Care Quality Commission

Elderet Limited

Woodbine Manor Care Home

Inspection report

25 Upper Bognor Road
Bognor Regis
West Sussex, PO21 1JA
Tel: 01243 841136
Website: www.woodbinemanor.co.uk

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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

The inspection took place on 5 and 6 October 2015 and was unannounced. Woodbine Manor Care Home is registered to provide accommodation and care for up to 29 older people who live with dementia. It is situated in a residential area of Bognor Regis, West Sussex. At the time of this inspection, there were 27 people living at the home. The home is purpose built and accommodation is provided over two floors in single occupancy rooms. A passenger lift provides access between the floors. There is one communal lounge and dining room.

During our inspection the registered manager was present. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the last inspection on 16 and 17 October 2014, we asked the provider to take action to improve as a result of breaches of regulations relating to quality and safety including notifying CQC of incidents, safe staffing levels, consent to care and treatment, respecting and involving people in their care and treatment, cleanliness and

Summary of findings

infection prevention and monitoring the quality of the service. At this inspection we found that some improvements had been made, however we found that other requirements were not met and new concerns were identified.

People's safety was compromised in many areas. Risks to people's health, safety and well-being had not been mitigated and staff had not followed risk management strategies set out in people's care plans. People were at high risk of receiving unsafe care. Some staff had not received recent vulnerable adults safeguarding training and lacked insight into what might constitute institutional abuse and neglect by omission of care. Whilst staff were safely recruited there were not enough staff to meet people's needs. The majority of staff had not completed training in many key areas. Staff did not have updated knowledge to ensure they carried out their role effectively. The staff felt that staffing was an issue and that the provider was aware of this. Some staff had received an appraisal of their work performance and most had received regular support and supervision. However this had not always been effective in identifying inconsistencies in staff knowledge and practice.

People were not given appropriate support at mealtimes and staff focussed on tasks rather than interacting with people they were supporting. There were unsafe practices at meal times and throughout the inspection, with variations in food consistencies given with little information about the risks and rationale for this. Therefore people may have been at risk of choking or receiving food in a way which did not meet their needs or preferences. People told us they felt rushed.

Staff were not consistently responsive to meet people's healthcare needs.

The majority of the staff had completed training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Applications had been made to the local authority for DoLS and some assessments had been carried out of people's mental capacity. Some information in people's care plans was out of date and not reflected in the applications made to local authorities for DoLS. We identified one person whose rights may not have been protected because the registered manager had not assessed their capacity to consent to receiving care in bed and had not considered whether they had their liberty deprived unlawfully.

Some staff practices showed a lack of respect for people and did not promote their privacy and dignity. We had to intervene on several occasions to ensure people received safe and appropriate care. There were few opportunities to engage in activities and people were seen sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place. Whilst people had an individual care plan, there was no evidence people or their families had been involved in reviews of their care. Care plans had not always been updated in line with people's changing needs and staff did not follow the plans when delivering care. People were at risk of harm because the service failed to respond promptly and appropriately to their care needs.

The management of the service was inconsistent and lacked continuity. There were no effective systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

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

The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there

Summary of findings

is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Within four working days of our visit at the service the registered manager handed in their notice with immediate effect and is now no longer working at the service. The home was being managed by the deputy manager and supported by another service manager with the oversight of the provider.

The significant concerns we identified at this inspection have been shared with the local authority safeguarding team and commissioning to alert them to the risks to people using the service.

During this inspection we found the provider was in breach of several regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014, some of which were continued concerns from our previous inspection. You can see what action we have asked 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?
The service was not safe.

The provider did not have measures in place to promote the safety and well-being of the people living in the home.

When risks to people had been identified, guidance to reduce the risks had not been followed.

People were at increased risk of choking and injury due to poor practices by staff.

People were at risk of not receiving the care and support they needed as staffing levels were insufficient.

Inadequate

Is the service effective?
The service was not effective.

People were not provided with appropriate care and support to ensure their nutritional and hydration needs were met.

Systems were not in place to ensure there was an appropriate response to people's changing healthcare needs. There were delays in people receiving professional advice and treatment.

Staff had not received suitable training to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

Inadequate

Is the service caring?
The service was not caring.

People were not always supported and cared for in a dignified and respectful way. Staff focused on carrying out tasks and there was little social interaction between them and people living in the home.

Care records did not show how people and/or their relatives were involved in planning their care and support needs.

Inadequate

Is the service responsive?
The service was not responsive.

People were not receiving a person centred service. The delivery of care did not meet their needs and reflect their preferences.

People were left unattended in the lounge or in their bedroom for long periods of time without any meaningful or stimulating activity.

There was no effective system in place for recording or monitoring complaints.

Inadequate

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

Inadequate

Summary of findings

There were no effective systems or processes in the home to ensure the service provided was safe and of good quality.

Records did not evidence people's care needs were met.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded. The leadership in place had not ensured systems and communication involved people in how the service was delivered.

People and their relatives felt able to approach the registered manager and there was open communication within the staff team.

Woodbine Manor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 05 and 06 October 2015 and was carried out by three inspectors and an expert by experience in services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

Before the inspection we sought information from representatives of the local authority. We also reviewed the information we held about the service, including notifications. A statutory notification is information about important events which the provider is required to send to us by law. During the inspection, we spoke with 10 people living in the home, six relatives, one visiting healthcare professional, eight care staff, the deputy manager and registered manager.

We spent time looking at records including five care records, six staff recruitment files, staff training records, staff rotas, staff supervision records, staff meetings, residents' meetings, quality audits and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

A person said the staff were very kind but there was not enough staff on duty, stating there were times their call bell was not answered for over 30 minutes.

Relatives and a visitor had mixed views on the care provided. One relative told us,"she is happier here, they understand her. It's a good place" and another person commented, "I think the staff are very nice here". A relative said that, even though they visited at irregular times, they felt there was always plenty of staff. A visitor said "I would like to live here when I need a home". Other relatives said there was not enough staff to help support their relatives, that when they visited they supported their relative as there, "Wasn't enough staff to help, wasn't enough clothing in [named relative] drawers. There are two pairs of trousers in their drawer and one of those are not theirs". Another relative said when they visited the staff do not know where their relative was. This occurred on the day of our visit, a staff member told the relative that the person was in the dining room but they were, in fact, upstairs.

We looked at how risks were managed. We found individual risks had been assessed and recorded in people's care plans. Examples of risk assessments relating to personal care included moving and handling, nutrition and hydration, falls and catheter information. However, we found gaps within care records with poor or missing information to safely manage risks. Risk management strategies did not correspond with care delivery. During lunchtime on the first day we observed two people were given food to eat whilst lying flat in bed. We were concerned about the potential risk of choking for both people. There was no care record or guidelines in place informing staff how to safely support people with meals in bed.

Staff told us there was sufficient and appropriate equipment for use in the home. However, we saw that on one occasion staff used an inappropriate technique to transfer a person from a chair to wheelchair. This placed the person and the staff at risk of injury. On another occasion we observed a person sliding out of their chair with no staff support to reposition safely. Some people had been assessed as requiring monitoring by staff, to ensure they were safe at all times. We observed this was not happening for people assessed as at risk of "wandering". This meant their safety was at risk and they were able to access peoples bedrooms without redirection and support.

At inspection, we observed doors that were labelled as needing to be kept closed were left open. One door was to the medication room, another to the boiler room, where a hot iron was left out, a further door at the top of the stairs and one door to the kitchen. These doors were also delegated as fire doors. They were propped open despite an inspector bringing this to the registered manager's attention. This posed a risk to people who may walk into these rooms and have limited capacity to understand the risk to their safety. **The above evidence demonstrates that the provider had not mitigated risks and had failed to provide people with safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. People's individual care and support needs were reviewed when incidents occurred to help keep them safe. For example, when people experienced falls that resulted in injuries, the registered manager reviewed the individual accident records and made changes to the care that people received. This included putting sensor mats next to people's beds at night in order to alert staff if someone fell and could not call for assistance.

At the last inspection on 16 and 17 October 2014, we found the provider had raised safeguarding alerts with the local authority when abuse was suspected. The service had taken steps to ensure people were safe. However, the registered manager had not notified the Commission when safeguarding issues had arisen at the home in line with their registration requirements and therefore we could not monitor that all appropriate action had been taken to safeguard people from harm. We identified this as a breach of regulation. Following the inspection the provider sent us an action plan which set out the action they were going to take in order to meet the regulation.

Inadequate

Is the service safe?

At this inspection, the necessary improvements had been made. Since the last inspection the provider has notified the Commission of any safeguarding issues. However at this inspection we identified concerns with the way safeguarding concerns were handled.

We looked at how the service protected people from abuse and the risk of abuse. Before the inspection we received detailed information from the home and local safeguarding authority. The information received highlighted a number of concerns about the safety of people using the

service. We discussed safeguarding procedures with staff during the inspection. Safeguarding procedures are designed to direct staff on the action they should take in the event of any allegation or suspicion of abuse. Staff said they understood their role in safeguarding people from harm and could describe the different forms of potential abuse. According to the staff training records many of the staff had not completed safeguarding training. This meant we were not confident all staff would know how to respond if they encountered any concerns

Our observations found staff lacked insight into what constituted abuse and, in particular, there appeared to be a lack of understanding of institutional abuse, neglect by omission of care and self-neglect. A number of safeguarding issues we identified during our visit had not been recognised or reported by staff. We observed a person appearing confused, walking across their bedroom in a state of undress. An inspector stayed with them while another inspector looked for care staff. The registered manager told us that the person usually slept in the afternoon and woke up at the same time each day feeling confused, so staff should have been checking for this. This had not taken place and their needs not met. There were two people who had been identified as at high risk of social isolation but there was no radio, TV or other stimulation in their room and despite us bringing this to the attention of the registered manager several times, no action was taken to remedy the situation. We noted a person's care plan and risk assessment clearly documented that the person was in need of stimulation and that tactile objects and music should be used. However there was no evidence in daily records that provision had been made for this. The person's bed faced into the room away from the window and photographs that were important to them were not within sight. We asked the registered manager about moving the bed so that the person could see out of the window but the registered manager said this was not possible in that room as the bed would not fit. There was a person who had received care in bed for a long period of time and despite deterioration in their mobility and health, appropriate advice had not been sought by health and social care professionals to ensure they were meeting this need. In addition, where staff had identified that staffing levels had compromised the care people received, this had not be reported as potential neglect of people's needs. The registered manager and staff had not identified where risk of institutional neglect or self neglect may have taken place and had not taken action to protect people from this. **The above evidence demonstrates that the provider had failed to ensure people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Woodbine Manor's website states, "attentive and compassionate carers are available twenty four hours a day. The high staff- resident ratio enables us to provide companionship and stimulation, as well as tending to your physical needs." The service did not provide this consistently.

At the last inspection on 16 and 17 October 2014, we found the provider had completed individual dependency assessments for people who lived at the home. However, the registered manager confirmed that an overall assessment was not completed when deciding safe staffing levels that considered other aspects such as the layout of the home and ancillary staff. We identified this as a breach of regulation. At this inspection we noted the necessary improvements had not been made and the service remained in breach of this regulation.

We looked at staffing levels on the first day of our visit. Members of staff told us the home was understaffed and one member of staff said "We are trying our best." Another member of staff commented, "We are constantly short staffed." The registered manager had held team meetings and these identified that, in some instances, people's care was compromised by staffing levels. For example "residents go two weeks without a bath or shower". Another comment stated that, "showers are overlooked due to staff shortages" and another recorded comments that night staff were, "Coming in at 5pm and working a 15 hour shift to help them through".

Inadequate

Is the service safe?

The staff rota showed there were four care staff on in the mornings, three care staff on in the afternoon and early evenings and two night staff overnight. The registered manager told us this was the usual level of care staff. The Registered Manager said that there was no dependency assessment tool used to determine how many staff should be on duty to meet peoples identified needs. The number of staff on duty left individuals with mobility needs, dementia needs, individuals at risk of falls vulnerable. There was not enough staff to support around meal time which left people waiting for the their food for over 20 minutes. There were more than four people who required two staff to support with hoisting and transfers. There were more than three people who required one to one staff support for eating meals. With the current staffing numbers, this would leave staff struggling to attend to people in a timely way. This left many people waiting for long periods of time with no support.

The rota demonstrated that some staff were going off sick or absent and this was not being evidenced as being followed up to ensure they would be arriving for their next planned duty. The registered manager stated that they had recruited a senior to work at weekends but they had left in July 2015. The registered manager had not made attempts to replace this role meaning they were short staffed. During our visit the manager placed an advert to increase staffing after discussion with the inspector.

This affected the quality of care in the home. A relative voiced concerns about the level of staffing and told us, "I don't think there's enough staff on." Throughout the inspection we noted people were left in the lounge areas unattended for long periods of time. People with needs related to dementia and mobility were unable to get the support they required. We observed a person drop their drink on the floor in front of them, in attempting to pick this up there was a risk of falling and no staff to respond to this. Other people appeared confused and distressed and there were no staff available to provide reassurance or support. At one point we observed a 25 minute period where there was only one member of care staff supporting 18 people with their food and drink which was not effective in ensuring people received the support they needed in a timely way.

Staff could not monitor people living in the home effectively and they were over stretched with the work load. There were delays in assisting people with meals and the delivery of personal care. There was no interaction between staff and people living in the home other than during the delivery of care as staff did not have time to spend with people. We observed two people who did not have access to their call bells and had not been checked on to ensure they were comfortable. We discussed our concerns about the lack of staff with the managers at the end of the first day. They agreed with our concerns and made arrangements for more members of staff to be placed on duty urgently. In addition the skills mix of staff were not suitable to meet the needs of people living at the home. A large number of the team had not received training in essential topics such as falls prevention, diabetes and catheter awareness to meet people's needs. The dementia training provided was a short course, not adequate enough for the staff to understand how to support the large number of individuals living with dementia. This was evident in the way people were supported and spoken to during our visit. **The above evidence demonstrates that the provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.** This was a continued breach as we identified concerns about staffing numbers at our October 2014 inspection.

From the second afternoon of our inspection, the overall level of risk to people's safety and well-being was mitigated by the use of additional staff which the registered manager had organised. The provider agreed to keep the additional staff in place until people's needs had been reassessed.

People's medicines were managed safely. A member of staff was able to explain the provider's medicines policy for reporting medication errors and records showed that staff had received training in how to manage medicines appropriately. Medicines were stored safely in a locked cabinet. There were suitable arrangements for medicines which required chilled storage in order to remain effective and records showed that medicines were stored at the appropriate temperatures. Controlled drugs were safely managed with all medicines accounted for and signed out by two members of staff. The deputy manager conducted monthly audits to check that people had received their medicines as prescribed. When audits identified that staff had, on occasion, failed to sign that they had administered medication, the registered manager had taken action to

Inadequate

Is the service safe?

address this with the staff concerned. A member of staff showed us how they would conduct an audit of one person's medicines and was able to demonstrate that the actual quantities held matched the provider's records. Therefore the person had received their medicines in line with their care plans.

Recruitment records showed that new staff had the appropriate checks undertaken before they began employment. This included references, DBS checks and proof of identity. This ensured as far as possible that only suitable staff worked in the home.

Appropriate checks were completed to ensure equipment was safe to support people who lived at the home. Checks had been undertaken on lift servicing, electrical portable appliance testing (PAT) and hoists.

At the last inspection in October 2014, systems were not in place to reduce the risk of infection. We identified this a breach of Regulations. At this inspection we noted the necessary improvements had been made to reduce the risk of infection spreading with the use of personal protective equipment, hand washing facilities and cleaning products being made available. The home was clean and maintained to ensure people were cared for in a hygienic environment. The registered manager said they were the infection control lead. A recent audit was carried out by West Sussex County Council on 27 August 2015 which highlighted areas that required attention and made recommendations on best practice. The registered manager told us that the report had taken time to arrive and they were working through the recommendations.

Inadequate

Is the service effective?

Our findings

People had mixed views on the food provided. For instance one person told us the meals were "not so good" and felt there was not much choice and variety offered. Another person said "I did not enjoy it. I ate it for something to do". The person was quite tearful, clearly upset. They then said, "You do it because they want you to". We observed this person and their lunch time experience in the dining room. However, another person commented "The food is very nice."

Woodbine Manor's website states, they are "well known for its superb hearty and wholesome home cooked meals. Our two cooks' marvellous culinary skills translate into an extensive, nutritious menu providing variety and choices every day. You may request meals that are not on the menu according to your diet and tastes and we love to see our residents enjoying their meals. Snacks and drinks are served twenty four hours a day. Meals are served in our elegant restaurant style dining areas and are always appetising and well presented. You may dine in your own room if you wish and can expect your meal to be hot, tasty and beautifully served. Assistance is always on hand at mealtimes for those who require it." We did not see evidence of this during our visit.

We requested menu samples and were not given any during our visit. The cook had called in sick on our first day and the second cook was also unavailable. The registered manager had arranged cover but informed us it was not the usual cook. We were also informed there were no choices for that day for lunch, the main meal being prepared was cottage pie, cauliflower cabbage and tinned tomato. We were informed if anyone declined this offer then a baked potato would be cooked. According to one person's care record, they did not like cabbage. However, we observed this was served to them in a pureed form as part of their meal. Some people's food was presented appropriately and portion sizes were adequate. However, some people were served mashed food, which had been blended together and brought to the dining room in bowls. This was not an appetising form and didn't help people to understand what they were eating. Much of this went to waste as people did not eat it. The food had been served too hot and those people living with advanced dementia struggled with this. As the food took time to cool down and reach an appropriate temperature, people started to leave the table and appeared to be confused. Therefore people were not enabled to eat sufficient amounts of food that met their preferences and needs.

We saw no evidence of swallowing guidelines on people's care plans indicating the consistency of the food recommended, amount of thickening agent to be put in liquids and the type of drinking cup best suited to the person. The kitchen staff were advised about special diets when people were admitted into the home. However, we saw one person in their room eating lumps of food and it was not clear whether this placed them at risk of choking. According to the person's records they were unable to be weighed due to being cared for in bed and the registered manager had not made a referral for dietician advice or occupational therapist for assessment or advice.

People who needed weighing monthly were not always weighed to accurately monitor any unintended weight loss. There was no evidence the registered manager had contacted external healthcare professionals for advice on people's nutritional needs or on the consistency of food for people with dysphagia or who were at risk of choking. It was not clear from people's risk assessments and records whether people were at risk and why food consistencies had been altered. We observed some people's drinks were out of reach. For instance a hot drink was placed out of reach of one person sitting in the lounge.They were finally assisted ten minutes later by a member of staff, by which time the drink was cold. A person asked if they could have a drink but it was over an hour before we observed them receiving support to drink. At the same time as people were offered drinks, staff were confirming the next day's dietary requirements. People were asked what they wanted for supper the following night, ham and mustard sandwiches or fish fingers and spaghetti. The lunch option was hotpot and there were no alternative choices on the main meal of the day. This also demonstrated poor understanding of people living with dementia being supported as people may not have been able to remember the food choices they had made a day in advance.

People living with dementia were not supported to make choices as there were no pictorial aids used. People appeared to not understand the choices available and staff questions to people about food and drink preferences were confusing. There was little or no interaction between the

staff and people living in the home during the meal time to support people to eat sufficient amounts. For example we saw one member of staff assisting one person to eat and did not speak to them during this task.

At lunchtime we observed one person had to wait longer than other people for lunch and had to sit watching others eat. They shouted out "help please" three times, but were ignored. They were given no explanation for their wait. One person told us they felt rushed at mealtimes we noted that one person was sat in a chair and they were given a bowl of pureed food then left without support for 25 minutes. A staff member was observed asking if they had finished, the person did not respond and the bowl was taken away without consent or alternatives offered. This did not ensure the person was supported to eat and drink sufficiently. **The above evidence shows that the provider had failed to ensure the nutritional and hydration needs of people were met. This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

During the inspection we found serious concerns regarding the management of people's health care needs, the timeliness of seeking professional advice and the poor arrangements for ensuring staff were following any professional advice and direction provided. The registered manager had not made GP referrals in a timely way. We noted from looking at one person's records, their healthcare condition had deteriorated, however, there was no evidence staff had made an appropriate referral to a GP. We alerted the registered manager who still did not contact the GP for assistance after we prompted her to do so.

One person had been cared for in bed for a significant time period and the registered manager was unable to explain the rationale for needing to care for them in bed with no medical review, or why they had chosen to change the person from solid food to pureed. There were risk assessments in place for two people who were at risk from isolation yet there was no evidence they received adequate time with staff for stimulation. Staff had received advice from visiting healthcare professionals, however, there were often delays in implementing advice or it was not carried out at all. For instance, a visiting district nurse instructed staff to maintain a turning chart for tracking a person who had pressure sores. However, there was no record that this had been done on the day of our visit for a six hour period. When we checked the records later in the day, they had been completed retrospectively for the whole day. This was brought to the registered manager's attention and they agreed they could not evidence they were appropriately turning the person at the agreed times set by the district nurse.

Staff told us about a person who had sensory impairments who had been assessed as needing hearing aids. However, the hearing aids had developed a fault in 2013, but no referrals had been made to their GP or an audiologist to address this. This placed the person at further risk of isolation and withdrawal as they were not supported with their hearing needs.**The above evidence shows that the provider had failed to provide care and treatment which was appropriate and met people's needs. This was a breach of Regulation 9 of the Health and Social Care (Regulated Activities) Regulations 2014.**

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

At the last inspection on 16 and 17 October 2014, it was identified that capacity assessments had not been completed for people before applications were made to deprive someone of their liberty. This was identified as a breach of Regulations. Although some action had been taken to ensure capacity assessments were appropriately completed, we found this was not the case for one person. Therefore this requirement was not met.

We saw a record had been made following an assessment of some people's mental capacity, which included the four stage functional test. We also noted the assessments were supported by a mental capacity care plan and records of restrictive practice. The latter considered the least restrictive care and support options. Where appropriate, this had been followed by applications to the local authority for authorisation of a DoLS and records confirmed this. Where the person was assessed to have a lack of capacity decisions had been recorded in their best interest. However, we noted one person had been cared for in bed for a significant period of time, without any medical review since that time. The registered manager had not

Inadequate

Is the service effective?

completed a capacity assessment for this and although they had consulted the family, no best interest meeting had taken place. The person may have been deprived of their liberty or care provided without lawful consent as the registered manager had not assessed their ability to consent to care and treatment and ensure decisions were made in their best interest to protect their rights.**The above evidence shows that the provider had failed to ensure they had the consent for care and treatment provided. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014**

Staff received an induction and were participating in training to gain the Care Certificate when they first started work at the home. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work. Staff confirmed they received supervision and yearly appraisals. All staff said they had received and read the policies and procedures to ensure they fully understood what was expected of them. Documents confirmed staff had completed mandatory training such as fire awareness and evacuation, food hygiene, infection control, health and safety. The majority of staff had completed mental capacity assessment training. However, there was no evidence that specific training needs were being addressed to reflect some of the conditions experienced by people that staff were expected to manage. This included areas such as catheter care, dementia awareness, diabetes, pressure care, falls prevention and deprivation of liberty (DoLS). This was evident in our observation of staff who did not understand how to support people living with dementia, people with changing mental capacity and people at risk of specific health conditions. Persons employed by the service had not received appropriate training and support necessary to carry out their duties effectively and meet people's needs. **This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Inadequate

Is the service caring?

Our findings

We asked people if the staff were caring. Most people responded positively. One person said, “They do the best they can here.” Another stated “They answer when we talk to them.” People told us they were generally satisfied with the service. One relative told us, “she is happier here, they understand her. It’s a good place” and another person commented, “I think the staff are very nice here”.

A relative said “Staff are very good because they become your friends. You hear such bad things about care homes, I know they will not mistreat [relative].”

Woodbine Manors website states, they “aim to provide an exceptionally high level of care and to ensure that you will be treated with utmost respect, your privacy protected and your dignity preserved.”

At the last inspection in October 2014 we identified that some staff did not show consideration or respect when they spoke to people. Staff had a brisk and directive approach when speaking to people and did not demonstrate warmth and respect. We identified this as a breach of Regulations. At this inspection we found that concerns remained with the way staff spoke with people and had additional concerns about how people’s privacy and dignity were not maintained.

During the two days we spent in the home we saw some instances where staff demonstrated a caring approach to people. For instance we observed a staff member talking to people in the lounge asking if they were warm enough, if they wanted particular music on and if they were comfortable. The staff member was kind and gentle when communicating with people. However this approach was not consistent throughout our observations. We found examples where staff did not treat people with dignity and respect and had not upheld their privacy.

One person told us they felt their privacy was compromised because staff did not knock on their bedroom door before entering. Several instances during our visit we had to ask staff to adjust people’s clothing to ensure they were appropriately covered. Whilst staff responded quickly to our requests, they had not be addressed without our intervention. We observed staff interactions on both floors throughout the inspection and there was very little social interaction, staff routinely walked past people and carried out tasks without speaking to them. On one occasion we observed staff discuss the person’s needs whilst standing over them, without asking the person for their views and wishes. We heard a staff member in the dining room say in a stern and uncaring tone, “sit down and get your knees under the table".

During a meal, one person was told by staff, "blow on it, it’s hot" to cool their food. The person, who did not understand the direction given to them, proceeded to blow, but not on their food. Staff were then observed to be laughing at the person and mocking them. There were 17 other people in the dining room at the time and this would have been humiliating. During the two days of the inspection we witnessed the same person being spoken to and treated in this way on numerous occasions.

We observed a member of staff assisting someone to eat in bed. The member of staff did not interact with them verbally throughout and the person could only communicate their desire for more food by sticking their tongue out. Before beginning to assist with the meal the staff member did not reposition the person to ensure they were in a safe and comfortable position to eat. At times the person struggled to swallow the food but there was no assistance given to improve their ability to eat and swallow.

Another person was lying in bed with their bedroom door open. The person had been incontinent and needed their continence pad changed. This person was cared for in bed and in need of pad changes at certain times However, there was no evidence the person had requested or been consulted with on whether they would like their door open or closed. Their door remained open on both days of the inspection which was for the convenience of staff rather than in line with the person’s wishes.

We found another person sat in their bedroom with the door open. They were dressed from the waist up, however they was clutching a blanket that was covering their lower half. The person was confused and could not call for assistance and the call bell was not close by. An inspector stayed with the person while another inspector fetched a member of staff. The staff entered the room and barely interacted with the person, nor did they ask the inspector to leave before removing the blanket and beginning to assist with personal care. The door was left open. The inspector had to intervene and prompt the staff member to close the door.

Inadequate

Is the service caring?

We observed another member of staff using a person's bedroom to complete the ironing for the service. The person was unable to access their bedroom and even if they could, there was nowhere to sit as the chair and bed were covered in laundry. The staff member told us that they had asked the person if they could use their room and that they had confirmed they could. We spoke with the person and asked them about their room being used, their response was that they did not know and they were lost. The inspectors informed the registered manager at the time who immediately said that the person concerned lacked mental capacity to make that decision and that the staff member did not obtain proper permission. They had not respected this person's personal space or considered whether they could even consent to this intrusion of privacy.

Where people were at risk of being socially isolated because they received care in their rooms, there was little interaction or support observed to reduce this risk and treat them with dignity. People were not able to use their call bells and we observed them in their rooms for long periods without staff offering support or reassurance. **The above evidence shows that the provider had failed to ensure people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.** This was a continuing breach of regulation identified from the last inspection in October 2014.

Records reflected that the registered manager had discussed their people's support needs, including their choices and preferences with relatives, at the time of the pre-admission assessment with relatives but this collaboration had not continued following people's admission to the home. The records did not evidence that families or people using the service had been involved in the care planning process since their family member moved into the home. None of the people we spoke to were aware of their care plan. This meant staff may not have been aware of people's wishes and aspirations. Two people's care plans placed emphasis on the importance of social interaction and stimulation. During both days of our visit there was no evidence these identified needs were being met. There was no evidence that people or their representatives were enabled to make their care choices known and where preferences were identified these weren't consistently carried out in line with this.

The provider had not ensured that care was carried out or assessed collaboratively with the relevant person and had not planned people's care to ensure their preferences and choices were considered. **This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Inadequate

Is the service responsive?

Our findings

Each person had an individual care plan. The initial care plan was produced by the registered manager following a pre admission assessment. All care plans we reviewed contained a pre admission assessment, which covered an assessment of people's needs and notes on their preferences for food, preferred routines, personal hygiene and appropriate forms of communication. The care plans were kept in locked cupboards on the ground floor. Members of staff told us they were encouraged to read the care plans and were given information about people's care needs at handover meetings.

The care plans were written in a person centred way. The plans were divided into sections according to people's area of need and included risk assessments. They also provided details about how the person could best be supported and what was important to them. People's care files contained life histories, but these were frequently incomplete. This information is important for staff in order to understand people's backgrounds and facilitate meaningful conversation. Whilst there were records to demonstrate the care plans had been reviewed, there was no evidence people or their relative had been involved in the review process. People were not routinely involved in the compilation or review process of their care.

One person's care plan contained out of date and inaccurate information about their physical condition. We asked for further clarification about this issue and were given conflicting information by staff. This meant staff were not fully aware of the person's condition. One person's care plan stated they needed to change position every two hours, but their care notes indicated a lack of recordings to demonstrate this had been done. A member of staff told us people were allocated a keyworker. This practice links people using the service to a named staff member who has responsibilities for overseeing aspects of their care and support. However, they added that the keyworker allocations changed. This meant people's care was not being overseen and monitored by a specific member of staff to ensure consistency.

We observed staff often failed to respond to people's needs in the way identified in their care plan. This included assistance with eating and drinking, pressure relief and personal care. For example some people were given different consistencies of food without any information about why this was needed and when. We reviewed the bath /shower records and noted the records conflicted with handover information. There was no evidence of who was having baths / showers and how often. We brought this to the registered manager's attention at the time and they agreed that the system in place did not work. More often than not the information recorded was also not dated. This meant people's personal hygiene was not being evidenced as being met.

Care records were neglected or in some cases completed in a way that would not inform or influence care delivery. For example, a two hour turning chart for a person receiving care in bed was not completed within a six hour period. Therefore it was difficult to determine whether this care had been given or not. Social interaction charts had a recording of "yawning". This was not evidence of social interaction. Records completed were not descriptive and could not evidence if a person was receiving the appropriate social interaction stipulated in their care plan. Weight charts were inconsistent and not regularly updated or completed, for example only five weights were recorded on in September for the weight records sampled of each person.

Two people's social and emotional wellbeing care plans stated they were at risk of social isolation and should be included in activities, given 1:1 support using tactile objects and included in conversation about their known interests. However, we observed these people were left alone in their room for many hours during our inspection. We checked the activities log and found that staff had recorded "Had a chat", but the information was brief and could not evidence that any meaningful interaction had taken place. Therefore it could not be assured that this need was being met consistently and in line with their care plan.

There appeared to be an 'ad hoc' approach to planning and carrying out activities,. No evidence was available to show that people or their families were asked how they wanted to spend their time and no future calendar of events to inform residents of what was coming up. The board on display had no activities advertised for the week.

There was another board with external entertainers visiting but these were not accessible to people or in a format understandable to them. During our inspection, we observed staff chatting to people and one staff member played Connect-4 with one person. However, for the majority of time, people were sitting in the lounges or their

Inadequate

Is the service responsive?

bedroom with no meaningful activity or positive interaction taking place. This placed people at further risk of social isolation, withdrawal and low mood, particularly for people living with dementia where social stimulation is essential to living well with the condition. **The above evidence shows that the provider had failed to ensure people received person centred care which met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.**

We looked at how the provider managed complaints. There was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. The home did not have a system of recording complaints. Complaints were logged but there was no evidence that they were handled within a reasonable timeframe or that the complaint was resolved to the satisfaction of the complainant. There was a complaint made about the registered manager and the provider allowed the registered manager to investigate this. This was not appropriate practice and not in line with the policy and procedures implemented in the service. This would not have ensured a thorough, unbiased and objective investigation was completed. **The provider had failed to ensure they had an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.**

Inadequate

Is the service well-led?

Our findings

People told us they found the management and staff at the home to be approachable and helpful. One person told us, "[Registered Manager] is always available and approachable, she's a very good listener, and she runs the home well."

However, we found the staff lacked effective leadership and management support and their morale was low. Our findings from this inspection demonstrated that the registered manager and provider had failed to provide good quality and safe care to people and had not acted upon known risks and shortfalls. Where breaches of Regulations had been identified at the previous inspection in October 2014, not all had been met and further concerns were identified at this inspection.

The culture of the home was largely task focussed, was not person centred and did not empower people to live fulfilled lives. The home had policies and procedures in place to offer the framework for how staff should conduct themselves but it was not followed through or embedded in their practice. On the provider's website, their philosophy of care is outlined as providing an 'exceptionally high level of care and to ensure that you will be treated with utmost respect, your privacy protected and your dignity preserved. Our goal is to support individuality and independence and to encourage you to exercise choice in all aspects of your care.' Throughout our visit we found this philosophy had not been applied and staff were unable to explain what the home's vision and values were. Staff had received training in safeguarding but demonstrated they were not identifying the concerns we had identified and reporting them inline with their policy and training.

At the last inspection on 16 and 17 October 2014, we found that systems to assess the quality of the service provided in the home were not effective. An action identified by the registered manager to include people in the reviewing of care plans had not been acted upon, despite the home having a monthly care plan review system in place. The registered manager completed audits of the service, but these had not identified areas of the home where there were inconsistences in the way that staff communicated with people, staffing levels that impacted on activities and the delivery of care. As a result, people received an inconsistent service. This was a breach of Regulations.

The provider sent us an action plan and told us what action they intended to take to ensure the regulation was met. However, on this inspection we found continuing shortfalls in various aspects of the service including record keeping. For instance, care plans had not always been updated in line with people's needs, some risk assessments were incomplete and diet, turning and fluid charts had not always been fully completed for people. It was therefore difficult to determine if people had received safe and appropriate care. Accidents and incidents were recorded including falls. There was no evidence of audit or review of incidents and accidents to identify patterns to inform care planning or flag up concerns. The evidence above shows that the provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person's care and treatment.

The quality monitoring programme at the service was ineffective. Checks on how the service was operating had not been completed. The registered manager told us they had focussed on the daily operation of the service and therefore had not had time to carry out routine audits. Audits had not been completed and there were no effective systems in place to ensure people's needs were properly monitored and reviewed to inform their care planning. Care plans were not followed by staff in the delivery of care. There were no systems in place to check monitoring charts, for areas such as food and fluid intake or pressure relief had been completed and any concerns had been acted on. There was evidence that people's care needs were not being met. Following residents and relatives' meetings, people and their families were asked to complete a short satisfaction questionnaire. Questionnaires were last completed in February 2015, however, there was no action plans in place to address the suggestions for improvement.

Service-wide concerns were identified at this inspection, including several breaches of Regulations. There were several areas of continued breaches from the previous inspection which had not been acted upon to improve and respond to known risks. This demonstrated that the provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. **The above evidence shows that the provider was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

Inadequate

Is the service well-led?

The registered manager left the service on Monday 12 October 2015. In the meantime, the home was being managed by the deputy manager and supported by another service manager with the oversight of the provider.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The care and treatment of people was not appropriate, did not meet their needs and did not reflect their preferences. They were not involved in planning their care. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not treated with dignity and respect and their privacy was not upheld. Regulation 10 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment was not provided in line with the requirements of the Mental Capacity Act 2005 Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met:

The nutritional and hydration needs of people were not met.

Regulation 14(1)(2)(a)(4)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: Complaints were not received and investigated as necessary and proportionate action taken in response. There was no system in place for handling complaints. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. Persons employed by the service provider did not receive appropriate support and training necessary to enable them to carry out their duties. Regulation 18(1)(2)(a)