their easy chairs with a table in front of them if that was what they preferred. Care workers were attentive to people. We saw one care worker asking a person "Is it nice, not too hot for you?" another "I've got some mash here for you are you ready for some more?" and another "Just this bit left now, did you want anymore?" Three people were being supported to eat their lunch. This was done calmly and gently, with care workers sitting with the people, giving good eye contact and having a sensitive approach. People weren't rushed and care workers checked back with people before more food was offered.

Inadequate

Is the service caring?

Our findings

We received positive replies from people about if Woodville Rest Home was caring. One person said "You only have to ask them to help you and they will." Another person said they felt "Well cared for," another person said the care workers were kind to them. As many people were not able to communicate verbally with us, we also made observations of how people were supported and responded to.

One person said they did not like the atmosphere in the home because "There are rotten smells." On our initial entrance and walk round the home, offensive smells around the building were very noticeable; they remained throughout both the inspection days. Care workers told us several of the people experienced incontinence. The systems in the home had not ensured people who were living with both dementia and continence needs were appropriately supported to ensure their dignity.

One particular part of a corridor on the ground floor was very malodorous as was a communally used shower room off this corridor. Care workers told us one of the people tended to use both areas as a toilet. The person's first language was not English. No steps had been taken like seeking an interpreter for the person (whose first language was a relatively common language spoken by many people in this country), to explain matters to them in a way which might ensure their privacy and dignity about using the toilet. The person's care plan also did not include any monitoring systems in relation to their behaviours as described by care workers to establish any trigger factors, so the person could be appropriately supported to ensure their dignity when needing the toilet.

Another person's room smelt strongly of urine, particularly by their bed. We looked at their bed and saw their under sheet had dried-on, watery-brown areas on it. Care workers said the person did not make their own bed and needed support with their personal care. On the second day of the inspection, three days later, the person's room and bed sheet remained in the same condition as previously. We showed the bed to the registered manager so they could ensure it was properly made up. Adequate systems were not in place to ensure people's dignity, taking into account their individual needs, where people were living with dementia and had continence needs.

A person told us they were concerned because they "Sometimes see their outfits on someone else, staff do what they can but it's ongoing." At the last inspection, there were not adequate systems to prevent communal use of net underwear. At this inspection some of the net underwear had initials written on them to denote who they belonged to. However, these systems were not effective. We went into one person's room, one of the drawers of their chest of drawers had been left open. It had some net underwear in it which had initials on them which were not theirs. We looked in other people's drawers to ascertain if this was an isolated occurrence. It was not, including instances of ladies who had the initials of gentleman who lived in the home on the net underwear in their drawers. Communal use of clothing, particularly underwear, does not up-hold people's dignity.

We saw other instances where people were put at risk of using other people's personal items. On a shelf in the communally used shower room on the ground floor, there was a beaker with seven toothbrushes and an unclean comb. All of the toothbrushes had been used. The beaker remained in the same place on the second day of the inspection. We showed it to the registered manager so he could take appropriate action to ensure such items were not used communally and people's privacy and dignity up-held.

At the last inspection, people were not routinely offered toilet breaks before or after lunch or an opportunity to wash their hands before or after their meal. This had not changed by this inspection and people were again not offered toilet breaks before or after lunch or an opportunity to wash their hands before or after their meal.

The lack of systems to ensure people's dignity by ensuring their continence needs were appropriately met and systems were in place to prevent communal use of personal items is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we identified a lack of information about people's past lives and preferences, so such information could be used to ensure people were cared for as individuals. In their provider information return it was stated that 'My life surveys have been distributed to family and friends for feedback on residents to assist with offering them dignity and respect.' They stated 'These will be used to create a better picture of the needs and preferences of

Is the service caring?

residents.' We asked a person's relative about if they had been asked for information about their loved one's past life and preferences, they said "I've still got all the information on my computer, but I don't know if it's been taken up."

A person had a very detailed life history on their file. Care workers told us the person was frail and needed full support with their daily life, spending all of their time in the bed in their room. Although the person's life history detailed a particular type of music which they enjoyed, there was none playing in their room on either of the two days we visited. We asked two care workers about this person's past life and interests but they said they did not know.

The home cared for a person whose surname indicated they were likely to belong to a particular non-Christian religion, they also had articles relating to this religion in their room. The person said to us they would like to practice their religion but they did not know if there was a place of worship which they could go to locally. The person's care plan had conflicting statements in it about their religious faith. We asked three members of staff about the person's religion, one said they did not know, another that the person was of Christian faith and another the religious faith the person said they belonged to. Action had not been taken to ensure the person's religious needs had been assessed and relevant action taken to support them.

A person's first language was not English. The care plan for this person recorded that care workers should explain that they 'Cannot understand [the person's] language and to be effective need them to try and translate'. The whole onus of supporting this person in the care plan was on the actions the person needed to take, not on how staff were to support them, such as communication in a way which was approachable to them. Care workers were also asked whether they had sourced other information, magazines or books in this person's own language but they had not.

The lack of systems to ensure people's care was appropriate and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care given to people to ensure their involvement and that they consented was mixed. We observed a care worker supporting a person to eat their lunchtime meal. There was limited communication with the person by the care worker and what there was, was functional, such as asking them if they wanted more. They did not seek to engage the person in conversation during the meal. However, this was not the case for all occasions when care workers supported people to eat their meals. A different care worker showed great patience and gentleness when helping a person to eat their lunch. They spoke encouragingly and tried to engage the person with the task at hand but also in 'small talk.'

At lunch time care workers offered people choice and were consistently polite and respectful to them. Blackcurrant or orange juice were offered and those people who found it difficult to make a choice were shown the jugs visually. Before lunch a care worker said to a person "You're going to have lunch can I put this apron on for you to protect your tea shirt?" Another care worker said to a different person "Can I move the paper away so that we can use the table for lunch. Shall I fold it for you and leave it there so it's ready for you to read after lunch?" A person had sat themselves too far from the table and may have dropped food on themselves. A care worker noted this and said "Shall I push you in a little bit?....There you go." A care worker was assisting a person to have a drink, they said "Can you manage to suck through the straw," the person seemed reluctant, so the care worker took the straw out and said "Is that better?"

Care workers were also polite and supportive to people throughout the day, involving them, and supporting them in making choices. There was a comfortableness and humour between care workers and people, including good eye contact and people looked at ease with staff.

We saw one person was having their nails done. A person sitting behind this activity started to get upset, so the care worker turned around and supported the person in also becoming involved with the activity, chatting and talking with both people so they both felt engaged. A care worker involved a group of people saying "We're going to play bingo in about 10 minutes do you want to play?" Five people said they wanted to play and the care worker supported them by offereing to teach those who were unsure of the game about how to play. One person clearly did not want to be involved and the care worker respected this. During the game of bingo, the doorbell rang. The care worker apologised to the group, saying "Excuse me ladies, I'm just going to answer the door," they then returned and supported the people in continuing with the game.

Inadequate

Is the service caring?

People's care plans and other records were kept in locked filing cabinets in the dining/sitting room. Care workers ensured these cabinets were always locked when not being accessed.

Inadequate

Is the service responsive?

Our findings

People were not able to tell us about their involvement in care planning so we asked people's relatives about this and received mixed responses. One relative told us "The old manager said there would be reviews of Mum's care plan but that's not happened. I can speak to people when I need to though." Another relative told us their loved one needed them there, for example when being seen by an external healthcare professional. They said they had not been informed by the staff of a particular visit "So they couldn't do anything, Mum wouldn't let them." Other relatives were more positive. One relative told us they had not been able to visit for personal reasons for a while "But they kept me informed and I had no worries about not seeing" their loved one.

At the last inspection, we found people were not supported in a responsive way, to prevent the risk of developing pressure wounds. After the inspection the provider sent us an action plan. Among other areas this stated 'Where a resident is assessed as being at high risk of developing pressure areas, actions will be identified to minimise these risks, such as turn charts and use of specialist equipment such as pressure relieving cushions and mattresses.' The provider was not ensuring this took place.

We observed a person whose records showed they had a recent pressure wound, spend a period of at least four and a half hours sitting in the lounge on a chair without a pressure relieving cushion. The person was unable to get up independently and move about, unless supported by care workers. The person was not regularly supported to move by care workers during this period. On the second inspection day, the person continued not to sit on a chair with a pressure relieving cushion. The person's multi-disciplinary notes of 4 June 2015 recorded that the district nurse had stated that the person 'Should be on a cushion at all times'. Care workers spoken with confirmed that this person should have been using a pressure cushion, they did not know why they were not doing so. Another person who was assessed as being at high risk of developing pressure wounds who also needed support from care workers to move, was not sitting on a pressure relieving cushion. We asked care workers why this person was not doing so. They said they did not know.

As at the last inspection, several people needed support with their continence. We found this continued to be the case at this inspection. Care workers told us about one of the people who sometimes urinated in inappropriate places in their room, who wore continence pads. Care workers confirmed the person had not been referred to an external healthcare professional for continence advice. The person's care plan did not document they were to use continence pads. It did document they would need 'regular comfort breaks'. No records were kept to evidence how often the person was assisted to go to the toilet or when their continence pad was changed. We asked care workers if they assessed people's continence patterns, including the times of day when they usually wished to use the toilet and behaviours they may show when they wished to use the toilet. They told us they did not complete such assessments. Such assessments can be key when supporting people who are living with dementia who have continence issues, in ensuring their continence care needs were met.

We met with another person whose care plan stated they were continent, they were on a 'toilet programme' and used pads. There were no records relating to this 'toilet programme'. We asked care workers what a toilet programme was. They reported about taking the person to the toilet at regular intervals throughout the day. This person was not supported to go to the toilet at regular intervals during the inspection. The provider was not ensuring effective care plans were in place or followed where people needed support with their continence needs.

At the last inspection we observed staff did not respond in an effective way to people who were living with dementia, to ensure their individual needs were met. This continued at this inspection. Care workers told us about a person who could show behaviours which may challenge others. The person did not have behavioural (ABC) charts to document and collate any incidences of these reported challenging behaviours. There was no information on their file about triggers for such behaviours and how to alleviate situations. This person's care file stated that pain flowcharts should be completed, but this had not happened. There had been no assessment of if the person's experience of pain also related to their need for support with their behaviours which may challenge.

We observed a different person who aimed blows at staff and a kick at a person who was passing by. We asked care workers about the person's behaviours. They reported the person did show such behaviours at times, they did not

Is the service responsive?

think the person had any particular triggers to such behaviours. The confirmed they did not keep an ABC chart to assess triggers to behaviours such as we observed and monitor the extent and duration of such behaviours. The person's assessment and care plan documented their 'low moods' there was no assessment or information about supporting their behaviours which may challenge.

A person was handling a vase of plastic flowers. On each occasion when they noticed the person doing this, care workers took the vase away from them. They were polite when they did this but did not explain why it was necessary to remove the vase when the person was actively engaged in what they were doing and it was not affecting other people or potentially putting them at risk. Care workers did not use the opportunity to engage with the person to stimulate interest for them. The person's care plan stated they 'may become very distressed at times if [the person] has to part with items that do not belong to them; [the person] will need replacement items of their choice to help stimulate them, also one that can't be put in the mouth'. The care plan also stated this person needed to be involved in activities to stimulate them. Records of activities were not routinely kept other than limited information in people's diaries. Care workers were not following this person's care plan or using opportunities to stimulate their interest, as stated in their care plan.

At the last inspection we identified action needed to be taken to support people with engagement, including with recreational activities. People gave us a range of views about activities provision. One person told us "They leave you by yourself but ask you if you're alright and you can do what you like." Another person said "Well I watch telly, that's about it and I'm bored sick of it. I'd love to go out." Another person said "Playing bingo wears off a bit, if I could go out, I'd be in my glory." A person's relative told us "I'm disappointed about the activity side," and a different relative told us "There is a lack of stimulation." A relative told us "Maybe going out in the garden for a bit more fresh air would be good."

This inspection took place on a hot summer's day. The large outside patio area had full access for people, including any people who were living with a disability, and also had a cool area with a gazebo. However, none of the people were supported to go out into this pleasant area throughout the day.

A person was capable of having quite an in depth conversation about what they clearly felt passionate about. No care workers sat with the person to engage them in discussions during the inspection. The only offer of a recreational activity was a care worker who asked them if they wanted to play bingo, which they declined. This person had limited information in their folder about what they would like to do about activities and engagement, although it did note they could 'communicate well, verbally.'

The lack of systems to ensure people's care was appropriate, met their needs and reflected their preferences in relation to risk of pressure wounds, continence needs, dementia needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we saw people's preferences for activities were not always followed, we saw care workers involving people in some activities. This included a care worker who was giving two people a nail and hand massage. The person who had originally had their nails done then assisted the carer in massaging gently the other person's hand. This person clearly wanted to be involved and was encouraged to be.

We asked people about raising issues of concern to them. One person told us they had raised an issue "Several times but they just tell me I am safe." They said they felt action had not been taken to meet their concerns. Another person said they had told the manager about something that concerned them, but nothing had happened. This was not echoed by other people. One person told us "I would speak up if there was anything, oh yes I'd definitely do that." A person's relative told us "I would speak to anyone here in authority if I had to." Another relative told us about being consulted and involved "There has been one relatives' meeting and I think the manager is aiming to have one every six weeks and there's a comments box now too."

The PIR reported on the complaints and concerns book which had been placed in the main foyer. They reported 'residents and family are welcome to record anything they wish to bring up, this book is checked once a week for any entries.' We asked to look at the complaints policy, it was undated and referred to the previous registered manager and gave the incorrect address title and address for the

Inadequate

Is the service responsive?

CQC. The provider said they had identified many of their polices were out of date and they had commissioned an external company to review and up-date all of their policies.

We looked at the complaints records. We saw the one formal complaint which had been received had been investigated and the person responded to in writing, within timescales. The issues raised with us by the people above were not documented. The registered manager said they were working on ways of making sure they were informed of all issues raised verbally by people and that such issues were documented and actioned. We were given a copy of the minutes for a meeting with relatives in February 2015. The registered manager had not yet taken up their post at that time but they had been introduced to people's relatives and they fed back on their plans for improvements to Woodville Rest Home and explained about their past experience as a manager.

Inadequate

Is the service well-led?

Our findings

We asked people if they thought the home was well-led. People gave us mixed comments. One person told us "I suppose I could recommend it." However, another person's relative said "Yes I would recommend it here and I have done" and another said "I think it's wonderful." People gave us positive comments about the new registered manager. One person's relative described the new registered manager as "Very approachable," another said the new registered manager "Was making a difference." Another person's relative described the improvements since the last inspection, saying "There seems to be much more information, it seems tighter and more orderly," also that care workers "Seem to know what's happening when."

We identified a range of issues relating to service provision after the last inspection and served the provider and previous registered manager with a Warning Notice about their quality assurance systems. Following this, the provider sent us an action plan. The previous manager left their role and the new registered manager was appointed. He had previously worked in the provider's sister home which specialised in providing care to people who were living with long term mental health care needs. The new registered manager had worked at Woodville Rest Home a few years ago, so was familiar with the building and its facilities. They had attended a basic course in dementia care since their appointment to Woodville Rest Home. They did not have any more advanced qualifications in caring for people who were living with dementia. They said they were planning to undertake such training in the future.

The provider's systems for quality audit continued not to identify a range of matters relating to people's safety and welfare. All people's assessments and care plans had been reviewed since our last inspection. The provider also reviewed a sample of care plans and made written reports about their findings when they visited. Although we found a wide range of areas in people's assessments and care plans which should have been identified and action taken, none of the systems of audit had identified such areas. For example a person's care plan stated they needed assistance to move by one care worker, however we observed they were always supported to move by two care workers, and they clearly needed the support of two care workers. The divergence between staff actions to support this person and what was in the person's care plan had not been identified and acted on. A different person whose previous weight records showed they had been losing weight had not been weighed since April 2015. This was because they were documented as being non-weight-bearing. The provider's systems for audit had not identified how the person's risk of weight loss was to be assessed in the light of this.

Other matters had not been identified during audits. The PIR stated a member of staff had been designated as medication officer. This member of staff would be responsible for all areas of medication ordering, auditing and checking, with a medication audit every two weeks. This auditing system was not effective. The audit checklist stated 'as directed' (PRN) instructions 'should not be evident.' The July 2015 audit form was ticked to confirm it was not an area which needed action, with the comment 'pharmacy notified if occurred.' We saw a wide range of medicines which had been prescribed PRN, but this had not been identified and action taken to address the matter. We looked at the medicines policy, which was un-dated. It gave no information about safe practice in relation to PRN medicines, although the care workers were administering medicines which were prescribed on this basis. The policy did not direct care workers on safe practice when administering prescribed skin creams, although people were being administered such medicines. Guidelines have been issued about safe administration of medicines to people by bodies such as the National Institute for Health and Clinical Excellence (NICE) and were referred to in the home's medicines audit but these guidelines they had not been taken into account in the medicines policy.

At the last inspection, we had identified issues relating to risk to of infection control. The provider had not taken appropriate action to reduce this risk. At this inspection, we asked for the home's current infection control policy. We were given an undated, single page document. This did not outline a wide range of areas relating to risk of cross infection such as ensuring high standards of cleanliness in toilets, bathrooms and the laundry. There was no mention of how shower chairs or commodes were to be cleaned and sanitised. Although the policy outlined the importance of hand washing, we found several people's bedrooms and communally used toilets did not have such facilities in them. We noticed a wide range of areas in the home were odorous, including corridor areas and some people's rooms. We asked the registered manager for their cleaning schedules and audits. They said the cleaning was all done

Inadequate

Is the service well-led?

by an external cleaning company who had their own cleaning schedules and systems for audit. Audits on the standards of cleaning by the provider had not taken place. We asked how they raised matters with the external contractors about quality of cleaning. They said they brought matters up directly with the company, but had not had needed to do so since they came in post. Systems for the audit of cleaning and infection control had not been effective to ensure Woodville Rest Home was clean and hygienic and people were protected from risk of cross infection.

The lack of effective systems to assess, monitor and improve services to people and mitigate their risk in relation to audits of care planning, medicines and cleaning were a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider reported in their PIR about making the environment more accessible to people living with dementia, by placing name identifier signs on people's room doors. These name identifier signs were not yet in place. They had been ordered and the registered manager informed us installation would take place shortly. They had started the process of identifying areas in the home to people who were living with dementia by putting up toilet identification signs.

The provider had made other improvements since the last inspection. This included redecoration of some areas of the home and the purchase of more aids for moving and handling for people who had mobility needs. Care workers spoke positively about these aids, particularly the new turn sheets which supported them in moving people who remained in bed all the time in a way which was both easier for care workers and more comfortable for the person. The registered manager had set up a full system for auditing of accidents. Audit reports were made available to care workers so they could monitor progress in making improvements. The provider reported a range of policies needed up-dating, including the home's statement of purpose. They had contracted with an external company to ensure all such relevant policies and procedures were developed.

Three staff spoken with felt there was now an open culture in the home and their views were taken into account by management. One care worker told us they had faith in the registered manager to direct them and to deal with any issues arising. Care workers appreciated the development of regular meetings for staff. A care worker said they felt able to bring up issues which they felt needed to be addressed at these meetings. We looked at the minutes of meetings and saw staff had raised issues such as their concerns about the current high dependency of some of the people and request for a meeting with the provider to discuss issues. The provider and registered manager said they were keen to work with us. After the inspection, the registered manager sent us a detailed action plan which set out when they would address the areas which their systems had not identified and we had told them about.

Woodville's aims and objectives stressed its "friendly and homely atmosphere" and that they wanted people to feel "at home in Woodville." Care workers we spoke with were aware of this philosophy. One saying "The philosophy is to make it feel like their own home," and another "To make them feel like they're at home as much as possible."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 HSCA (RA) Regulations 2014 Staffing **Staff employed did not have appropriate training and support to meet people's needs. Regulation 18(2)(a)**

This section is primarily information for the provider

Enforcement actions

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

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. Regulation 10(1)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care was not provided in a safe way because risks to people's health and safety were not assessed and relevant actions taken to mitigate these risks. People were not protected by the proper and safe management of medicines. People were not protected by systems for prevention of spread of infection. People were not protected by the timely care planning together with other healthcare professionals. Regulation 12 (1)(2)(a)(b)(g)(h)(i)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems did not operate effectively to assess, improve and monitor the safety of services or mitigate risk to people and others. Regulation 17(1)(2)(a)(b)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People's care was not provided in an appropriate way which reflected their needs and preferences by carrying out an assessment of their needs, designing care to meet these needs, including with a relevant healthcare professional and also having regard to their nutritional and hydration needs.

Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(i)

The enforcement action we took:

The CQC will be taking legal action in line with our policies and procedures.