Care Quality Commission

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 30 December 2014 and 2 January 2014. It was unannounced. The first inspection day started at 7am. We inspected because we were informed of a wide range of concerning information about the service from more than one source.

Woodville Rest Home provides care to 30 older people who are living with dementia. When we inspected, there were 27 people living in the service. Due to changes in people's physical health, some people needed increased support with their daily lives, including with their personal care.

The service was laid out over four floors. There were two sitting/dining rooms. People's bedrooms were provided across three floors. There was a passenger lift between the floors and wheelchair accessible patio garden areas to the rear of the building.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Before the inspection, we had been told people were being got out of bed early in the morning, not by their own choice. We found this was the case and care workers told us what we saw was normal for the time of day.

Before the inspection, we had been informed people who needed support to move were not moved in a safe way. Also hoist equipment for moving people would not go through some room doors and we had been told there was a lack of other equipment to support people with moving. This information was confirmed during our inspection.

New care workers did not always receive an induction to prepare them for their role. Care workers told us there was insufficient training. The training programme was not up to date. Care workers were not being supervised in their roles. Care workers said they did not feel supported in their work.

Managers had not identified or taken action in several areas where improvements needed to be made. We had been told the service was short of staff before the inspection and people's care needs were not being met. No recent measures of people's dependency had taken place to assess if staffing levels were sufficient to meet their current needs. There had been no recent audits of care plans to assess if they were effective in meeting people's needs.

Where audits had taken place, for example for maintenance and records, they did not identify areas where action needed to be taken. During the inspection, we identified issues which could have seriously affected people's health and welfare. There had been no timely review of what had happened and relevant procedures had not been put in place after the event, to ensure people were protected in the future.

Accurate assessments of people's needs had not been performed, including where they were at risk of developing pressure ulcers or at nutritional risk. Care was not planned and delivered in an effective way to meet people's needs. Where people needed support from healthcare professionals, for example with seating or mobility, this had not been sought.

Where people lacked the mental capacity to make decisions, the service was not guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. No-one living at the service was currently subject to a Deprivation of Liberty Safeguard (DoLS), however care workers were unclear of their responsibilities in relation to DoLS.

The storage, record-keeping and disposal of medicines were not taking place in a safe way. An external pharmacy audit in October 2014 had identified a range of deficits where the home needed to take action. Some of these deficits continued at this inspection.

Safe systems for cleanliness and hygiene were not being followed. There were a range of unclean items, including a bath hoist and commode inserts. Care workers were not following safe procedures in the use of disposable gloves. Communal toilets did not have hygienic systems to ensure people could wash and dry their hands after use.

Other systems in the home were safe and people were supported in the way they needed. The care worker giving out medicines did this in a safe way, ensuring the trolley was fully secured when they were not with it. They signed for medicines only after they had administered them.

Care workers offered people choice about where they would like to eat their meals. They supported people in a kindly, gentle manner.

Some of the care workers knew people as individuals, describing their needs and how they met them in some detail. They also told us about people's individual likes and preferences.

The complaints procedure was available. People's relatives said they would not be concerned about raising matters with staff if they needed to.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

People were not being supported to move in a safe way. Risk assessments were not accurately completed, so people's risk was judged to be lower than it was.

Where people sustained bruising they were not safeguarded as reviews of their condition and referrals to relevant professionals did not take place. There was some unsafe equipment and furnishings.

People said there was a lack of staff. Staff were not readily available to support people when they needed assistance. Systems for recruitment of new staff did not show all relevant assessments had taken place to ensure staff were safe to work with people. The service did not have safe systems for management of medicines. Inconsistent infection control procedures meant there was a risk of cross infection.

Is the service effective?

Inadequate 

The service was not effective.

New staff did not consistently receive an induction into their role to prepare them for working with people. Training in a range of areas was not up to date. Staff were not supported by supervision in their role.

The requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) were not being fulfilled. Correct procedures were not being followed where people lacked capacity to make decisions for themselves. Some people's healthcare needs were not met. This included not seeking assessments from relevant external healthcare professionals when people needed.

People were not offered a choice of meals. Where people needed support with nutrition, risks were not regularly reviewed or appropriate care plans developed to support the people.

Is the service caring?

Inadequate 

The service was not always caring

At 7am most of the people were up and dressed. There was no evidence this had happened through their own choice. Some people were in unclean clothing; staff did not have time to attend to them. People were not supported when they were not able to do things for themselves.

Other people commented on the caring nature of the service. A person's relative described the excellence of care. Care workers offered people choice at times, for example where they would like to eat their meal. Care workers were consistently polite and kindly towards people.

Is the service responsive?

Inadequate 

The service was not responsive.

Summary of findings

People and their supporters were not consulted about their care plans. People's care plans did not direct how their care needs were to be met. Care plans were not consistently reviewed to take into account people's different and changing needs. The service was not responsive to people's social needs. There was a lack of meaningful and appropriate activities.

The service had a complaints policy available. People reported they could raise issues if they wanted to. The manager did not have a system for documenting or reviewing informal concerns.

Is the service well-led?

Inadequate

The service was not well-led.

Management systems had not prevented the service from returning to previously identified breaches with Regulations. Necessary audits such as the dependency of people were not taking place regularly. Other audits such as audits of maintenance and accidents did not identify areas which needed addressing. The service had not identified and taken action on inaccurate information.

The service described itself as a "specialist" dementia care service. However it did not use readily available information to ensure people living with dementia were appropriately supported in their lives, including choice, surroundings and staff qualifications.

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.

This unannounced inspection took place on 30 December 2014 and 2 January 2015 and was carried out by two inspectors. The inspection of 30 December started at 7am. The inspection was carried out because information of concern from several sources had been raised with us. We reported some of this information to the local authority as safeguarding alerts.

We reviewed the service's previous inspection reports and inspection history. We also reviewed notifications sent to us by the service. A notification is information about important events which the service is required to send us by law.

We contacted East Sussex County Council who commissioned the service for some people at Woodville Rest Home. This was to seek their views as to the quality of the service provided. We met with 10 people and three people's relatives. As some people had difficulties in 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 reviewed services provided across the building, including communal rooms and some people's own rooms. We reviewed records relating to seven of the people we met with. We spoke with 10 care workers. We met with the manager of the service on 2 January 2014. We reviewed management records, including quality audits, the service's statement of purpose and policies and procedures.

Inadequate

Is the service safe?

Our findings

When we started our inspection at 7am on 30 December 2014, it had been a cold night, with temperatures below freezing. People told us they felt cold. One person said, "It's freezing" and another "I've been freezing all night." It felt cold in the building. Care workers reported the heating had failed. They gave us a wide range of different timescales for how long the heating had not been working. There were no records, so we could not see when the heating had failed. At 10:15am a care worker took the temperature of the main sitting room on their mobile phone. This showed the room was 0°C. There were no emergency procedures to advise care workers on actions to take when the heating failed. We phoned both the manager and the provider. They sent the maintenance worker to the service. They did not attend the service themselves. Care workers wrapped people up in blankets following our suggestion. The maintenance worker provided some portable heaters. They did some work on the heating system and by 1pm, the temperature in the main sitting room reached 23°C. On 2 January 2015, the building was warm. There had been no investigation into what had happened, to ensure people were safe from risk of hypothermia or from a re-occurrence in the heating failure. An emergency procedure about heating failure had not been developed.

The service had not identified, assessed or taken action to review its systems and ensure the health and safety of people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw a range of areas which required maintenance. These included, a person's room where both the bulb in the bedside light and main light were not working, so on an overcast day or at night, people were at risk of a tripping injury. We saw a broken foot pedal operated waste bin in a frequently used toilet. To dispose of waste in this bin, a person would need to hold the lid open with their hand and so could contaminate their hand from the lid of the bin. There was a recliner chair in the downstairs sitting room which had a torn plastic cover. The edges of the plastic cover were sharp and could have damaged the skin of the frail person who was sitting in the chair. The last record in the maintenance log was dated 23 December 2014 and previous record was in October 2014. The areas we noted had not been documented or identified during internal audits.

The service had not maintained appropriate records about management of the service. This was a breach of Regulation and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not consistently safeguarded from harm. Relevant referrals did not take place following unexplained bruising. The service's safeguarding policy noted bruising as a possible indicator of abuse and stated any such concerns should be reported to the manager. The policy stated all such allegations would need to be taken seriously. Before the inspection, we had been told there were concerns about a person who had sustained extensive bruising. We made a referral to the Local Authority safeguarding team when we received this information. During the inspection, we saw the person's records detailed their bruising. No records had been made of actions taken, or referral to the Local Authority safeguarding team. We asked to see the accident record relating to the bruising. The manager told us they did not complete accident records where a person was observed to have bruising. This did not follow the service's own policy. As this unexplained bruising was not reviewed, there were no analysis of how it might have been caused such as moving people safely, possible abuse or a medical condition which needed to be referral to the person's GP.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had received information before we inspected that staff were supporting people to move in an unsafe way. Also equipment to move people would not go through some of the bedroom doors.

We saw care workers supporting a person to walk and sit in a chair in a way which could have damaged the person's shoulders. Care workers could also have injured their backs by the way they supported the person.

One person remained in bed in their room. When the person wanted to move, care workers brought the hoist.

Inadequate

Is the service safe?

They were unable to get the hoist through the person's bedroom door. They would have lifted the person inappropriately if we had not advised them of an alternative safe way of supporting the person to move.

We asked care workers how they usually supported people to move. They were reluctant to talk, saying they knew the way they were supporting people to move was not the right way. One care worker told us they moved people "by hand" when in bed. We asked about equipment such as slide sheets. Care workers reported they did not use them to support people.

There is a large amount of guidance from agencies such as the Health and Safety Executive about safe ways of moving people. The service were not following these guidelines.

Where people had risk assessments, they were not accurate. Due to inaccurate risk assessments people's assessed risk was significantly lower than was actually the case. For example two people had risk assessments for pressure ulcers which did not reflect their current needs. One of the person's pressure ulcer risk assessment stated they were fully mobile, which was no longer the case. Due to this, appropriate actions were not being taken by the staff to reduce the person's risk of pressure ulcers.

The issues above demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before the inspection, we had been told the service was short of staff. This was because people had increased needs and staffing levels had not been reviewed to ensure they could meet people's changed needs. A person's relative told us "there don't seem to be as many staff as there were." They said if they needed a member of staff "you have to go and find them." Care workers told us they were very busy. We saw people who sat in the main lounge remained for long periods without any staff interaction. These people were not able to support themselves independently, for example if they wished to have a drink. Additionally as these people were living with dementia, they were not receiving regular support from staff to orientate them with what was happening in the home.

People did not receive support from care workers because they were busy supporting other people. There were not enough care workers to support people who remained in their rooms. For example at 12:20pm we had to go and find care workers because we saw a person who was unwell leaning half out of their bed. They could have been at risk of injury if they had fallen. There were no care workers in the area who could have monitored the person's safety.

There were not sufficient numbers of staff to meet people's needs. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One of the newly recruited members of staff had not had their suitability for their role assessed, as they only had a telephone reference and no written references on file. Their interview assessment did not assess their suitability for their role in the light of the lack of clear references. Two other staff files included all relevant information to verify they were safe to work with people.

There was separate room designated for the storage of medicines. We looked in one of the medicines cupboards. In it, there were three medicines pots with tablets left in them. The care worker reported there was meant to be a book where such medicines were documented. They did not know where it was. None of these medicines pots had a date to show when they had been put in the cupboard. Only two of the three pots identified the person the medicines should have been administered to. Therefore it was not possible to identify which people, had not been administered their medicines, when this was or why.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs or medicines. We looked in the controlled drugs cupboard and checked the controlled drugs register. One of the controlled drugs in the cupboard was dated October 2013. The care worker told us this person was no longer in the service. This medicine was not listed in the controlled drugs register. The register documented there were five of one medicine and four of another in the cupboard. None of them were in the cupboard. The care worker told us both of these people were no longer living in the service. The service were therefore not following requirements of the Misuse of Drugs Act when they stored and recorded controlled drugs.

People's safety was not ensured as they could have been administered drugs which has not been agreed as suitable for them. There was a box of medicines, which the care worker told us were homely medicines. These are medicines which can be supplied and administered

Inadequate

Is the service safe?

without prescription for simple ailments such as headache. As such medicines may interact with other prescribed medication, the service followed guidelines and had a policy to ensure the safety of people when administering them. The box of homely medicines included three medicines which were not included in the service's homely medicines policy. One of these medicines had expired on October 2011 and so would not have been effective for use.

An external pharmacist had performed an audit of the service's medicines in October 2014. They had identified a range of areas which needed addressing, including issues we found relating to homely medicines and controlled drugs. We asked the manager for their action plan. They said the matters had been dealt with by the care worker who had responsibility for medication, so there was no action plan.

For the above reasons the service was not following safe systems for medicines management. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found a range of areas which were not clean and practice which presented risk of cross infection. These included unclean commode inserts and a bath hoist. The seats of some dining chairs were unclean. There were soiled sheets left on the floor of laundry room. We spoke with three care workers who gave us different answers about how they managed linen which had become contaminated by urine.

Care workers continued to wear disposable gloves and aprons after providing personal care and did not safely dispose of them when they had finished supporting a person. This included when bringing people into the sitting room, supporting them to sit down and opening the front door. We spoke with four care workers about this. They said they were not aware that not disposing of disposable gloves and aprons presented a risk of cross infection, as this had not been covered in their training for infection control.

Many communal toilets did not have single use paper towels or soap in them. Many light pull cords in communal toilets were stained. This included the toilets closest to the sitting room on the ground floor and the top floor sitting room. Both of these toilets were used independently by people. People could therefore not cleanse and dry their hands hygienically after using the toilet. Also there was a risk of cross infection as light pull cords were not clean in toilets being used by people.

Due to the above, this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

We had received information before this inspection that staff did not receive the training they needed to meet people's needs. We observed staff supporting people. Some staff did not show an awareness of how to support frail people. For example one person showed signs of being unwell on the first day of our inspection. The person appeared to be asleep during all of the morning. When staff tried to rouse them, they were unable to do so and the person seemed to remain asleep. Staff did not consider the person's sleepy and unresponsive condition throughout the morning indicated they were unwell and they might need a GP referral, until we asked if they had done this. We asked a care worker what was the one issue which was most needed in the service. They said "training."

New staff were supposed to have a one day induction. We observed this was not always completed before staff starting working with people. We met with a newly employed care worker. This new care worker had not had an induction by the end of their first shift. The service cared for people who were living with a range of medical conditions which could cause them to become unwell and who might need emergency intervention. This new member of staff was not aware of the service's emergency procedures. They also had not had access to the service's policies to advise them on actions they were expected to take to support people. They would therefore not have known how to appropriately support a person if they became unwell.

We saw one person who moved about in an unfocussed, restless way throughout the morning. They looked tired. Care workers did not intervene to support the person by orientating them to where they were and what the time was. They did not check to see if they wanted something such as a drink or something to do. Care workers told us all training was by e-learning. One care worker told us dementia e-learning training had not included information on supporting people who showed such behaviours. They felt they needed such training and gave us examples of when they had been unsure of how to support a person. Other care workers reported where they had received training, it had not been recent.

We looked at staff training records to see if other staff had been appropriately trained. These showed care workers were not up to date with training across a range of areas. This included the theory of safe moving and handling, where the records showed 11 care workers out of 18 had not received recent training in the area. The training records also showed 12 care workers had not received recent dementia care training. We asked the manager about the deficits in training. They reported they were aware of them but the service had been so busy recently due to the increased needs of people, that they had not had time to ensure all care workers were trained as needed. We saw the lack appropriate training meant staff did not support people to move in a safe way and were not aware of how to appropriately support people who were living with dementia

Care workers also told us they were not supervised in their roles. One care worker said they had not received supervision since they started working in the service. Another said they had received one supervision in nine months. A third care worker said their last supervision had been about three years ago. The manager reported they were "behind" with ensuring care workers were supported by supervision. Care workers felt if they had received supervision, they would be able to raise issues where they felt they needed support, so they could care for people in the way they needed. The manager also added they had never received a supervision or appraisal of their performance in their role. They did not feel supported by the provider as they did not have a formal way of receiving feedback on their performance from the provider.

Systems did not ensure care could be delivered to an appropriate standard because staff were not receiving the training and supervision they needed. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked care workers about supporting people who did not have the capacity to make decisions, and how they made best interest decisions on their behalf. None of the care workers said they had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Such training was not included on the training plan the manager gave us.

All care records had a prompt question which had been circled, stating the person did not have capacity. None of the records included a capacity assessment, information on how day to day consent was to be supported for the person or how decisions were to be made in their best interests. One of the people spent their days in a recliner

chair. Some care workers reported this was to stop them getting up unassisted, others because the person was more comfortable that way. There was no evidence from discussions with care workers or a review of the person's records to show if consideration had been given to whether putting the person in a chair they could not get out of independently was a deprivation of their liberties and in their best interests.

Suitable arrangements for acting in accordance with the consent of people, and in their best interests were not in place. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care workers did not always seek advice from relevant healthcare professionals when needed. Several of the people needed support with their mobility. Care workers confirmed a physiotherapist had not been contacted to advise on how people would best be supported. One of the people tended to curl up in their chair when they were sitting. They did not look comfortable or safe. Care workers reported finding the correct seating for them was difficult. We asked care workers if they had sought external professional advice on appropriate seating for the person. They reported they had not.

People not assessed to ensure they received the care they needed. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

However there was some contact with other professionals. Care workers told us they had close working relationships with the district nurses. We saw from people's records district nurses had been contacted, for example when one person's skin had shown a sore area in November 2014.

All of the five people's records we reviewed in detail were losing weight. One person had lost 7 kilograms between June 2014 and December 2014. Another person had not been weighed since October 2014, despite their losing 2 Kilogrammes in a month. When the person was weighed during the inspection, they had lost a further 4 Kilogrammes since October 2014. None of these people's weight loss had been identified in their nutritional risk care plans. Nutritional care plans did not identify how the people might be supported with eating. For example one person's relative told us they liked foods they could eat with their fingers, as they could be more independent. This was not considered in their care plan. They were not given finger foods at lunch-time. None of the people's care plans indicated if they were being given fortified diets. We asked care workers about these people's weight loss. They said they saw people every day, so had not noticed it. They said changes in weight for people was not an issue routinely brought up at shift handover meetings.

We asked people about the meals. People told us there was no choice. One person said "You just have what's given you." Another person said if they did not like the food they would "Probably do without" for that meal. A third person reported "They are very busy at mealtimes, they couldn't do a choice then." Care workers cooked the main meal on both days. People were not offered any choice.

The information above demonstrates a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

We started our inspection at 7am because we had been given information that people were got up out of bed in the morning from an early hour. This was not because people had actively chosen to be up early, but because it was the system in the service. When we arrived, 23 out of the 27 people were up, dressed and either in their rooms or one of the two sitting rooms. The majority were asleep. We asked one person if they had chosen to get up at that time. Their only response was to say "They got me up." They looked blankly at us when we asked if they had been involved in the decision about when they got up. Another person said they had also not made an active choice to be up early. They had got up because "In the mornings they like you to get up."

We asked all the care workers on night duty and day care workers if this was an unusual night in the numbers of people who were up and dressed by 7am. They all confirmed what we saw was normal for the service and this number of people were usually up and dressed by that time. We asked why so many people were up at this time and if they had actively chosen to be up early. They told us if people were incontinent and wet, they would get them up and dressed. None of the care workers considered supporting the people asking them if they would prefer to have their clothes and bed linen changed, have a warm drink and snack if they wanted one, and assisting them back to bed. None of the people's records we looked at documented any information about their individual choices about getting up.

People's independence and dignity was not reflected in how they were dressed. One person had one slipper and no socks or tights or lower leg coverings from when we started the inspection. Staff did not intervene to support them to ensure they did not become cold during the heating failure. Some people's clothing was stained. One person was not swallowing well. They did not have a clothes protector on, so their drinks had dribbled onto their clothing. This person was frail and needed support from staff to drink fluids. Their care plan had not been updated when their needs changed to reflect their current needs and preferences. At 12:20pm we saw a person who was walking about on the first floor. Their clothing had come loose and their bare legs and underclothing were showing. There were no care workers in the area to observe the person needed support to maintain their dignity.

People in the downstairs sitting room remained sitting in their chairs from when they got up, until lunchtime. Unless they asked, their comfort and well-being were not ensured by moving them or offering them toilet breaks. People's dignity was not considered by offering them an opportunity to freshen up before meals or after meals.

We saw a pile of used, laundered net underwear. None of the net underwear was named. A care worker reported most of the people used this net underwear. They confirmed net underwear was not individually named and all net underwear was used communally. The service had not considered systems to ensure such underwear was not used communally to support people's dignity.

The wellbeing of frail people was not supported in a considerate way. One person's care plan stated they should be offered cold water to keep their mouth feeling fresh. The person had no water in their room from 7am until 12:30pm. Another person was unwell and cared for mainly in bed. Their records showed they were drinking very little. Care workers had not considered the person might need support to keep their mouth moist and comfortable. A person in the sitting room looked unwell. A care worker made only one effort to support them in eating and drinking, then left them. The person did not receive any further intervention to ensure their comfort and well-being. The person remained in this condition without further support from care workers until they were seen by their GP later on in the day.

All the information above demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

While we observed people were not cared for in the way they needed. People we spoke with gave us positive comments about the service. One person said "I'm very happy here" and another "I can't fault them" about the staff. A person's relative said "The staff here are all lovely," "I think the care here is excellent." Another person's relative said they liked the way they could visit anytime, saying "I come when I want to." Care workers commented on the caring approach in the service. One care worker reported "All the staff really do care."

Inadequate

Is the service caring?

We saw some individual staff showed a caring approach and offered people an opportunity to be involved in decision making. One care worker asked people if they wanted to go up to the upstairs lounge for breakfast. They were very polite to each person, checking back with them and carefully explaining what they were saying. A care worker gently woke a person who was asleep, waited until they were orientated, before giving them a choice of where they wanted to eat their breakfast. We saw a care worker gently persuading a person to have a drink, giving them the support they needed, not hurrying them in any way. A person called out loudly that they wanted go to the toilet at a very busy time. The care worker was very polite to them and made sure the person was promptly supported.

Inadequate

Is the service responsive?

Our findings

Relatives told us they were not involved with supporting their relative in planning their care. The next of kin of one person who had lived in the service for over a year told us they had "Never been involved in a care plan." This is contrary to the provider's policy which stated "Families are actively encouraged to read and understand the care plans."

People were not given the individual care they needed. Care workers told us about a person who had sustained pressure ulcers in the past. When we met with the person just after 7am, they were sitting fully dressed in a chair in their room. They were not sitting on a pressure relieving cushion. We returned to review how the person was twice during the morning. On both occasions, they remained in the same position. They continued not to be sitting on a pressure relieving cushion. There were no change of position records to show the person was supported in moving regularly. Care workers told us the person was put back to bed every afternoon to reduce their risk of pressure ulcers. They did not tell us about any other interventions. We looked at the person's care plan. It did document about them going back to bed during the afternoon but it did not document any other interventions, such as equipment they needed to use to reduce their risk or how often they were to be supported in changing their position.

Another person's air mattress was on the incorrect setting for their weight. This could have increased the risk of pressure ulcers for them. Their care plan did not include any information relating to the correct setting for their air mattress. A third person had records which showed they had been referred to the district nurse in November 2014 because of a "sore" on their skin. Their care plan was not reviewed after this to consider how their risk was to be reduced.

The National Institute for Health and Clinical Excellence (NICE) state that pressure ulcers, once developed take an extended period to heal, are painful and can present a risk of infection. Therefore the emphasis must always be on their prevention before they occur. Care workers we spoke with knew any reddened areas of skin or skin breaks needed to be reported to the district nurse. They did not know about their key role in supporting people by reducing pressure to prevent tissue skin damage before it occurred, as detailed in the above guidance.

The service was not responding appropriately where people experienced continence needs to ensure they were appropriately supported. One person was documented as being incontinent. There was no guidance for care workers to follow to support the person in encouraging continence or information on how often care workers should check their skin. We saw the person was not supported by care workers in ensuring they were going to the toilet at regular intervals. The person was therefore at risk of continued lack of support with maintaining their continence. They would also be at risk of not having their skin checked when they needed to ensure it was fresh and comfortable for them.

Care workers reported on the use of continence pads, not any other interventions to support people with continence needs, such as regular comfort breaks. The service's continence management policy only directed staff to contact the continence service. It did not outline standard assessments or follow guidance on how best to support people with continence needs. The service were not responsive because they were not following appropriate ways of supporting and improving care to people who had difficulties with continence.

People's dementia care needs were not responded to appropriately. One person's care plan stated 'give medication' if a person showed signs of aggression, with no description of types of symptoms the person should be showing for them to need the medicine. The care plan did not outline any other interventions other than medicine which could be used to support the person. Another person was prescribed a medicine which can have a major effect on mood. Records showed they had been given the drug five times in December 2014. The person did not have a care plan about when and why the medicine was to be given or what other interventions could support them. The care worker who was administering medicines did not know when the person might need such medicine as they had not been on duty when the person had been given it. The care plans did not show the effect of medicines or other interventions for each person had been evaluated to review the benefit for the person.

The television was on in the downstairs lounge all day. People were not offered a choice of programmes to watch. Care workers were busy supporting people, so if a person did not actively need assistance, they received little interaction with staff. Most people sat and dozed or looked blankly at their surroundings.

Inadequate

Is the service responsive?

In the upstairs sitting room, the care worker was more actively involved with people, engaging them in conversation and leading individual or small group activities. We asked them if there was an activities plan. They told us there was one "somewhere" but they didn't know where it was. The care worker described individual activities for people. They had a detailed knowledge of what each person preferred to do and how they responded to individual and group activities. This was not documented and developed into a care plan, so people could be provided with consistent diversional activities in the way they wanted.

The service's statement of purpose stated their policies advocated "physical and mental stimulation." It also stated Woodville provides a "diverse range of activities and outings. We found no evidence to support this statement.

All the information above demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home had a complaints policy, which was available. Relatives told us they felt they could bring up matters of concern with staff should they wish to do so. The provider reviewed if any complaints had been made about the service in their monthly visit reports. No complaints had been made recently about the service. The manager did not have a system for recording and reviewing verbal and informal concerns. Although the external sources who raised issues with us all felt they had raised matters with the manager, there were no records of them. The manager said they had not been informed about any of issues raised with us and so had not taken action to review such reports about people's care. The manager told us they worked regularly in the service, supervising care and felt they would have been aware of and taken action on such matters of concern as had been raised with us.

Inadequate

Is the service well-led?

Our findings

Before the inspection we had been given information that the service was not well-led. Care workers spoke with us during the inspection but were concerned about being identified and wanted their responses to be anonymous. Care workers reported they did not feel listened to. A care worker reported "I feel we have just been left to sink without any support." Another care worker reported they felt the provider "does not care." A care worker reported if they brought things up at staff meetings "nothing happens". However another care worker reported "I suppose I can bring up issues". Some care workers spoke positively about the deputy manager. One care worker reported "she tries."

The manager was registered with the CQC and had been at the service for several years. They told us they spent time working with people and staff, so they felt they knew people's needs.

The service's statement of purpose included their aims and objectives. The manager reported the statement of purpose was usually made available to people when they decided to be admitted to the home. One person's relative recalled some information about matters such as agreeing to photographs of their relative, but nothing more. The service's aims and objectives stated the service wished to provide the "highest person centred care possible." They outlined a range of ways in which they would do this. Among these areas, they would encourage people to continue with any hobbies they had. One of the ways they would support people in doing this would be to train staff in reminiscence. Staff had not been trained in reminiscence. There were no records of people's past hobbies. People were not able to describe to us what their previous hobbies had been, so without records of what they were, such interests could not be continued. The service's aims and objectives also stated equipment was provided to help the people remain comfortable and safe. The service did not provide a range of different seating to meet people's individual needs. On our first visit, one person was sitting in a recliner chair, on the second day a different person was sitting in this chair. The person who was sitting in the chair on the first day on the second day was sitting crookedly in an ordinary arm chair. They did not look safe or comfortable. Care workers told us the service only had one recliner chair so people who felt comfortable and safe in it were not always able to use it.

The management systems did not effectively review the dependency needs of people. We had been told before the inspection, and by care workers during the inspection, that the dependency needs of the people had increased. The last full audit of people's dependency needs had been performed in 27 May 2014. It had not been reviewed since. All people had individual dependency assessments completed. These were not totalled to provide an overview of people's dependency. These dependency measures were not accurate. For example one person's mobility and continence dependency rating did not reflect their current high needs. Another person's dependency rating did not reflect the increased supports they needed with eating and drinking. These issues had not been identified during management audits.

The last audit of care plans was dated 15 May 2014. It concentrated on factual accuracy such as people's names and date of birth. The provider's monthly reports also showed they reviewed care plans when they visited. Neither their reports nor the most recent audit indicated they had used a broad approach, including meeting with people, talking with staff and other persons, as well as a review of their documentation. Due to this, management systems had not identified a range of issues to ensure people received high quality care. For example, one care worker told us of one person's health condition in considerable detail and about how they supported them. The person's care plan used generic wording and did not document the specific actions the person needed. Similar matters had not been identified by management review systems.

We looked at accident records. Of the 20 records documented since 19 November 2014, 15 had occurred during night duty. The manager had not identified this in their audit of accidents. They had therefore not taken steps to ensure people's safety during the night.

Where matters were identified during audits, accountability for action was not clear. We saw two care workers who had long painted fingernails. The length of the fingernails meant people who had frail skin could be placed at risk of tissue damage. Also as they were painted, it was not possible to see if the care workers' nails were clean

underneath. There was a record to show the last spot check on staff nails had taken place on 29 November 2014, a month previously. It showed a care worker had been identified as having long nails. No actions were documented about what happened. The manager said they thought the care worker in question would have been spoken with. There was no information to show once it had been identified as an issue during audit, this matter had been followed up to ensure all staff were aware of the risks to people from long or unclean fingernails.

The board outside the service described it as a "specialist" dementia care service. This was not demonstrated by the service across a wide range of areas. For example, none of the staff, including the manager, had any specialist training in dementia. Other areas did not show they were a specialist dementia service. There is a large body of evidence available on how to support people who experience continence issues, by appropriate signage for toilets. These state toilets should be clearly marked as such and signage well lit. This was not the case. For example, the toilet closest to the ground floor sitting room was marked as a toilet but the sign was in a dark area of the corridor and could not be easily seen. There is also a wide body of information available from bodies, including the Alzheimer's Disease Society, which provides guidelines on the diverse methods of supporting people who are living with dementia in making choices. We asked the manager why the service did not offer a choice of meals to people. The manager told us this was because people did not remember the choices they had made. They were not aware of the readily available ways of supporting people who were living with dementia in choosing in such areas as meal choice.

The information above demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records about the service was not accurate. For example, when we looked at the staff rota, it documented the manager was on duty and had been on duty the previous day. A care worker told us the manager had not been on duty since Christmas Eve. They reported the manager was on call and directed us to a name and number written on a wipe-able whiteboard. One of the night care workers was not aware the manager would not be on duty and had told us we would be able to see the manager later on that day. These inaccurate and impermanent records meant people, staff and external agencies would not know the actual situation about staff and management of the home over a holiday period. We asked for the list of people living at the service. We were given the list which would be given to a fire officer. It was not accurate as some people no longer lived at the service and others had moved rooms. This meant in emergencies such as fire people, staff and external professionals could be put at risk as correct information about which people were in the service was not available.

Due to the information about this is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The service did not have suitable arrangements to ensure people were safeguarded against the risk of abuse. This was because they were not taking suitable steps to identify the possibility of abuse. Regulation 11(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The service was not ensuring people, persons employed and others were protected against risk of infection. This was because their systems to assess, prevent and control the risk of infection were not effective. The service was also not maintaining effective standards of cleanliness and hygiene. Regulation 12(1)(a),(b),(c)(2)(a)(c)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The service was not protecting people against the risks associated with unsafe use and management of medicines. This was because they did not have appropriate arrangements for recording, handling, safe-keeping, dispensing and disposal of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The service was not protecting people from risks of inadequate nutrition and dehydration by providing a choice of food and drink. They were also not consistently enabling people who needed support to eat and drink sufficient amounts for their needs. Regulation 14(1)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The service was not making suitable arrangements to ensure the dignity, privacy and independence of people and treat them with consideration and respect. Regulation 17(1)(a)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The service did not have suitable arrangements to obtain and act in accordance with the consent of people, including where best interest decisions needed to be made for people. Regulation (18)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The service did not ensure people were protected against the risks of unsafe or inappropriate care because there was a lack of proper information about them. They did not maintain an accurate record for each person in relation to their care or for the management of the service. Regulation 20(1)(a)(b)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The service was not safeguarding the health, safety and welfare of people because it did not ensure that at all times there were sufficient numbers of staff to meet people's needs. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The service did not ensure staff employed were appropriately supported to enable them to deliver care to people to an appropriate standard. This was because they did not ensure staff received appropriate training, supervision and appraisal. Regulation 23(1)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The service did not take proper steps to ensure each person was protected against the risks of receiving care which was inappropriate or unsafe. This was because they were not carrying out accurate assessments of people's needs. They were also not planning and delivering care to meet people's individual needs and ensuring their welfare and safety. They also did not follow appropriate guidance when providing care. Regulation 9(1)(a)(b)(i)(ii)(iii)

The enforcement action we took:
A warning notice has been issued. The service is to be complaint within two months of receipt of the warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The service did not protect people and others who may be at risk from the risks of inappropriate or unsafe care. This was because it did not have effective systems to enable them to regularly assess and monitor the quality of services provided. Their systems did not identify, assess and manage risks relating to the health, welfare and safety of people and others. The service was not making changes in their service provision having regard to information contained in records, following appropriate expert advice and reports from the Commission. Regulation 10(1)(a)(b)(2)(b)(iii)(iv)(v)(c)(i)(ii)

The enforcement action we took:
A warning notice has been issued. The service is to be complaint within two months of receipt of the warning notice.