Cedars Care (Winscombe Hall) Limited

Winscombe Hall

Inspection report

Winscombe Hill
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Date of inspection visit: 21 and 22 January 2016
Date of publication: 14/06/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Winscombe Hall is a care home providing accommodation for up to 39 people, some of whom are living with dementia. During our inspection there were 36 people living in the home. The home comprises two areas; Stable Cottage provides care to people living with dementia, and The Halls which provides nursing care. The home is situated on the outskirts of the village of Winscombe.

We inspected Winscombe Hall in November 2014. At that Inspection we found the provider to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The regulations included; supporting staff, consent to care and treatment, records and assessing and monitoring the quality of service provision. These correspond to regulations 18 staffing, 11 need for consent and 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider wrote to us with an action plan of improvements that would be made. They told us they would make the necessary improvements by April 2015. During this inspection we saw some of the improvements

Summary of findings

identified had been made. However we found some of the actions identified by the provider had not been completed. We found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place on 21 and 22 January 2016 and was unannounced.

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

There were not always enough staff available to respond to people's needs. People were waiting for long periods of time without staff support. Views from the staff were mixed over staffing levels. Staff were busy but told us they felt there were enough staff to keep people safe.

Risks to people were not always identified and measures were not always implemented to reduce the risk. Where risk assessments were in place they did not always contain accurate or enough information for staff to safely support the person.

Medicines were not always administered safely. People were left to take their own medicines with no risk assessment in place. Medicines were not always looked after in line with national guidance. There was no system in place to check the expiry dates of creams and ointments.

We found people's rights were not fully protected as the manager had not followed correct procedures where people lacked capacity to make decisions for themselves. We observed where decisions were made for people the principles of the Mental Capacity Act 2005 were not always followed.

Staff did not always support people in a way that promoted dignity and respect. People and their relatives told us they were happy with the care they or their relative received at Winscombe Hall. We observed staff were caring in their interactions with people.

Staff had an understanding about the assessed needs of people and how to keep people safe. However; care plans had not always been updated to reflect people's needs when they had changed or contain enough or clear information on how staff should support people.

The registered manager and provider had systems to monitor the quality of the service provided. Audits covered a number of different areas such as care plans, infection control and medicines. We found the audits were not always effective at identifying shortfalls in the service.

Where there were areas of the home requiring maintenance and repair the provider had improvement plans in place to address these.

People and their relatives told us they or their relatives felt safe at Winscombe Hall.There were systems in place to protect people from abuse and most of the staff we spoke with knew how to follow them. One staff member who was not directly employed by the service was not aware of where to report concerns outside of the home or aware of the whistleblowing policy. There was information detailing the whistleblowing policy displayed around the home.

A recruitment procedure was in place and staff received pre-employment checks before starting work with the service. Staff received training to understand their role and they completed training to ensure the care and support provided to people was safe. New members of staff received an induction which included shadowing experienced staff before working independently. Staff received supervision and told us they felt supported.

People were complimentary of the food provided. Where people required specialised diets these were prepared appropriately.

Relatives were confident they could raise concerns or complaints with the registered manager and they would be listened to. The provider had systems in place to collate and review feedback from people and their relatives to gauge their satisfaction and make improvements to the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement 

Some aspects of the service were not safe.

There were not always enough staff available to respond to people's needs.

Medicines were not always administered or stored safely.

Risks to people were not always identified, where risk assessments were in place they did not always include enough or accurate information.

Recruitment procedures were in place to ensure staff with suitable character and experience were employed.

Staff told us about the different forms of abuse, how to recognise them and said they felt confident to raise concerns with the manager.

Is the service effective?

Requires improvement 

Some aspects of the service were not effective.

Where people lacked capacity to make decisions the principles of the Mental Capacity Act 2005 were not always followed.

People had to wait for long periods for their food at lunchtime. People and relatives were positive about the food provided.

People's healthcare needs were assessed and they were supported to have regular access to health care services.

Staff received training to meet the needs of people. Staff received one to one supervision to discuss their concerns and development needs.

Is the service caring?

Requires improvement 

Some aspects of the service were not caring.

People were supported in a way that did not always consider their dignity and respect.

People were supported by staff who knew them well and had developed relationships.

People and their relatives spoke positively about staff and the care they received.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's care plans did not always include up to date information and were not always written in a timely manner.

Summary of findings

There were systems in place to collate and review feedback from people and relatives on the service received.

There was a system in place to manage complaints. Relatives told us they knew how to raise any concerns or complaints and were confident that they would be taken seriously.

Is the service well-led?

Requires improvement

Some aspects of the service were not well led.

The quality of the service provided to people was monitored and where there were shortfalls these were not always identified.

The manager promoted an open culture and was visible and accessible to people living in the home, their relatives and the staff.

People were supported and cared for by staff who felt supported by an approachable manager.

Winscombe Hall

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 inspection took place on 21 and 22 January 2016 and was announced.

The inspection was completed by two adult social care inspectors and a specialist advisor who was a nurse.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We also obtained the views of service commissioners from the local council who also monitored the service provided by the home.

During the inspection we spoke with 16 people and four relatives about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home because they were living with dementia and were unable to communicate their thoughts. We therefore 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 also spoke with the registered manager, the care manager, two nurses and 11 staff members including the maintenance person and housekeeper. We also spoke with a visiting health professional. We looked at documentation relating to 13 people who used the service, four staff recruitment and training records and records relating to the management of the service. After the inspection we spoke with one further relative.

Requires improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.

There were systems in place to manage people's medicines. We found the systems did not always ensure medicines were safe for people receiving them. For example, some people were left to take their own medicines after the nurse had given them to them. The nurse told us, "Some of the clients I can leave their meds in front of them and then I obviously go back and check". We looked at the care plans for the people who had their medicines left with them and could not find any risk assessments in place for this. Later in the day we observed one person taking a tablet from their handbag, there were no staff present at the time. We spoke with the nurse who told us they would go and check the person's bag. We discussed this with the registered manager who told us people should not be left with their medicines; they told us they would ensure all of the nurses were aware that this should not be happening.

One person's medicines were mixed with their food before taking them. Whilst there was information relating to them taking this in their care plan and the GP had been involved, there was no evidence of the home contacting the pharmacy to obtain information to ensure the medicines were safe to take this way. We discussed this with one of the nurses who was unaware of the requirement to do this. Following our inspection the registered manager told us they contacted the pharmacy who confirmed the medicines were safe to be taken this way.

Accurate and up to date records were not kept of people's medicines. Medication administration records (MARs) had medicines recorded on them that were not being taken. One person had three pages of medicines recorded on their MARs that were no longer in use. Two people's MARs that we looked at were hand written and not signed or countersigned by staff, which meant there was no accountability to who had written the record. We observed the nurse completing their medicines round and noted they were interrupted by staff. The nurse told us they, "Frequently get interrupted to deal with things, even during meds". This meant the nurse was not able to fully concentrate on administering medicines and could be at risk of making a mistake.

Some people were prescribed creams and ointments which were kept in their rooms and applied by care staff. We found the creams were not dated when they were opened, this meant staff would not be able to determine if these creams were still safe to use. The registered manager told us they would purchase labels and ensure all staff were aware of the need to label creams once they were opened. There was information in people's care plans relating to the creams and ointments the staff supported them to administer. We found one person's records did not include information on where staff should apply the cream. Some medicines were required to be stored in a fridge located in the nurses office and we saw the fridge was unlocked. The registered manager told us the door to the office was locked when the room was not in use. Following the inspection the registered manager told us they had located a lock for the fridge.

Where there were risks to people these were not always identified and measures put in place to reduce the risk. For example, where people had bed rails in place to prevent them from falling from bed, these were not risk assessed. This meant people were at risk of becoming trapped in the rails. We measured the bed rails and found some of them were not within the recommended safe height to prevent people from falling. During our inspection we highlighted this to the registered manager who arranged for the maintenance team to put measures in place to ensure all of the bed rails met safe standards relating to their height. The registered manager told us they would ensure all people with bed rails in place would be risk assessed. Following our inspection the provider told us risk assessments had been completed for all of the people using bedrails. The provider also sent us records of the maintenance team carrying out monthly safety checks on the bedrails for January 2016.

Where risk assessments were in place there were not always enough information in them for staff to safely support the person. For example, where people had moving and handling risk assessments in place there were no recorded details in the assessment of the size of the slings used to support them whilst using a hoist. We spoke with staff who told us this information was given to them during their induction and they were aware of the correct slings to use. Whilst staff were aware of the needs of people, the information would not be available if regular

staff were unavailable to support people. We spoke with the registered manager who acknowledged this and told us they would ensure the risk assessments would be updated to include this information.

Some people received support in their beds and had pressure relieving mattresses in place to prevent them from developing pressure ulcers. We found there were no systems in place to check the air mattress was set at the correct pressure and the mattresses did not automatically adjust to the person's weight. We spoke with the nurses who told us they were set at medium regardless of what the person's weight was, they said, "The air pressure dial is at the end if the bed, it usually goes on medium if it goes over we are aware of it, I couldn't tell you off hand what the pressures are". There were no details in people's care plans of what the air pressures should be set at. We discussed this with the registered manager who was in the process of contacting the manufacturers of the beds to find out more information relating to this to ensure the mattresses were on the correct setting. Where people were at risk of pressure ulcers risk assessments were in place. We found one person's risk assessments did not contain accurate and up to date information. The risk assessment stated they had a pressure ulcer, however their review notes stated they no longer had the wound.

This was a breach of Regulation 12 (a) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

One person we spoke with told us they were happy with their medicines commenting, "They give me my tablets and I am happy with that". A relative commented, "I know about my family members medication, they always keep me up to date". We observed the nurse administering medicines and asking people if they would like any medicines for pain.

Following our previous inspection in November 2015 the registered manager told us they had increased staffing levels to have an additional staff member available in The Stables. During this inspection we found there were still not enough staff to respond to people's needs. For example, we observed one person calling out to staff for over 35 minutes from their bedroom. During this time a staff member walked past the bedroom and did not respond to them, we observed they were involved with supporting another person. We saw the person was unable to get up themselves and although they had a call bell in their room it was not in their reach. The person was calling out and banging on the wall to summond staff support. We raised this with staff who then put the call bell in place. We raised this with the registered manager who told us the person was new to the home (moving in the evening before) and they did not know the call bell was not in reach. They went on to say they were not sure if the person was able to use the call bell appropriately. We noted that other people who were living at the home had a call bell assessment in place that detailed if they were able to use the call bell.

We observed one person who was sat in the lounge of The Halls attempt to get up off of a recliner chair twice during a 30 minute period, they were unable to get out of the chair themselves and during this time there were no staff available to support them.

Views from the staff were mixed over staffing levels, comments included; "Staffing is up and down, we are busy, shifts are generally covered" and "We are busy all day and I get so tired, we don't really get time to sit and talk with people". One staff member told us how things had got a lot busier since the occupancy of the home had increased on The Halls and there were more people to support at lunchtime. Another staff member commented, "It can be hard work sometimes but people are safe". Staff had communication radios that they carried around with them and we observed them using these to call for assistance when required. We saw minutes from a staff meeting in August 2015 where staff had expressed they thought the workload was 'heavy'. The registered manager had identified the day and night team needed to work more effectively together.

Staff were responsible for clearing dishes after each meal and taking them into the serving kitchen to clean them and load the dishwasher. Staff told us they had to complete this task for all of the people living at the home four times a day. One member of staff from each side of the home were responsible for completing this task which took them away from completing care tasks. Although staff told us if the call bell rang during this time they would respond to it, this meant staff were not always available to spend time with people engaging with them and monitoring the needs of people who were unable to call for assistance.

The registered manager told us they had increased the care staffing levels from six during the day to seven following our previous inspection where we raised concerns about staffing. They said that the nurse, care manager and themselves were also available to help out if needed. The

Is the service safe?

staff we spoke with confirmed this. We looked at the staff rotas and noted the home was running on six care staff for the majority of the time with some days where there were seven staff. We noted there were occasions where the staffing levels dropped to five when there was staff sickness. The registered manager told us that the occupancy levels were lower at these times and we saw records that confirmed this. However we noted the occupancy levels did not drop below 30 people.

We saw the provider had a tool in place that was used to determine the staffing levels within the home. The tool calculated staffing levels annually on the amount of people living at the home and their needs. The provider showed us their calculation of the average weekly care hours requirement. From this calculation we saw that they were exceeding their staffing level requirement according to the tool. However during our inspection we observed at times there were not sufficient numbers of staff deployed to respond to people's needs.

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

Following our inspection the registered manager told us they had spoken with the housekeeping staff to request them to help out with the dishes to relieve the care staff. They also told us they had another staff member they had recruited and were waiting for their pre employment checks to be carried out before they could start work.

Views from people were mixed regarding the staffing levels, one person said, "I don't think they have enough staff really, but everyone seems happy and clean". Other comments from people included, "The staff always come when you ring the bell, sometimes they go off quick though" and "The staff come fairly quickly". Relatives told us they thought there were enough staff to meet people's needs. One relative told us, "I have never felt there are not enough staff, sometimes they seem busier than others" and another said, "I think there are enough staff, there always seems to be someone about". During our inspection we observed staff were busy and people who were able to call for assistance had their call bells answered in a reasonable time.

People and their relatives said they or their family member felt safe at Winscombe Hall. One person told us, "I feel safe here, I have no worries". A relative commented, "They are very safe here" and another said, "Yes I am happy my relative is safe". Staff told us they were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. Staff described how they would recognise potential signs of abuse through people's body language, their mood and physical signs such as bruises. They told us this would be reported to one of the nurses or registered manager and they were confident it would be dealt with appropriately. One staff member said, "I would report it straight away and I am confident something would get done". Staff told us they had received safeguarding training, records demonstrated some staff needed a refresher in this subject. We saw from the training record that there were three care staff identified as not having safeguarding training certificates in their personnel files. The registered manager had plans in place to ensure all staff had up to date training.

Staff directly employed by Winscombe Hall were aware of the whistle blowing policy. They were aware of the option to take concerns to outside agencies such as CQC and the local authority if they felt they were not being dealt with. Staff told us they would take concerns further if they were not satisfied with the outcome from the registered manager. One of the staff members that was not directly employed by the service however was not able to tell us the outside agencies where they would report this if they were not satisfied with the outcome. They said they would report concerns to higher management. When asked about outside agencies, they were unable to tell us where the concerns would be reported outside of the organisation.We spoke with the registered manager who confirmed they would raise this with agency staff. We saw there were posters around the home providing phone numbers of outside agencies that could be contacted if staff had concerns.

We observed some areas of the home were in need of updating. For example, the home had an area called the 'serving kitchen'. We saw this area was used for preparing breakfast, drinks and snacks for people and staff, staff also did the washing up in this area. This room was separate to the main kitchen. The kitchen surfaces in this area were worn and chipped and there was a wooden area behind sink that was worn and looked black in areas where water had seeped into the wood. The walls had paint chipping off of them and had stains on them. This meant thorough

cleaning of these areas could not be effectively undertaken and people were at increased risk of being exposed to infection.There was only one dishwasher in place in the home for the 36 people who were living there.

One of the bathrooms was in need of updating because the bath had five scratch marks on it, the bath chair was rusted underneath, there was paint on the flooring and where something had been removed from the wall the screw holes were still present. The registered manager told us there were plans in place to address this.

There were two passenger lifts in the home. One of the lifts was out of use and had been since June 2015. This meant people living on The Halls side of the home had to go through to The Stables and use their lift to come downstairs. Staff told us people did not use this route without their support and the registered manager told us people were supported by staff to go downstairs using the the working passenger lift in wheelchairs. The registered manager told us they had been trying to source a lift shaft that would fit into the present lift dimensions and they had not been successful at sourcing this to date.

The registered manager told us there was a refurbishment plan in place for the home and the lift and serving kitchen were going to be replaced at some point in the future. We looked at the refurbishment plan and saw it covered areas such as decorating bedrooms, work to the roof of the building, installing new lights in the car park and refurbishment of the areas identified during our inspection. The plan was for 2015 and identified the work that had been completed. We saw a health and safety audit that identified the work required to the serving kitchen and lift. Following our inspection the registered manager told us the work on the serving kitchen would be started the following week. The provider told us following our inspection that they were considering options to replace the passenger lift such as a stair lift.

During our inspection we noted one bathroom had a tile missing from the ceiling and the tap on the sink was loose. We raised this with staff who reported it to the maintenance team and this was fixed during our inspection.

The home had a plan in place to evacuate the building in the event of an emergency this included an overview and brief details of people's needs. We saw there was information available for staff to evacuate people in the event of an emergency. Staff told us they received regular fire training and felt confident to evacuate in the event of an emergency.

A recruitment procedure was in place to ensure people were supported by staff with the experience and character required to meet the needs of people. We looked at four staff files to ensure checks had been carried out before staff worked with people. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant had any convictions that may prevent them working with vulnerable people. Staff told us these checks were completed prior to them starting work. Records confirmed the checks had been completed.

Requires improvement

Is the service effective?

Our findings

Some aspects of the service were not fully effective.

At our last inspection in November 2014 we identified that people did not always received effective care because the correct procedures were not always followed where people lacked capacity to make decisions for themselves. During this inspection we found the provider had taken some action to address our concerns. For example, best interest meetings had been held for one person who had moved from The Halls to The Stables and another person who was refusing personal care. However we identified there were still areas where the principles of The Mental Capacity Act 2005 were not being followed.

The Mental Capacity Act 2005 (MCA) provides the legal framework for making particular decisions on behalf of people who may lack the cacpacity 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found where people lacked capacity to make decisions for themselves the principles of the MCA were not always being followed. For example, care plans included a mental capacity assessment, we found these assessments did not relate to specific decisions that needed to be made and included statements that people generally 'lacked capacity'. One person's capacity assessment stated that they had capacity; however family members were signing consent forms for bed rails and for photographs to be taken. This meant relatives were making decisions for this person where they had capacity to do so themselves. Another person's care plan stated they were assessed as having capacity in April 2015, this had been reviewed monthly by staff and during September 2015 it was noted they 'lacked capacity'. There were no details or evidence of how the staff member came to this decision. Where people had bed rails in place and lacked capacity to agree to their use, we found a capacity assessment and best interest decision had not been completed. One person had a sensor mat in place to detect their movement whilst they were in their bedroom, the person did not have capacity to understand the sensor mat was in place or agree to its use and there was no best interest decision for this. This meant people were at risk of receiving care and treatment which was not in their best interests and breached their rights.

This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We spoke with the registered manager who told us they would review their processes for assessing people's capacity in line with the MCA. They said they had started this process and they were seeking advice from the local authority and using their forms to complete the process. Relatives told us they were involved in making best interest decisions for their family member.

At the time of the inspection there were no authorisations to restrict a person's liberty under DoLS. The manager had made five applications to the local authority and was waiting for the outcome of these. They were in the process of completing further applications where required and we saw they were liaising with the local authority regarding this.

At our previous inspection in November 2014 we identified that staff did not always receive appropriate training and supervision to meet people's needs. During this inspection we found that some improvements had been made. We looked at the staff training records and identified that some staff needed refresher training in some subjects.The manager showed us the dates that they had planned for future staff training and staff had been booked onto this.

Relatives told us they thought staff were trained to meet the needs of their family member. One relative told us, "Yes, staff have the right training". Staff felt they had enough training to keep people safe and meet their needs. Training included core skills training that the provider had identified such as moving and handling, safeguarding adults from abuse and fire safety. Staff also received training in caring for people living with dementia and end of life care, diet and nutrition. One staff member described the training they had received as, "Brilliant, it's explained in a way you

can understand", they went on to say if they needed additional training the manager would arrange this. Another staff member told us how they had found the dementia training "Useful" in relation to supporting people who were experiencing memory loss.

Staff said they received an induction when they joined the service and records we saw confirmed this. They said the induction included a period of shadowing experienced staff and looking through records. They also told us they completed their mandatory training during their induction and said it prepared them for working in the role. The registered manager told us they were in the process of linking their induction to the Care Certificate Standards. The Care Certificate Standards are standards set by Skills for Care to ensure staff have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. They told us they had attended training on the induction and they were in the process of setting up computer log in details for staff. They confirmed all care staff would be undertaking this training.

We observed lunchtime meals in both areas of the home and we observed one person being supported to eat their meal in their bedroom. Nine people living in The Stables required staff support with their meals, there were three staff supporting people at lunchtime in The Stables for both days of our inspection. On the first day of our inspection we observed one staff member supporting two people with their meals at the same time. During lunchtime on both days of our inspection most people waited for up to 30 minutes for their food and at least one person was sat in the dining room waiting for their meal for up to 45 minutes. Staff told us this was usual practice. We also noted staff refered to people who required assistance with their meals as 'feeds', which meant staff were not respecting people's dignity. On the second day of our inspection the registered manager had changed the timings of lunchtime to see if they could avoid people waiting for long periods for their lunch, however this was not effective in reducing the time people had to wait.

We observed staff supporting people with meals and telling them what the food was that they were eating and checking if people had finished what they were eating before being offered more. Staff sat with people on the same level and on the second day of our inspection we observed staff engaging in friendly conversations during the meal. We observed one person being supported to eat their meal in their bedroom. The staff member informed the person what the meal was and supported them in an unhurried and relaxed manner checking with them throughout the meal that they were happy with the food provided.

People and relatives told us they were happy with the food provided. One person told us, "The food is very good, you are well fed here". Another commented, "I think they are quite good really, they do the diabetic stuff all right for me every day and they give me a choice". One relative told us, "The food is very good, appetising, my family member has always eaten the food and never complained and I see staff encouraging food".

There were three hot meal options on the menu daily. The cook was on a day off on the day of our inspection and a staff member who worked as a carer and cook was covering this role. They told us if someone wanted something different on the day they would offer different choices. The staff member demonstrated knowledge of people's likes and dislikes and dietary needs and they had a list of these available in the kitchen. We observed people had jugs of drinks and snacks available. The cook had a list of people who had lost weight and the staff member who was covering for them told us people would be offered more calorific meals to support them to gain weight. Guidelines were in place to ensure people received a diet in line with their needs and staff were following these.

People saw a GP when required. A local GP visited the home routinely every two weeks or sooner if required and relatives told us they were kept up to date with any changes to their family member's health. One relative told us, "They always keep us up to date". Records confirmed nurse's monitored people's changing health needs and people were supported to see health professionals such as their GP and chiropodist.

The Stables had an adapted environment to meet the needs of people with dementia. The walls had been decorated with a variety of scenes to provide visual interest for people living with dementia. The Stables also had a 1950's room filled with items from this era. People had 'memory boards' outside of their bedrooms that included pictures from their past and details about their interests. The registered manager told us these were for staff to use to engage with people about their past lives and interests. During the two days of our inspection we observed the registered manager using a memory board to engage with

Requires improvement

Is the service effective?

a person on one occasion. The registered manager told us the boards were created by staff and people's relatives. They told us they regularly observed staff using the boards. During our inspection we did not observe staff using the boards to engage with people.

Requires improvement

Is the service caring?

Our findings

Some aspects of the service were not caring.

Our observations of staff interactions were mixed. Staff did not always support people in a way that promoted dignity and respect. For example, one person was moving into the home and we observed staff supporting them into the building. The person was in a wheelchair being supported by staff. We observed during this time their clothing had risen which exposed their underwear, the staff member did not act to cover them. On another occasion we observed a staff member pulling one person in a wheelchair backwards and the person was calling out for help and the staff member did not stop to reassure them. We observed several interactions where people were moved in wheelchairs without the staff member explaining what they were doing or seeking their consent. We also observed occasions when staff did not knock on people's bedroom doors before entering. We discussed this with the registered manager and provider who told us the staff members involved were not directly employed by the service. They were employed by an agency. Following the inspection the provider told us they would contact the agency to raise the concerns. The registered manager told us they were arranging for all staff to attend the dementia training course which involved practical training where staff were supported to empathise about what it may feel like to live with dementia.

Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains, covering people's body parts whilst supporting them and knocking on people's bedroom doors. Staff told us how people were encouraged to have private time with their family members in their bedroom and there was also a family room available for them to use if they wanted time alone with their relatives. Each person who lived at the home had a single occupancy room where they were able to see personal or professional visitors in private. Relatives told us they could visit at any time, there were no restrictions and they were made to feel welcome.We saw staff meeting minutes from May 2015 where the registered manager had discussed respecting people with the staff team.

People and relatives told us staff were friendly and caring. One person told us, "They are very good" and another said, "They make you feel comfortable and take an interest in you". Comments from relatives included, "The staff are lovely and friendly they all seem nice" and "They are pleasant, welcoming and kind". One relative told us how they had overheard two residents talking and one said to the other 'I couldn't be in a nicer place they look after me and nothing is too much trouble'. They told us they saw the second person agreeing with the first.

During our inspection we observed some caring interactions from staff towards people. For example, staff engaged in friendly converstation, one staff member commented on how 'lovely' a person's shoes were and staff gave people reassurance where they appeared to be anxious or confused. We observed staff supporting a person to transfer using a hoist, the staff checked the person was alright throughout the transfer reassuring them and telling them what was about to happen at each step. People appeared to be relaxed and comfortable around staff and staff talked positively about working at Winscombe Hall and the people living there.

People were supported by staff who knew them. Relatives thought staff knew their family member well. Comments included, "The staff know and understand them", they went on to say how staff had supported their family member to settle into the home. Staff were able to describe people's likes and dislikes and what was important to them. For example, one staff member told us how a person liked the radio and their audio story books, they went on to tell us how it was important for them to have a specific toy bear with them and how this made them happy.

Relatives told us they were involved in the assessment and planning of their care. One relative commented, "I am involved in the care plan and reviews, they sat us down and went through everything". The registered manager told us they held three to six monthly reviews and family members were invited to comment on their relatives care, they said they had an open door policy in between these dates. Records we saw confirmed reviews were being held with relatives.

We saw the compliments file which showed positive comments had been received by the home from relatives these included, 'We are over the moon with the care', 'Thank you for all the wonderful care' and 'Thank you for all the kindness shown'.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive.

At our last inspection in November 2014 we identified people were not protected from the risk of unsafe or inappropriate care because of a lack of accurate records and information. During this inspection we found further concerns relating to records.

We found that care plans did not always include accurate, clear and up to date information and information was not recorded in line with people's identified needs. For example, one person was assessed as being at high risk of malnutrition and their care plan stated they should be 'weighed weekly if any concerns and liaise with GP'. Records demonstrated between November 2015 and December 2015 they had lost 4.5 Kilograms of weight. Following this weight loss they had not been weighed weekly. Another person's weight was recorded on their weight record chart in November 2015. Their nutrition and hydration care plan was updated on the same day as the weight record was recorded in November 2015. However we found these weights differed by 2.1 kilogrammes. Which meant this person's records were not accurate. This person's records indicated that they had lost weight and the registered manager told us this had happened whilst they were in hospital.

Another person was noted to be at 'high risk of pressure sores' in their care plan. The person's care plan stated they should have 'regular change of position' during the day and night. Staff told us they should have their position changed every two hours. We looked at their daily recording sheet to observe how often they had been supported to change position. We found that in three days they had been supported to change their position once from being on their back to their left side. We discussed this with the registered manager who told us the person could reposition themselves and staff should check on them every four hours. This information was not clearly documented in the person's care plan.

One person had moved into the home six days before our inspection, whilst there were risk assessments, records of support given for two days and a pre assessment in place for the person there was no care plan in place relating to how they wanted their support. Staff told us when people moved into the home the information they needed to support the person was recorded and discussed in the handover and communication book. We looked at the handover record and it included basic information relating to the date they arrived, visitors, medical conditions, the location they were washed and the equipment they used to transfer. The communication record included basic information relating to their needs. We noted four days after they moved in it was recorded on the handover that they had been 'coughing with fluids'. The GP had visited the following day but there was no record of a discussion with the GP regarding the coughing. The communication book did not include this information for staff and there was no nutrition and hydration care plan in place. The registered manager told us they couldn't understand why the care plan had not been completed as these were usually in place within three days of the person moving in. They said they were not aware of the person coughing when drinking fluids. The registered manager clarified the nurses were responsible for writing the care plans. One of the nurse's told us when we asked why it had not been implemented, "I have been off for two days".

This meant people were at risk of receiving care that did not meet their needs because accurate, complete and contemporaneous were not kept in respect of these service users.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Following our inspection the registered manager told us the care plan was in place, they also said they had planned to spend a day with the nurses going through the care plans to ensure they were all up to date and included relevant information.

Relatives were involved in decision making relating to their family member and care plans review. Relatives also said they were kept informed of any changes to their family member commenting they were contacted straight away. We saw people had 'This is me' documents in place. This is a form designed by the Alzheimer's society to give information about the person's needs and what is important to them. The forms contained relevant information realting to people which meant staff were informed of what was important to people.

The home had an activities timetable in place and staff told us they were responsible for providing activities in the

Requires improvement

Is the service responsive?

afternoon and they did not have designated time for this, it was part of their care shift. One staff member said, "We don't manage to get anything done in the morning, we usually manage to do something in the afternoon". During the mornings we observed people sat in front of the television in The Halls and some of the people were having conversations between themselves. There was an activities room with crafts available for people to use of they wished. In the afternoon we observed staff supporting people in The Halls with a quiz, people appeared to be engaging with and enjoying this activity.

People and relatives told us they were happy with the activities on offer, one person said, "We have people in to sing songs where you sing along with them and they have quizzes and funny things like that once a week". One relative told us how they had attended a fireworks display arranged by the home. The home had developed links with the local community, the registered manager told us they arranged for the library service to come into the home and they had links with a local club that arranged outings for people to attend. They also told us they had a visiting vicar and the local Methodist church arranged to take people on outings.

Relatives said they would feel comfortable about making a complaint if they needed to. Relatives were aware of the complaints policy and were confident if they did raise any concerns they would be dealt with by the registered manager. One relative said, "I am aware of the complaints policy but have never had to complain, I would speak to the staff and I am confident they would respond instantly". There had been six complaints received by the service and these were responded to in line with the provider's complaints policy. The registered manager told us, "I encourage feedback and don't see complaints as negative as we can quite often turn it into a positive".

Resident's meetings were held to discuss items relating to the home and for people to give their feedback. We saw records of these meetings and they covered people giving feedback on staff, food, laundry, activities and the environment. We saw the lift being out of action had been discussed with people to give them an update on why it was taking time to replace it. Relatives held their own meetings and had a 'relatives group' to discuss concerns and share information relating to the service. The relatives we spoke with said they were aware of the meetings but were unable to attend them. We saw records of the meetings and they covered areas such as, the environment, staff and they offered a forum of support for relatives.

Surveys were undertaken to receive feedback on the service from relatives. The last survey had been completed in September 2015. Areas covered in the feedback were, staff, atmosphere of the home, satisfaction with staff keeping relatives up to date with their family member's needs, cleanliness of the home and activites. All of the feedback received stated they were 100% 'happy' apart from activities where 33% were 'happy' and 67% 'impartial'. In response to this the registered manager created a reply which stated they acknowledged the feedback and they had reviewed their activities and were looking at activity courses to motivate staff. They also recorded they had passed the positive feedback back to the team. Which meant they were responding to feedback.

Requires improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led.

At our last inspection in November 2014 we found the quality assurance system was not effective in highlighting areas of concern found during the inspection. During this inspection we found the audits were still not identifying the concerns we raised during this inspection. For example, medicines audits had been completed monthly and we looked at the audits for 2015. The audits did not cover the areas of concern that we identified during our inspection. The care plan audits did not identify that bed rail risk assessments were not in place and that the information relating to air mattresses was not present. The audits did not identify that the home was not following the principles of the Mental Capacity Act 2005.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Other audits we saw in place included, health and safety and an administration audit covering personnel files, accidents and recruitment. We found these audits identified where there were shortfalls and actions required to remedy these. Records showed all accidents and incidents which occurred in the home were recorded and analysed for trends. The registered manager notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

There was a registered manager who was a registered nurse and they told us they kept their skills and knowledge up to date by on-going training and research on the internet. The registered manager told us they were included on the rotas to undertake nursing duties for up to eighteen hours each week. We asked them if they felt they had enough time to complete their management tasks, they said this may have impacted on their ability to check things “Thoroughly”. They went on to say they had recruited a care manager in October 2015 which was working well, they also said they were looking at recruiting another floor manager which they said would help out. They told us following our inspection they would look at arranging time with the nurses and care manager time to complete the tasks required.

Staff told us the registered manager was approachable and accessible and they felt confident in raising concerns with them. The registered manager told us they had a commitment to promoting an open door policy where staff could approach them with concerns. They said they regularly walked the floor, spent observing staff and giving them feedback to support their development and promote best practice. One staff member told us, “The manager is assessable and supportive, they are here a lot” and another commented, “You can approach the manager, they are supportive and make time for you”. The registered manager had a system in place for staff to be nominated for employee of the month, they told us this involved staff and visitors voting for the staff member they thought deserved this nomination. The nominated staff member received a certificate and £40 gift voucher. We spoke with two staff who had received employee of the month and they both told us it made them feel appreciated and valued.

We looked at staff meeting records and they were held to address any issues and communicate messages to staff. Items discussed included, training, changes in paperwork, policies, discussion on how staff can support each other and reminders for staff to keep records up to date. One staff member told us, “You can definitely voice your concerns in staff meetings, that’s what they are for”.

The registered manager told us they felt supported by the organisation, they said they received supervision two monthly and had access to a senior management team for support. They told us they attended managers meetings twice yearly where they were able to discuss concerns and share ideas with other managers.

We spoke with the registered manager about their vision for the service and they told us this was, “To provide a really caring home from home where people can carry on and do things they did when they were at home”. They went on to tell us they had people living at the home who still attended groups that they were involved in when they were living at home such as pilates and a dinner club. They said they shared their vision through staff meetings. One relative told us they chose the home for their family member because they felt it was “A home from home”. Staff told us the vision for the service was, “To provide good care to people and be there for them”.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where restrictions were in place effective processes were not in place to support people to make best interest decisions in accordance with the Mental Capacity Act 2005. Regulation 11 (3).

The enforcement action we took:
We have issued a warning notice to the provider. They must become compliant by 07 June 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not always administered safely. Regulation 12 (2) (g). The service was failing to monitor and mitigate the risks relating to the health, safety and welfare of services users. Regulation 12 (2) (a).

The enforcement action we took:
We have issued a warning notice to the provider. They must become compliant by 14 July 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Accurate, complete and contemporaneous records were not kept in respect of each service user. Regulation 17 (2) (c).

The enforcement action we took:
We have issued a warning notice to the provider. They must become compliant by 14 July 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Sufficient numbers of staff were not deployed to respond to the needs of people. Regulation 18 (1).

The enforcement action we took:
We have issued a warning notice to the provider. They must become compliant by 14 July 2016.