Care Quality Commission

Woodchurch House Limited

Woodchurch House

Inspection report

Brook Street, Woodchurch,
Ashford, Kent TN26 3SN
Tel: 01233 861600

Date of inspection visit: 7,8 and 11 January 2016
Date of publication: 13/04/2016

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 7, 8 and 11 January 2016 and was unannounced. Woodchurch House provides accommodation, nursing care and personal care for up to 60 people. It also provides personal care and/ or nursing to people who rent or buy their accommodation within Woodchurch House. However it was difficult to determine who was receiving a service under which arrangement even when we asked the manager to show evidence of these arrangements. There were 78 people using the service during our inspection; of which 58 were receiving nursing care. The service caters for mainly older people and some younger adults. People may have physical frailty, long term health conditions and/or dementia. People living with dementia were accommodated on the first floor, while people on the ground floor had a range of health conditions and/or physical disabilities.

It is a requirement of this service's registration with the Care Quality Commission, that there is a registered manager in place. There had not been a registered manager at Woodchurch House for just over three months at the time of our visit. There was a new manager who was applying to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's safety and welfare had not always been appropriately addressed. Medicines and creams had not been managed safely, and actions to minimise some other risks such as to people's skin or their nutrition, had not been followed through. There was not a robust system for raising safeguarding concerns with the local authority, because incidents were not properly recorded or consistently referred.

There were not enough staff to meet people's needs. Staff training had not always been effective and there were gaps in staff knowledge in some areas. Not all staff had regular supervisions but new staff completed an induction and the Care Certificate. The Care Certificate is an agreed set of standards that health and social care staff follow in their daily working life.

The principles of the Mental Capacity Act 2005 (MCA) had not been properly followed in regard to restraint but applications to authorise deprivations of people's liberty (DoLS) had been made by the manager.

Most staff were gentle and respectful but others were less so. People's dignity was not always adequately protected. A range of activities were on offer, but more meaningful occupation was needed for people living with dementia.

Complaints had not been managed appropriately by the manager and there was no evidence of learning from them. Actions had not been taken in response to recommendations arising from a survey of people and relatives.

Auditing had been ineffective in highlighting shortfalls in the quality and safety of the service. All of the staff spoken with said they had faith in the new manager to improve and develop the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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?
The service was not safe.

Risks had not been appropriately mitigated to ensure people's health and safety.

Medicines had not been managed safely.

There were not enough staff to meet people's needs.

Inadequate

Is the service effective?
The service was not always effective.

The principles of the mental Capacity Act 2005 (MCA) had not always been followed in practice.

Staff training was not always effective in helping them to carry out their jobs.

People's risks of poor nutrition and hydration had not been managed properly.

Inadequate

Is the service caring?
The service was not consistently caring.

People's privacy and dignity was not always considered.

There was little meaningful interaction between staff and people.

People were encouraged to be independent where possible.

Inadequate

Is the service responsive?
The service was not always responsive.

Care planning was not consistently person-centred or up to date.

Complaints had not been managed in line with the provider's policy.

There were a range of activities on offer but more was needed for people living with dementia.

Inadequate

Is the service well-led?
The service was not well-led.

Feedback had been sought about the quality of the service, but had not been acted upon.

Audits had not always been effective in identifying shortfalls in the safety or quality of the service.

The manager had not engaged well with people and relatives.

Inadequate

Woodchurch House

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 and in response to information of concern we had received. 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 inspection took place on 7, 8 and 11 January 2016 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor and an expert by experience. The specialist advisor had clinical experience and knowledge of medicines management within care settings for older people and those living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of caring for people living with dementia.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met fifteen people who lived at Woodchurch House. Not everyone was able to verbally share with us their experiences of life at the service. This was because of their dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We inspected the environment, including communal areas and some people's bedrooms. We spoke with twelve care workers; including two registered nurses, kitchen staff, 12 relatives, the provider, the manager and the business development manager.

We pathway tracked eighteen of the people living at the home. This is when we looked at people's care documentation in depth 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.

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

Inadequate

Is the service safe?

Our findings

One relative told us, "X is receiving better care here than in hospital" but another relative told us "I feel I have to come in all the time just to make sure X is ok".

Medicines had not been managed safely. There were a number of missing staff signatures on medicines administration records (MAR) and it was not always possible to reconcile the tablets remaining to check people had received their medicines. This was because there were several open boxes of the same medicine in use at once. However, the number of tablets remaining for one person did not tally with the MAR chart, and indicated that they had not received one dose of their prescribed medicine. People had individual, named trays within trollies, but some peoples' contained medicines belonging to others. Loose tablets and capsules were found in these trays which meant staff may not know which medicines they were or how they should be given. There were no photographs on some MAR charts to help staff identify the correct person to receive medicines. This was unsafe practice and could lead to errors.

Staff sometimes signed the MAR charts to show that medicines had been given, when we observed that they had not; or did not wait with people to make sure they had swallowed all of their medicines before signing the MAR chart. One person had been assessed by the service as able to self-administer their medicines. This person had strong pain relief that was prescribed at one capsule four times per day. However, records showed that staff were in fact administering this medicine and had given the person ten capsules every few days, for them to manage. Where medicines are given to people by staff, this must be in accordance with the prescriber's directions. Staff could not know if or when this person had taken each of the capsules or if there had been appropriate time gaps between doses.

Some large boxes of Paracetamol had no dispensing labels on them. We asked staff about these and they explained that if a person no longer needed them, they would use the remaining tablets for other people. All medicines, including prescribed Paracetamol, should only be given to the person they were intended for. Eye drops were in use after the date when they should have been disposed of and some medicines were being crushed inappropriately. Staff did not understand that crushing can change the way medicines work and, in some cases, can cause side-effects. The provider's policy stated that medicines should not be crushed unless a doctor had approved this but staff had not followed this direction in practice.

Some people received their medicine covertly, or without their knowledge, but MAR charts did not record when medicines had been given in this way. Where handwritten MAR were in use, rather than printed ones provided by the pharmacy, staff had not consistently signed these to confirm that the entries and directions were correct. There were no records to show that topical creams had been applied, so the service could not evidence that people on the first floor had received their creams as prescribed for them.

The unsafe management of medicines is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had been made about possible risks to people's health, safety and well-being. However, actions to minimise those risks had not always been followed through in practice. For example; where people were at risk of breakdowns to their skin, or pressure wounds, they had been assessed as needing special air mattresses. Care plans showed that these should be set according to people's weight; but this had not always happened. One person's weight was recorded at 90kg in December 2015 but their air mattress was set to a weight of 203kg. Other people had air mattresses that were set at soft, medium or firm. Staff were unable to tell us how these settings correlated with people's weight or who was responsible for setting and checking the mattresses. Two staff members told us that air mattress settings were not reviewed when people gained or lost weight. The manager checked all the air mattress settings when we made her aware of the issue but there was a risk that people's skin had not been adequately protected.

Another person's care plan highlighted that their skin was very fragile and required a prescribed cream 'To be applied at all times'. There was an empty tube of cream in this person's bedroom but there were no records at all to show when their cream had been applied. This person had a very recent skin wound and the service could not evidence that care plan directions had been followed in order to help prevent further skin breakdowns. A further person was assessed as unable to reposition themselves independently and requiring staff to turn them every two to

three hours. This was to help with healing of a skin wound. However records showed there had been between four to six hours between some repositioning, which was not as directed within the care plan. Four-hourly turns were instructed in another person's care plan, but staff confirmed there were no turn charts in use to confirm this had happened. They told us "X doesn't need turning" which was contrary to their plan of care.

Plans to evacuate people in the event of a fire or other emergency had not been sufficiently personalised so that they described any equipment needed and routes for helping people out of the building. Each person had been assessed as being high, medium or low risk but there was no information about how many staff would be needed to assist individuals. Even those people assessed as low risk would require escorting from the building according to the evacuation plan; and the lack of a robust strategy could place people at risk in an emergency.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Injuries to people had not been recorded as incidents, nor consistently referred to the local authority safeguarding body when appropriate. There were no incident reports available during the inspection and the manager confirmed that none had been completed. Staff said that if they noticed any unexplained bruising or injuries to people, they completed a chart called a body map to show where on the body they had occurred. They told us that this information was then filed away but could not describe what happened after this. We heard from a relative about injuries their loved one had in previous months. There were no incident reports about these and no referrals had been made to local authority safeguarding by the service.

Staff described how one person was sometimes restrained during personal care because they became aggressive towards staff. This person was living with dementia. We heard how one care staff would hold each of this person's hands, another care staff would hold their leg and a sheet would be used to contain them while a fourth staff member delivered personal care. Although staff said this did not happen frequently, they acknowledged that the person was upset by it. They had been prescribed medicine to help calm them before being washed by staff, when needed. The directions were that this should be given half an hour before washing; to give the medicine time to work. However, records showed the medicine had not always been given half an hour prior to washing, but at different times throughout the day. This meant that the person may not have received the intended benefits of the medicine in situations which caused them distress. This was improper treatment and these episodes had been degrading for the person.

Staff lacked knowledge about keeping people safe and did not understand the types of event which should be reported and escalated. The manager said that she was aware of this and had started to educate staff. She told us that she would be introducing incident forms for staff to complete and had made some safeguarding referrals herself since becoming manager. However, at the time of our inspection there was not a robust system in place to recognise, prevent and investigate any allegations or evidence of possible abuse.

This is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to consistently meet people's needs. People had varying and complex conditions like dementia, stroke, diabetes, Parkinson's and epilepsy. Some people living with dementia showed behaviours that challenged others, and nursing needs included catheterisation, special feeding, wound and tracheotomy care.

On the first floor, staff told us that around 18 out of 41 people needed help to eat their meals and 17 people needed two staff to deliver their care. Some people were nursed in bed or chose to stay in their rooms and we heard about one person who sometimes needed four staff to assist them with personal care, due to their dementia. There was one nurse on duty for both floors of the home. In addition there were two duty managers and 15 care staff in the mornings and 13 in the afternoons. The manager told us that there were two nurses on duty overnight with seven care assistants to cover both floors. Rosters showed that two staff members had worked night shifts as nurses before they had qualified to practice nursing in the UK. These staff had qualified and worked as nurses in other countries but needed to undergo a programme of training and assessment before they could become sanctioned by the Nursing and Midwifery Council (NMC) to work as nurses in the UK. The manager explained that these nurses always

Is the service safe?

worked under the supervision of another UK-qualified nurse. However, on the occasions when these staff members were rostered, there was in effect only one NMC-qualified nurse on duty in that role overnight.

People and relatives told us that call bells were not responded to promptly. One person said, "There are just not enough staff around. You can wait ages for a call bell to be answered and I've had several accidents, which is really embarrassing". Another person said, "Sometimes they [staff] say 'We're busy; you'll just have to wait your turn'". A relative told us, "I'm not impressed. There are just not enough staff; X often has to wait ages for someone to come and help when they buzz".

A survey of relatives issued in October 2015, contained comments about call bell response times. Some of these read ,'Staff are too slow to respond to the nurse call'…'On several occasions there have been no staff around to help X when they have pushed the call bell'… 'X is often left on the toilet for 20 minutes or so as care workers either ignore buzzers or the resident does not have a buzzer'.

The manager said that she had not carried out a service-wide audit to establish how long people waited for call bells to be answered. Following the inspection however, the provider sent us results of an audit of call bells for December 2015. This showed that 56% of calls had been answered within five minutes. A further 21% were responded to within 10 minutes. 10% of calls took between 11 and 15 minutes and 12% were answered in 16 minutes or more. However, an individual room audit we reviewed, showed that within that 12%, some calls had taken 18, 23, 26 and 45 minutes for staff to respond. People and relatives told us that this situation sometimes made them feel unsafe and that their dignity was compromised by being unable to reach the toilet in time.

Staff said that they were constantly rushed and did not always have time to give people the individual attention they needed. They said that this was largely due to trying to manage people's challenging behaviour; which took them away from other people and tasks. Both staff and the manager told us that everyone using the service could access care "24/7", regardless of whether they rented or owned their rooms and bought an additional care package; or were being provided with accommodation and care by the service. We observed staff interrupting medicines rounds to distract people who were agitated, and one staff member struggling alone to manage two people who were becoming verbally aggressive in the dining room. We made staff in the lounge aware that a person's lower garments were wet through but they said they could not leave the lounge to help change them and would have to wait until another staff member became free. This person was sat on a chair in their wet clothes until other staff came to the lounge. At lunchtime, a staff member who was assisting a person to eat was repeatedly interrupted by others needing attention and at one point left the person they were assisting to attend to another person's needs. One person shouted and banged their cutlery on a table throughout the meal and other people became agitated, making lunch on the first floor noisy and fraught. The provider said that staffing levels were calculated taking into account people's care needs and that extra staffing over and above this had been deployed. However, our observations and the feedback from people, relatives and staff showed that this had not been sufficient to consistently meet people's needs.

The failure to ensure sufficient staffing is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

References received for some staff were not adequate. The referee for one staff member confirmed that they had not directly managed them, and a personal reference for another staff member gave no detail about the person who was providing it. A further professional reference said that they would not reemploy the staff member and gave unsatisfactory responses to questions about their conduct. There was no assessment about the possible risks of employing these staff without suitable references and no evidence that further checks had been made to protect people using the service.

The failure to properly operate a robust recruitment procedure is a breach of Regulation 19(3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was an annual servicing register in place to show when equipment was checked and serviced. This included items such as hoists and the passenger lift, which were all up-to-date.

Fire extinguishers and other equipment had been regularly serviced and the fire alarms had been tested weekly. The

Inadequate

Is the service safe?

provider had a business continuity plan in place which detailed arrangements for ensuring continuity of care for people in the event of emergencies resulting in evacuation of the premises.

The premises were well-maintained and well-decorated and furnished throughout. People's rooms were large, comfortable and warm with en-suite bathrooms. Communal areas were bright and inviting with plenty of seating options making a pleasant living environment for people.

Inadequate

Is the service effective?

Our findings

One person told us, "The food's alright. I get enough and there's a choice if I don't like what's on offer". A relative said, "The food is poor here".

People had not been protected from the risks of inadequate food and hydration. Some people had been assessed as at risk from poor nutrition and had instructions in their care plans for how this should be managed. For example; one person had been seen by a dietician on 1 December 2015, who prescribed daily food supplements, regular snacks and meals enriched to make them more calorific. On the second day of our inspection, 8 January 2016, this person had yet to receive any of the prescribed supplements as staff told us they were "Still not in stock". Staff said that they had spoken to the GP about the supplement in late December and confirmed that it was still required for this person. Food and fluid charts showed very poor intake of both, in the weeks prior to our inspection. On six days out of 20, there was no food recorded at all and on other days there were no snacks noted or details about how food had been enriched. This person had lost 1.2kg between December and January.

Another person's care plan stated that their food and fluid intake needed to be monitored closely 'To tackle any unwanted weight loss'. Food and fluid charts showed poor recording of both. Staff had made entries such as '100% supper eaten', without any details of the meal or size; and fluid intake was not totalled at the end of each day. This would have helped staff to identify if the person had not eaten or drunk enough to keep them well. Weight records showed that this person had lost 2.8 kg between December and January.

A further person had been identified as needing around 2000mls of fluid each day as they were prone to infections. Fluid charts showed that they had sometimes had as little as100mls in a day and 250mls on several others. This person had had a recent urine infection and since then, staff had noted they had been advised to drink more. However, fluid charts did not evidence that this had happened. Two relatives told us that they had concerns that people did not receive enough to drink.

There was a list to show which types of meals people ate and staff showed us that one person we asked about was on a pureed diet. This person's care plan recorded that they had no history of choking or swallowing difficulties and staff were unable to tell us why this person was having their meals pureed. The care plan also stated that they enjoyed cakes and finger foods and those items should be cut up into small pieces. Staff were unable to confirm which information was current or correct, but there was a risk that this person might be given foods that were the wrong consistency, which could be a hazard for them. The provider's policy about food safety and nutrition did not include any information about assessing people's risk of poor nutrition or how to manage this in order to keep people safe.

People's nutritional and hydration needs were not properly met which is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received a range of training through either e-learning or face-to face sessions. However, they were not always able to evidence the effectiveness of this training in practice. For example; staff administering medicines had been trained to do so, but had not consistently followed basic safety checks. Staff told us that they had e-learning about nutrition but were not all able to tell us how to recognise dehydration or describe appropriate levels of fluid intake to maintain individual peoples' health. Food charts had been completed with insufficient detail because staff did not appreciate the need for accurate information. This lack of knowledge placed people at risk of receiving inappropriate care and treatment.

Most staff said they had received training about dementia and managing behaviours that challenge, but our observations showed that this was not always effective. One person was verbally unpleasant to staff and other people. Staff were observed repeatedly telling them that this was inappropriate and not to do it again. This person was living with dementia and staff did not try to distract or comfort rather than reproach them. Woodwork was being painted in the first floor corridors and 'Wet paint' signs had been put up. We asked staff if people would be able to read and understand these notices and they said that they would not. Staff had not thought about using picture notices to help people understand until we suggested this. All of the people on the first floor were living with dementia and staff actions demonstrated a lack of competency in this area.

Inadequate

Is the service effective?

Staff completed a full induction to their roles and the Care Certificate within 12 weeks of starting work. The Care Certificate is an agreed set of standards that health and social care staff follow in their daily working life. Supervisions to assess staff competency and encourage development however, had not been carried out regularly for some staff. While nurses had received supervision sessions every two to three months, many of the care staff had no supervisions recorded at all for the period July to December 2015; while others had one or two supervisions in the same period. The provider's supervision agreement with care staff was for a minimum of six supervisions per year. The manager said that she was aware of a shortfall and planned to address this in the coming weeks. The lack of regular staff supervision meant that gaps in staff knowledge or competency may not have been identified and addressed in order to ensure safe and appropriate care for people.

This is a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This 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.

Staff described how one person was washed, by restricting their movement. Staff said this person was very challenging and that sometimes up to four care staff were involved. None of the staff we spoke with had restraint training and the manager told us that staff were not trained, as restraint should not be practiced in the service. This person's care plan, however stated, ' When restraining X, appropriate, recognised techniques should be used with the minimum amount of force needed to complete the task without injury to X or staff'. Instructions noted that restraint should only be used as a last resort but there was no step-by-step information about exactly how this should be achieved. This meant it was not possible to tell whether the recommended approach was the least restrictive option. We asked to see an MCA assessment or best interest decision in relation to this person's personal care but neither staff nor the manager could provide them. Staff said they had been trained about the Mental Capacity Act 2005 (MCA) but they could not evidence that this person's rights had been properly considered.

The failure to consider and act in accordance with the MCA is a breach of Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people received their medicines covertly; that is, without their knowledge. This can only happen after an MCA assessment shows a person lacks capacity to decide about taking their medicines, and with GP/pharmacist approval. The manager told us that fourteen people had medicines covertly. One person had covert administration agreed by a GP in September 2015, but staff told us this person had capacity to make their own decisions and simply preferred to take their medicines in food. In a number of cases a GP had agreed to this method of administration some months previously, and over a year ago in one instance. However, MCA assessments had not been carried out for anyone until 4 January 2016. The business development manager explained that she had only recently become aware that MCA assessments were not in place, and had completed all of them on the same day. This meant that the service had been administering medicines covertly up until 4 January 2016, without regard to the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).The manager had made applications for DoLS where this had been assessed as necessary and had received one authorisation from the responsible body.

People's health care needs were managed day to day by nursing staff; with support from a local practice nurse for some specialist blood testing, a visiting dietician, physio and occupational therapists and GPs. Care plans showed that people were able to have chiropodist treatments and sight tests when required. Skin wounds and pressure areas were treated and monitored by nursing staff with advice from an external specialist nurse. However, records about this were confused or contradictory. For example; one person's care plan recorded that they had been visited by a Community Matron in September 2015 about a pressure wound. The notes showed that at this point the wound had

healed and there was no further mention of it in the care plan. However, we found wound care records that showed this person still had a wound in the same place and of the same grade at the time of our inspection. The wound was being dressed and was due to be reviewed by staff on 6 January but on 8 January the wound care record had not been completed to document that it had. Staff were unable to tell us whether the initial wound had actually healed and recurred or if the latest records referred to a new wound in the same place.

Staff told us about another person who they said had a dressed wound on their hip. They showed us repositioning charts which recorded that the person should not be turned onto their left side because of it. However, there were no current records of the wound to the hip. Nursing staff then told us that this person did not have a current hip wound as it had healed. The care plan stated that there was a skin tear to the hip in December 2015 and that this person should be 'Turned every two hours to their back and sides'. The care plan had not been updated to show that the wound had healed. We asked staff if there was any reason then, why this person should not be turned onto their left side now and they said that there was not.

However, three days later, on 11 January 2016, we checked again to see whether the repositioning charts had been changed to show that this person could now be turned onto their left side, but they had not. These contradictions between records and in the information staff gave us meant that people could be at risk of receiving inappropriate care and treatment.

The assessment of people's needs had not been reviewed to ensure they remained accurate. Care and treatment plans had not been designed to make sure staff were able to meet all of people's needs. This is a breach of of Regulation 9(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were given a choice of meals, and portions were adequate. Kitchen staff maintained a list of food allergies and those people who required special diets, such as for diabetes. The chef was knowledgeable about nutrition and people's individual likes and dislikes. One person told us, "The food is excellent and always plenty of it- I can have seconds too if I want". People on the ground floor appeared to be enjoying their lunch; which had been nicely presented and was hot.

Inadequate

Is the service caring?

Our findings

One person told us, “The care is good and respectful but there’s just not enough staff around and they seem to change a lot”. Another person said, “Staff take good care of me and treat me well but we could do with more of them as they can be rushed”. A further person said, “ There have been lots of changes in staff and there aren’t enough of them-it’s sad because you get to know them and then they go; it’s like losing a friend”.

We received mixed views about the standard of care provided. Where people and relatives were happy with the care delivered, they also commented that staffing levels affected their experience. The recurring theme of our conversations with people and their families was that they often waited too long for call bells to be answered. They said that this caused them distress and discomfort but most said this was not the fault of staff, who tried their best. Most staff were gentle and respectful in their approach to people but we did observe others who were brusquer in their delivery and disregarded one person’s protests when they were being helped to move using a hoist. The person was agitated and saying that they did not want to be moved, but staff carried on regardless. Another person told us that staff sometimes belittled them by “Speaking in a childish voice”, and that they had seen staff “Mocking” another person.

Other people said that the accents of some staff, for whom English was not their first language, were a barrier to communication and sometimes left them feeling frustrated. One person told us, “There are not a lot of staff around and I have different ones each time, some are foreign and can’t speak English but if two of them come, usually one can understand”. Many other people were living with dementia or other conditions which limited their ability to communicate and understand; and one relative said that the added language difficulty was “Just unfair and not considerate of people’s needs”. Another relative commented," Some staff don’t know what they’re doing and their accents cause us real difficulty”. One person described the numerous attempts they had made to convey a simple request to staff. They had needed help to adjust their clothing but said they had tried various ways of explaining this, without success. There was a risk people’s needs might be misunderstood by staff who had a poor command of English.

We observed little interaction between staff and people at times; with staff focussed on tasks rather than people. For example, some staff assisted people to eat without making eye contact or describing the meal and others consistently walked past a person who was calling out, without acknowledging them. When we asked about this, staff told us it was “Normal” for that person to call out. There was a risk that staff would ignore this person’s calls because it was something they did frequently, when the person genuinely needed support or reassurance. A relative asked for a food protector for another person and the staff member replied, “We can’t automatically just give it to them-you have to ask us, it’s the rules”.

The care people received was not always appropriate and did not consistently meet their needs, which is a breach of Regulation 9(1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People’s privacy and dignity was not always protected by staff. One person’s door was wide open onto the communal corridor and they were almost naked in their bedroom chair. Another person was being prepared to be helped to move by staff using a hoist.Their dress was caught at the top of their thighs. The staff did not take note of this and continued regardless. One staff member was trying to pull the hoist sling from under the person by rummaging between their legs, which was undignified for them. This was in a communal lounge and staff did not take into account that there were visitors and other people in the vicinity. A further person was twice observed walking through the corridors naked from the waist down. Staff walked this person back to their room past painters, visitors and other people but they did not put something around the person to cover their private parts and preserve their dignity.

This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Other people told us that staff always knocked on their doors before entering, even when their doors were ajar. People who were able to speak with us said that they were given choice about what to wear and their meals; and care plans showed what people liked and disliked to eat. People were encouraged to be as independent as possible. One person said, “Staff help me to wash and dress if I need them to; or I do it myself if I’m up to it”. Care plans gave step-by-step guidance to staff about how best to support people to be independent, for example by providing

Inadequate

Is the service caring?

regular, discrete prompts to a person who needed reminding to use the toilet. People had been supported to help themselves when they could, which enabled them to retain some independence.

Care plans recorded details of people's known wishes about the ends of their lives. Where people were not for resuscitation in the event of cardiac arrest, proper clinical assessments and orders were in place. Information about funeral arrangements had been recorded along with any specific wishes people may have expressed. Staff told us that they would fulfil people's wishes as far as possible and explained that the aim of end of life care would be, "To provide peace and comfort, the very best way we can".

Inadequate

Is the service responsive?

Our findings

One person told us, "I do join in some activities, but the last activity lady left at Christmas. We did have a Christmas party which was nice". Another person said, "I'm not interested in the activities and no one talks to you anyway, so I'm better off here with the TV". A relative said, "There's no stimulation for anybody here. If they spent more time talking and doing things it would make people more settled". Another relative said," I can visit whenever I like and I always feel welcome". We found that there was a difference of opportunity for people to be active, stimulated and occupied depending on their level of needs. For people living with dementia or for those that spent more time in their rooms this affected their quality of life and welfare.

Complaints had not been properly managed in line with the provider's own policy. This stated that all complaints should be logged and progress recorded before a final response given. None of the complaints we read had been logged and were loose in a folder .The manager said that she had not been aware of the policy. We asked the manager specifically about one complaint that was received two days before our inspection. She told us that she was not aware of the complaint, which we had found inside the complaints file. There were no records of investigations into complaints or details of how matters had been dealt with. One response to a complaint stated that the manager would arrange further training for staff. We asked the manager about this but she said she had not had time to do this. Another response to a complaint said "I will investigate-thanks for letting me know", but there were no records of what had happened subsequently. There was no evidence of learning from complaints in order to improve standards.

Some people told us their experiences of making complaints. One person said they had spoken to staff about an issue but, "They just dismissed me as if I was a second class person". Their family said they had taken the matter up with the manager who said she would "Look into things", but nothing had happened and they felt ignored. Another person told us they had complained about the time it took for call bells to be answered but, "Nothing has changed". Following a 'Customer satisfaction survey' in October 2015, concerns about the handling of complaints were raised by the external organisation conducting the survey on behalf of the provider. They recommended that all complaints should be reviewed by senior management to ensure they had oversight of concerns and actions. This had not happened and effective systems were not in place for the management of complaints.

The failure to effectively operate a complaints system is a breach of Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Care plans included information about people's individual care needs but had not been kept up-to-date to reflect changes. For example; important details about people's nutrition, skin wounds management and medicines were not always current and could lead to people receiving inappropriate or unsafe care. In some cases the care plans had been noted as reviewed recently but changes had not been made to the guidance about people's needs. Therefore staff did not have up to date information about people's individual needs to provide person-centred care for them.

People's preferences around getting up and going to bed were documented and one person told us, "Mum gets up when she likes and sometimes it's early, so the night staff help her to get up and dressed". However, two people complained to us that, despite their preferences, they had been left in bed for much longer than they wished on some occasions. One person told us, "Staff know what time I like to get up but it's often an hour or even two after that when they wake me". A relative said, "It's 11:20am and Mum's only just been washed. I've complained about this before". Two other people said that they did not like having their care delivered by male staff and had expressed this preference. However, they told us that this request was not always observed, which made them uncomfortable. The manager told us that people were able to make this choice, but when we asked staff to show us where this was recorded in care plans, they were unable to do so.

There was no consistent information in care plans about people's spiritual or religious needs. A church service was advertised within the service but staff were unable to tell us which denomination it served. Activities staff had started to record people's life histories but these were not in place for everyone. While some staff were knowledgeable about people's lives before they came to live in the service, others were not as informed. This information could help staff to interact with people in a more meaningful way but had not been used in this personalised way.

Inadequate

Is the service responsive?

There was a lack of meaningful activities for people living with dementia. Although people's care plans had a section about social interaction, for most people living on the first floor, there was little activity for them to enjoy. The amount of information held varied from person to person but generally highlighted the things they liked to do. People either sat in chairs or at tables for long periods without stimulation. The activities planner for the first floor included 'Morning coffee and biscuits' as an activity every day. People were served coffee and biscuits at tables or seated in armchairs but there was no particular interaction between staff and people or between people during these sessions. On three days each week,' Resident's free time' was listed. There was a music session in the afternoon of one day we visited and board games, arts and crafts and bingo were available on others. We spoke with activities staff who confirmed that they had not had any training in providing meaningful activities for people living with dementia. There were a number of people who showed behaviours that challenged; and appropriate stimulation and distraction may have helped to reduce people's agitation. The provider told us that he had approached a specialist service called 'Ladder to the moon' with a view to them developing staff knowledge and improving the quality of activities available to people; but this had yet to be implemented.

People's care needs were not consistently met through person-centred care planning or meaningful activities; which is a breach of Regulation 9 (1) (a)(b)(c)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On the ground floor there was a detailed programme of activities advertised; including cider tasting and arts and cookery clubs. There were also games and puzzles available for people to use if they wished. There were two dedicated activities staff working full time during the week and one part-time activities staff at the weekends for 78 people. There were photo montages on display which showed people engaged in various hobbies and activities. The people who actively took part in and benefitted from these sessions were mainly those living without complex needs or advanced dementia.

Inadequate

Is the service well-led?

Our findings

The manager had been in post for three months at the time of our inspection. The service is required to have a registered manager as part of its conditions of registration with the CQC. The manager was applying to be considered to become registered. Some people and relatives told us that they had yet to meet the manager. One person said, "The manager hasn't even been around to introduce herself-I think that's bad" and a relative commented, "You'd think the first thing for any new manager to do would be to go around and meet people. That hasn't happened and we're extremely disappointed by it". Another relative said they had met the manager and "I'd no cause for complaint".

There had been no recent resident or relative meetings to gain views about the quality of the service. The manager said that she planned to arrange these for 20 January but this had not been publicised in the January 2016 newsletter. A 'Customer satisfaction' survey had been conducted by an external company on behalf of the provider. Results had been analysed by this company and recommendations made in November 2015. However we found that these had not all been actioned. For example; following survey responses about the manager's lack of interaction with people and families it was recommended that she should engage more with people. However, by January 2016 people and relatives were still saying that they had not met the manager. It was also recommended that a call bell audit should be undertaken in light of the negative survey responses about delays in calls being answered. This had not happened at the time of our inspection, but was carried out by the provider immediately afterwards. The service had not taken improvement actions in response to feedback from people and relatives.

The manager told us that there had been a recent survey of staff opinion but responses from this had not been analysed. The supervision templates in use for care staff asked, "Do you feel our residents are generally well cared for?" This offered another route for assessing the standards of the service from staff's perspective. However, as a number of staff had not had regular/recent appraisals, there had not been the opportunity to discuss their opinions or ideas at these meetings. This meant that staff concerns or views about how the service operated had not been fully considered for the purposes of making positive changes.

The failure to actively seek, analyse and respond to the views of people, their relatives, staff and others involved in the service is breach of Regulation 17(1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Auditing carried out by the manager, the provider and business development manager had not always been effective in identifying the shortfalls highlighted during our inspection. For example, medicines audits conducted on 3 and 11 November 2015 had not picked up on all of the issues we found. However, the lack of photos on MAR charts to ensure medicines were given to the correct person was noted in the auditing. The manager told us that there were no action plans in place following the audits and we found that photos were still missing. The audits had not been used properly; as tools to assess the quality and safety of the service and bring about improvement.

A monthly wound audit had been completed but this was mainly concerned with the number of wounds rather than the people who were affected by them. For example; the audit recorded how many of each type of wound there had been in the preceding month but was not helpful in highlighting trends, people at particular risk or deterioration. The wound audit for 5 December 2015 documented that all airflow mattresses had been set in accordance with people's weight, but this was not the case during our inspection; and staff did not know how or when to change settings.

The manager was unable to show us any audit of care plans and we found a number of them that held out of date and inaccurate information about people's needs. Food and fluid charts had not been checked to see that they had been adequately and appropriately completed. A robust auditing system would have highlighted discrepancies in these areas and enabled them to be put right, so that people's appropriate care could be ensured.

The failure to ensure effective quality and safety assurance systems and to maintain accurate, complete records are a breach of Regulation 17(1) a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

The provider had not consistently notified the CQC when incidents had occurred in the service. These included unexplained bruising or injuries to people; which could have indicated abuse. During the inspection we heard about injuries and saw bruising which we raised with the local authority safeguarding team. It is a statutory requirement that these notifications are made without delay.

The failure to notify these incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

All of the staff we spoke with said that they had faith in the new manager to make positive changes and develop the service. The manager was open with us during the inspection and had started to implement proper incident reporting and improve staff's knowledge of safeguarding issues; because she had identified these areas as lacking. Staff said they felt the manager was approachable and that they were listened to, but people and relatives did not always share that view. We heard from some people that their complaints had been dealt with dismissively or even rudely; and that they had little confidence in a resolution. The manager had not apprised herself of the provider's policy about complaints which meant that these had not been managed in line with it. The provider had not made sure that during their regular visits to the home, the manager was working according to the policies and procedures of the service.

Although staff were not uncooperative, they often showed a lack of accountability when being asked questions about people's care or their needs. There were many occasions during the inspection when staff would refer us to others who, in turn, passed us on to different staff. This was particularly evident when we tried to establish how air pressures were set on people's mattresses and when asking for care records. This situation was made more difficult by the fact that care plans were maintained electronically. This in itself was not a problem, but there were many separate files, sheets or other documents that did not form part of the electronic records; such as weights books, turn charts and wound records. There were often delays when we asked either staff or the manager for records; and when they were produced, they were often not those requested or were incomplete. This made it difficult to properly track people's care to gain a full picture of their needs and how they were being met.

The manager said that she was supported by the provider who visited the service at least once each week. She had not yet had any supervision but said she felt able to raise any issues of concern and that she would be listened to. The manager was a registered nurse and had kept up her NMC registration to keep abreast of best practice. She told us that she also did this by reading academic articles; and planned to attend local care home forums in future.

Links to the local community were maintained through monthly church services which were open to people from the local village. This gave people the opportunity to meet others with similar interests from outside the service. Events taking place in Woodchurch village were also publicised in the service's monthly newsletter and included Royal British Legion meetings and a Darby and Joan club.

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 Nursing care Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Complaints had not been handled effectively.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Proper and robust recruitment processes had not been operated.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not made statutory notifications to the CQC as required by this Regulation.**

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 Nursing care Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Service users' needs were not met and did not always meet their preferences.**

The enforcement action we took:
A warning notice was issued to the provider that they take action to ensure that people's needs are properly met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not consistently treated with dignity and respect.**

The enforcement action we took:
A warning notice was issued that the provider take action to ensure that people are treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The principles of the Mental Capacity Act 2005 had not been applied in order to observe service users' rights and wishes.**

The enforcement action we took:
A warning notice was issued that the provider operates in accordance with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines had not been managed safely in the service.**

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	Assessments about identified risks to service users had not been used effectively to mitigate those risks.

The enforcement action we took:
A warning notice was issued that the provider provides care and treatment to people in a safe manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users had not been adequately protected from abuse and improper treatment through the failure to operate proper safeguarding systems and processes.

The enforcement action we took:
A warning notice was issued that the provider take action to ensure people are properly protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Service users had not been protected from the risks of inadequate nutrition and hydration.

The enforcement action we took:
A warning notice was issued that the provider protects people from the risks of inadequate nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Feedback had not been used in order to improve the quality and safety of the service. Quality assurance processes were not always effective in identifying shortfalls in the service provided.

The enforcement action we took:
A warning notice was issued that the provider ensure they act on feedback to improve the quality and safety of the service and that they implement effective and robust quality assurance processes.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff deployed to meet service users' needs. Staff training and supervision had been ineffective in ensuring that staff had the knowledge and competency to fulfil their roles.

The enforcement action we took:
A warning notice was issued that the provider ensure that there are sufficient number of trained staff deployed to meet people's needs; and that effective supervision processes are in place.