Lifeways Community Care Limited

Woodland Grove

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

We conducted an unannounced inspection at Woodland Grove on 23 April 2018. Woodland Grove is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Woodland Grove accommodates up to 10 people in one building. On the day of our inspection, seven people were living at the home; all of these were people with a learning disability. This was the first time we had inspected the service since they registered with us.

There was no registered manager in place at the time of our inspection. The previous registered manager had left Woodland Grove in November 2017. 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 was a service manager in post at the time of our inspection and they informed us they would be submitting an application to register with CQC. We will monitor this.

During this inspection, we found action had not always been taken to protect people from risks associated with their care and support. Support provided to people whose behaviour could pose a risk to themselves and others was inconsistent; work was underway to improve this. There were not enough staff to meet people's needs at all times. The environment was not clean and hygienic and effective infection control and prevention measures were not in place. Environmental risks were not always safely managed. There were systems and processes in place to minimise the risk of abuse. Safe recruitment practices were followed. Overall, medicines were managed safely. However, some improvements were required to ensure medicines were stored safely.

People were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible; the policies and systems in the service did not support this practice. People's day-to-day health needs were met. However, there was a risk that people may not receive the support they needed with specific health conditions as support plans lacked detail. Care and support was planned and co-ordinated when people moved between different services. Overall, people had enough to eat and drink. Further improvements were needed to ensure food was available and stored safely. Staff did not receive sufficient training to enable them to effectively meet people's individual needs and staff did not receive regular supervision and support.

People told us staff were kind and caring. However, people were not always treated in a respectful and dignified manner and were not involved in choices and decisions. Most staff knew people well and understood their needs and preferences; however, high turnover of staff and use of temporary staff made it hard for people to develop relationships with them. People had access to advocacy if they required to help them express their views.

Overall, staff had a good knowledge of people's support needs. However, some improvements were required to support plans to ensure people received consistent support. Overall, people's diverse needs were recognised and accommodated and they were provided with the opportunity to discuss their end of life wishes. People were offered some opportunities to take part in social activities. However, these were limited, inconsistent and adversely affected by staffing levels. People were supported to maintain relationships with people who were important to them. There were systems in place to respond to concerns and complaints.

A lack of consistent, effective leadership at Woodland Grove had a negative impact upon the quality of the care at the home. Systems to ensure the safety and quality of the service were not consistently effective. Action was not always taken in response to known issues. People and staff were not involved in the development and running of the home. Accurate and up to date records were not kept of people's care and support. Throughout our inspection, the service manager was open, honest and responsive to our feedback.

This was the first time the service had been rated as Requires Improvement. During this inspection, we found four breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not consistently safe.

People were not always protected from risks associated with their care and support. Support provided to people whose behaviour could pose a risk to themselves and others was inconsistent; work was underway to improve this.

There were not always enough staff to meet people's needs and ensure their safety.

The environment was not clean and hygienic. Environmental risks were not always safely managed.

There were systems and processes in place to minimise the risk of abuse. Safe recruitment practices were followed.

Overall people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions.

Staff did not receive sufficient training to enable them to effectively meet people's individual needs. Staff were not provided with regular supervision and support.

People were supported to have enough to eat and drink. However, we identified some concerns about the supply and storage of food.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always involved in decisions that affected them. People were not treated with dignity at all times.

People told us staff were kind and caring.

People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff had a good knowledge of people's support needs; some improvements were required to support plans to ensure people received consistent support.

People were offered some opportunities to take part in social activities. However, these were limited and inconsistent and opportunities were affected by staffing levels.

People were supported to maintain relationships with those who were important to them. There were systems in place to respond to concerns and complaints.

Is the service well-led?

Inadequate

The service was not well led.

A lack of consistent, effective leadership at Woodland Grove had a negative impact upon the quality of care.

Systems to ensure the safety and quality of the service were not consistently effective. Action was not always taken in response to known issues.

People and staff were not involved in the development and running of the home. Accurate and up to date records were not kept of people's care and support.

The service manager was open, honest and was responsive to our feedback.

Woodland Grove

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, to look at concerns we received about the quality of the service and to provide a rating for the service under the Care Act 2014.

Prior to our inspection, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

The inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. During our inspection visit, we spoke with three people who lived at the home and two people's relatives. We also spoke with seven members of care staff, the home manager and the service manager.

To help us assess how people's care needs were being met we reviewed all, or part of, four people's care records and other information, for example their risk assessments. We also looked at the medicines records of three people, four staff recruitment files, training records and a range of records relating to the running of the service.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also 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 did not request a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what they do well and improvements they plan to make. However, on the day of inspection we gave the provider the opportunity to share this information.

After our inspection visit, we asked the service manager to send us a copy of various records, policies and procedures, which they did prior to this report being completed.

Requires Improvement

Is the service safe?

Our findings

The home was not clean. Upon our arrival to Woodland Grove we found all bathrooms and toilets were in an unhygienic state. Toilets were coated with old waste matter and grouting and seals were damaged and stained. Light pulls were stained and unhygienic and toilet brushes were heavily soiled. Furthermore, soap and disposable hand towels were not available. We also observed that other areas of the home were not adequately clean. For example, there was heavy dust behind the washing and drier machines in the laundry and a build-up of washing powder on the floors. There was no dirty to clean flow in the laundry and clothes were piled on the floor, which compromised effective cleaning. These unhygienic practices did not promote the control and prevention of infection.

Appropriate cleaning agents were not always used and were not available in the home. During our inspection, we observed staff using inappropriate cleaning products to clean up a spillage of bodily fluid. Furthermore, staff did not have access to suitable cleaning products on site to clean the carpet. This did not assure us staff had the required competency or resources to ensure the effective cleaning of the home.

Some areas of the home were not properly maintained and were in a poor state of repair. Some carpets were stained and worn and were not properly fixed to the floors which posed a trip hazard. Bathrooms were also poorly maintained, we observed cracked tiles, missing sealant, rusted bath panels and damaged warped wood. The poorly maintained environment did not promote good hygiene practices and increased the risk of the spread of infections.

Systems to ensure the cleanliness of the home and to monitor this were not effective. There was a member of domestic staff employed at the home, but the impact of their work was not evident. Staff also had responsibilities for undertaking some cleaning duties. However, staff told us there was a culture of some staff leaving the cleaning to the next shift, which resulted in cleaning tasks not being completed. Systems to identify and address concerns about the environment were also ineffective. Regular infection control audits had been undertaken, but areas of concern were not always identified and when issues were, they were not addressed quickly. For example, concerns about the state of the environment had been identified in January 2018 audits. However, action had not been taken to address these issues and consequently they remained of concern at our inspection.

The above information was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about staffing levels at Woodland Grove. People's relatives told us they felt there were normally enough staff but commented that changes in the staff team could affect people's anxiety and consequent behaviour. A relative said, "The main staff aren't a problem, but if [relation] doesn't take to them (new staff) they'll know about it, that's the problem." Staff also gave variable feedback about staffing levels. For example, one member of staff described staffing as "horrendous" and said it had a negative impact on people living at the home. In contrast, other staff told us there were usually enough staff to ensure people's safety.

We reviewed staffing records and found it was not clear if people received the support they required. The service manager explained that, as they had only recently taken over management of the service, they did not have clear information about how many hours of one to one support were funded for people. After our inspection visit, we were provided with information about the one to one support commissioned for people. We reviewed staffing rotas against this information and found there had been some recent occasions where staffing levels had fallen below the required level. For example, on one recent occasion only five staff had been on shift, this meant there would not have been enough staff to provide people with the one to one support they required. The service manager was aware of recent pressures on the staff team and told us they were in the process of recruiting to vacancies. They told us that in the interim, temporary agency staff were used to cover shifts.

People were not always protected from risks associated with their care and support. One person was at risk of causing harm to themselves with dangerous objects. During our inspection, we found potentially dangerous items were accessible to them in their bedroom. This placed the person at risk of harm. We told the service manager about this who took immediate action to reduce the risk. Other than the above, we found steps had been taken to protect other people from risks associated with their care and support. A relative told us, "Yes I do (think relation is safe). I know the staff can deal with [relation] and they have had no falls." Plans were in place that detailed risks relating to people's care and support and how these risks should be managed. For example, one person was at risk of choking, this had been risk assessed and during our inspection staff followed guidance to reduce the risk to the person.

Support provided to people whose behaviour could pose a risk to themselves and others was inconsistent. Records of incidents showed that staff were taking an inconsistent and sometimes punitive approach to supporting people when they became distressed and agitated. Records showed staff frequently told people their behaviours were 'unacceptable' or 'inappropriate' and documented staff telling people to go to their bedroom. This did not demonstrate insight into the anxiety and distress experienced by people and was not a dignified or constructive way of supporting people. Other records documented staff did not always follow guidance in support plans resulting in an inconsistent approach. For example, one person was known to cause injury to themselves, some incident records showed staff followed guidance to make the environment safe and used behavioural approaches to de-escalate the situation. However, records of similar incidents showed staff administered 'as needed' medicines without trying other measures first.

The service manager told us they had identified issues with how behavioural incidents were managed. They were in the process of retraining all staff in a new approach to physical intervention to encourage a more proactive approach. They had also recently introduced a new incident monitoring system, which they told us would enable better oversight of incidents and ensure action was taken to reduce future risks. During our inspection, we found this had had a positive impact. A relative commented, "They (staff) know their ways. They are very good at distraction techniques." Some of the staff we spoke with had an in-depth understanding of people's behaviours and took a positive approach to supporting people. One member of staff told us, "The behaviour is about them trying to communicate, sometimes it's through their frustration." Another staff member was able to recognise changes in the tone of a person's voice and used this to guide the level of support provided. A third staff member talked about sticking to people's routines to minimise anxieties.

Environmental risks were not always safely managed. Although there was a fire risk assessment, we saw that some of the fire safety checks were insufficient. For example, checks of firefighting equipment, such as extinguishers, had not been conducted. This meant we could not be assured this equipment was in working order. A legionella risk assessment had been completed; however, records of checks to reduce the risk of legionella developing in the water supply were intermittent. This meant we were not assured that sufficient

action had been taken to protect people from risks associated with the environment.

The relatives we spoke with said they had no concerns over the safety of their loved ones. One relative told us, "Yes, I do feel [relation] is safe here. I don't have to worry because there are staff so there's no problem." Relatives also commented on the safety of the environment, one relative said, "From what I see the security keeps them completely safe." Processes were in place to minimise the risk of people experiencing avoidable harm or abuse. Although only four of the 15 staff employed at Woodland Grove had up to date training in safeguarding adults, they were knowledgeable about indicators of abuse and knew how to respond should they have any concerns. Most staff felt confident any issues they reported would be acted on appropriately. Managers were clear about their responsibilities to protect people from the potential risk of abuse they had taken action to protect people from abuse by making referrals to the local authority safeguarding adults team.

Medicines were not always stored safely. We found a medicine, which should have been stored in the fridge, was being stored at room temperature. This could have an impact on the efficiency of the medicine. We also found discontinued medicines were being stored with those, which were in use. This increased the risk of error. We discussed this with a member of staff who took immediate action to address these issues. Other than the above, we found people received their medicines as required. Medicine records were completed accurately to demonstrate that people had been given their medicines as prescribed. Staff had training in the safe management of medicines and their competency was checked regularly. Recent audits had been effective in identifying and addressing areas for improvement.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been correctly applied to ensure decisions were made in people's best interests. Mental capacity assessments had not been completed in all required areas. This meant people's capacity to consent to restrictions on their freedom had not been formally assessed. One person had restrictions upon a certain type of drink. Throughout our inspection, we saw the person repeatedly requested this drink and staff declined their requests. There was also evidence in records to demonstrate that this restriction had resulted in the person's behaviour escalating. Despite this, the person's capacity to consent to this restriction had not been assessed. The same person also had restrictions placed upon personal care items. Again, their capacity to consent to this had not been assessed. This meant we could not be assured that decisions made in people's interests were the least restrictive option and posed a risk that their rights under the MCA may not be protected.

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. Applications for DoLS had been made as required. However, when people had DoLS in place, conditions imposed to ensure their rights were protected were not always complied with. For example, a DoLS had been granted for one person. The condition stated that level of monitoring of the person must be reviewed to ensure it was the less restrictive approach. There was no evidence this had been addressed and the person was still subject to high levels of monitoring. This did not respect people's rights and did not ensure that people were supported in the least restrictive way possible.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a risk that people may receive care and support from staff who did not have the necessary skills and qualifications to support them effectively. Training records showed some staff did not have up to date training in areas such as safeguarding, the MCA and infection control. For example, one member of staff did not have any up to date training in safeguarding, basic life support, food hygiene, health and safety, infection control or manual handling because the courses they had previously attended had expired. Records showed that 11 of the 15 staff employed did not have up to date training in safeguarding adults. This meant there was a risk people may be supported by staff who did not have the required competency or skill.

Despite the above gaps, people's relatives told us they felt the regular staff were well trained. This was also reflected in the comments of staff who told us they had enough training.

Staff did not always receive regular supervision of their work. The service manager was aware of this and had started work to ensure staff got the support they needed. There were no records of staff supervision prior to March 2018 and at the time of our inspection, 10 staff had not had any recent supervision. This meant that staff were not given regular, formal opportunities to access support, reflect on their practice and share any concerns. This was of particular concern given the gaps in staff training.

Systems were in place to ensure information was shared across services when people moved between them. Before people moved into Woodland Grove the management team conducted an assessment to ensure the staff team could meet their needs. Once a placement had been agreed a transition plan was developed to gradually introduce people to the service and staff, with visits and overnight stays. In addition, the service manager told us they had developed 'hospital passports' for each person living at the home. Hospital passports are designed to share information between care homes and hospitals, to ensure care is person centred.

Overall, people had enough to eat and drink. People and their relatives were positive about the food. One person we asked about the food told us, "It's nice" and another person responded "Yes" when we asked them if they liked the food. A relative told us they were "very happy" with the food their relation was served. Staff told us people were involved in deciding what was on the menu. They said they used a picture menu as "you eat with your eyes." We saw that weekly menus consisted of a variety of foods.

We identified some concerns about the supply and storage of food. On the day of our inspection visit, we observed there was a very limited amount of fresh food available on the premises. Staff informed us this was because it was 'food shop' day. We saw the food shop was not completed until 4:30pm; this meant that people had limited access to fresh food and snack items for the majority of the day. We also found that basic food hygiene practices were not always followed. A number of items in fridges and cupboards had no date of opening on them, which, meant that staff could not tell if the food was still safe to give to people. In addition, we found food stored in the cupboards was not stored in sealed containers.

Staff had a good knowledge of people's dietary requirements. For example, one person using the service had been assessed as requiring a specific texture diet, staff were aware of this and we observed the person was served food in line with this requirement. People's weight was monitored regularly to ensure they maintained a healthy weight.

There was a risk people may not receive the support they required with specific health conditions, as staff did not have access to sufficiently detailed information. Information from health professionals was not always incorporated in to people's support plans. For example, one person experienced frequent seizures. A recent letter from a health professional provided details to help staff identify the start of a seizure. However, this had not been incorporated in to their support plan. This lack of information placed people at risk of not receiving the support they required with their health.

Despite the above, we found people received effective support with their day-to-day health needs. We saw records of contact with health professionals in people's support plans, which showed people, were supported to access the GP as needed and other health professionals such as dentists and opticians.

Woodland Grove is situated in a large house, which has been adapted to accommodate the service. There was one communal lounge, a communal kitchen and adjoining dining area. Records showed people's

access to the kitchen area was restricted from 8:00pm onwards; this meant their access to the dining area was also restricted. Consequently, people only had unrestricted access to the communal lounge in the evenings. The service had an annex area, which consisted of two large communal areas; however, this was not used. This meant people had limited communal space. There were no toilets or bathrooms on the ground floor of the building, which meant people had to go upstairs if they wished to use the bathroom. Some signage had been used to help people to navigate their way around the building; however, this was inconsistent. The service manager told us that the provider was planning to change the configuration of the service. They told us the planned work would result in a downstairs toilet and increased communal living spaces.

Requires Improvement

Is the service caring?

Our findings

Staff did not always talk to people in a dignified and respectful manner. For example, we heard one member of staff saying to a person "don't be impatient" in a sharp and authoritative tone. On another occasion, we observed two members of staff talking about a person who was present in the room; they did not attempt to involve the person in the conversation.

People were not always involved in choices and decisions about their support. During our inspection, we observed several occasions where people's choices were not respected or where people were not involved in decisions that affected them. For example, one person asked a member of staff for food. The member of staff responded, "No you are not having yoghurt and fruit and no you cannot have chocolate until this afternoon." On another occasion, we heard staff deciding how a person should spend their day, they did not involve the person in this decision and we later observed the person doing as staff had planned.

We received some negative feedback about the conduct of some staff before and during inspection. Prior to our inspection the local authority shared concerns that some staff put their own needs before the needs of the people they supported. This was also supported by feedback during our inspection. A staff member we spoke with confirmed this. They told us this had an impact upon people's care and provided examples where they had witnessed staff making people wait unnecessarily for their support and also where staff had made agency staff support people because they did not want to.

Although we observed some instances of kind and compassionate care and support, we found that some staff were task focused and had limited interaction with the people they were supporting. We observed that staff spent more time with those people who were able to verbally communicate or those who posed a risk to others, compared to people who did not or were not able to initiate interaction. While staff were not being outwardly unkind to people, they sometimes overlooked people who, due to their disabilities, were not able to seek staff company and interaction. This was reflected in a comment from a staff member who told us, "Because [name] is nonverbal, they think they don't need as much attention, so they don't get the attention, but [name] craves it. It's not fair on them."

People were not supported to maintain their dignity. During our inspection, we observed there was no toilet roll available in any of the toilets. We were told this was due to a risk posed by one person living at the home. A member of staff told us that people kept toilet roll in their bedrooms and had to remember to take it with them if they wished to go. This did not assure us that staff had considered people's dignity when assessing and managing risk.

The above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, people and their families were positive about the approach of the staff team and their experience of Woodland Grove. People living at Woodland Grove were able to say or indicate that they were happy and that staff were kind to them. One person told us, "It is nice here." A relative commented, "Most of

the staff have been incredibly caring." Another relative said, "The ones I know are very caring, we've grown to love them (staff). We have even had them to Christmas lunch, they are very sociable and support us." However, relatives also commented that the high turnover of staff made it hard to get to know staff and develop relationships. A relative told us, "They come and go so you can't build a relationship with them." Another relative said, "We can't keep up with the new ones (staff). We hope this will calm down soon." The staff who had been working at Woodland Grove for some time had an in-depth knowledge of the residents. They talked about people with fondness and were aware of people's likes and dislikes. One staff member said, "We all want the best for these guys." In contrast, temporary agency staff had a limited knowledge of people's individual personalities, needs and preferences.

The service manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.

People were supported to develop and maintain their independence. People's relatives told us staff promoted people's independence. One relative said, "[Relation] does help with food prep, they quite enjoy it and are keen to do it." Another relative said, "They (staff) get [relation] to independently brush their teeth and hair." Throughout our inspection, we saw that staff were keen to promote independence and supported some people to prepare food or make drinks while keeping them safe. There was a domestic tasks rota displayed in the kitchen and we saw tasks such as cleaning and tidying the home were allocated to people.

Requires Improvement

Is the service responsive?

Our findings

Before people moved into the service an assessment of their needs was conducted. This assessment, along with other information, was then used to develop people's support plans. Support plans contained detailed information about each person's individual needs and preferences, their level of independence and areas where support from staff was required. Some improvements were needed to ensure support plans were updated to reflect learning from events and incidents. For example, records for one person documented two, recent occasions when they had become upset about a certain object; however, their support plan had not been updated to reflect this, or to provide guidance to staff on how to reduce the risk of this happening again. This meant there was a risk the person may receive inconsistent support. Despite this, we found overall, staff had a good knowledge of each person.

We recommend the provider review how learning from events and incidents is used to update support plans.

People were offered some opportunities to take part in social activities; however, this was limited and inconsistent. A relative told us, "Staff do take (the person) out every now and again." Another relative stated, "[Relation] gets out quite a bit," but added that they had requested their relation was supported with a specific activity to enhance their fitness, but this had not happened. Staff said that activities were planned in a person-centred way, working on an individual basis to meet people's preferences. However, some staff commented that staffing levels could have a negative impact upon the opportunities people were offered. They told us, "It is chaotic; we don't know when we can take these guys out." They said there was a plan of activities, but they could not always stick to this due to the availability of staff who could drive and had access to a vehicle. We looked at weekly activity planners, these showed a range of activities such as, going to the library, cinema, swimming, bowling, and day trips. However, we found the activities planned did not match with the activities people took part in. Staff told us some people declined activities, but, there was no evidence to demonstrate this and that the reasons why had been explored.

At the time of the inspection, the service was not supporting anyone who was coming to the end of their life. However, we noted people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their support plans.

Overall, people's diverse needs were recognised and accommodated; however, this was affected by staffing levels. One person's relative told us it was important to their loved one to visit a local place of worship, but said this was an "irregular" occurrence. They said, "They (the staff) have taken [relation], not every Sunday. We have tried to mention it over the years but it is always a staffing problem. It is something [relation] would like to do more regularly." The service manager told us people's diverse needs were assessed when they moved into the home and would be accommodated as required. They provided an example of how they ensured one person was provided with food, which met their cultural needs.

People were supported to maintain relationships with friends and family and people's friends and relations were welcome to visit Woodland Grove. The regular staff team had a good knowledge of who was important

in each person's life and supported people to maintain relationships with family members, for instance, by supporting them to visit the homes of family members. Relatives told us there were not any restrictions on visiting. One relative said, "We can turn up at any time."

The management team explained how they met their duties under the Accessible Information Standard by providing information in different formats as required. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. During our inspection, we saw examples of pictorial menus and other communication aids, which were used to enable people to access information.

There were systems and processes in place to deal with and address complaints. People told us they would feel comfortable raising complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. There was a complaints procedure on display in communal areas informing people how they could make a complaint. We reviewed records of complaints and these had been investigated and responded to in a timely manner. For each complaint, there was a written record of the complaint and details of the actions taken to resolve the issue.

Inadequate

Is the service well-led?

Our findings

Throughout our inspection of Woodland Grove, we identified a number of shortfalls in the way the service was managed. This resulted in us finding concerns related to the safety of the service, staffing, the cleanliness of the premises, the implementation of the Mental Capacity Act 2005 (MCA), person centred care and the quality of records. This led to four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a lack of consistent, effective leadership at Woodland Grove. This affected the quality of the care and support provided at the home. Woodland Grove has been without a registered manager since 5 November 2017. In this period, there had not been consistent management of the home. Staff informed us this had a negative impact of the morale of the staff team and we found that this inconsistent leadership also had a negative impact on the quality of the service provided. For example, there was very limited evidence to demonstrate that management audits and checks had been completed prior to March 2018. Other management systems, processes and paperwork were disorganised. For instance, there was no system in place to track and monitor DoLS applications and conditions. The lack of organised systems posed a risk that people's need may not be met.

Quality assurance processes were not always effective. In November 2017, we received concerning information about the cleanliness of the premises and availability of cleaning products. We shared these concerns with provider whose investigation concluded the home was sufficiently clean. Despite this, during our inspection we found that the environment was not sufficiently clean.

Systems to ensure the safety and quality of the home were not effective and did not ensure action was taken to address significant concerns. A recent quality improvement plan documented 'high' priority actions related to the cleanliness of the environment, compliance with the MCA, community access and dignity and respect. The action plan did not have any timescales for completion of these actions and no records of progress were kept. During our inspection, we found continued concerns in these areas.

Action was not taken in response to known issues. An audit conducted by the local authority in March 2018 highlighted a person was at risk of harming themselves as they had access to hazardous items. Despite this being identified, during our inspection we found the person continued to have access to dangerous items. The failure to implement and sustain effective systems to ensure the safety of service users placed them at risk of harm.

Staff did not always feel supported or listened to. During our inspection, staff told us they had raised concerns about the quality and safety of the home. Two staff members told us they did not feel action had been taken to address these concerns. One member of staff said, "It feels like things have just been brushed under the carpet." We looked at records of staff meetings and found staff had raised concerns about conflict in the staff team, confidentiality, staffing, the cleanliness and maintenance of the home and ineffective recording processes. There was no action plan developed because of these meetings and during our inspection, we found many of these issues remained a concern.

The provider had not ensured staff had the competency required to make sure systems were completed effectively. Staff told us there had been many changes since September 2017. They said reasons for changes were not always well communicated with them and stated they were not given the information or explanation they required to ensure the effective implementation of changes. For example, a fire risk assessment had identified a need for additional checks of fire equipment. A fire equipment check had been implemented but records showed staff had recorded checks of the 'phone'. There was no evidence that they had checked equipment such as extinguisher and evacuation equipment. This failure to provide staff with the explanations and knowledge they required resulted in increased risks to people living at Woodland Grove.

There were no effective systems in place to seek and act upon feedback from people living at the home and others. The manager told us monthly meetings were held with people. We reviewed records of these and found these had been completed by staff on behalf of people and there was no evidence of involvement. The service manager told us they had implemented an accessible way of people providing feedback about activities; however, during our inspection we found the completion of these new forms was inconsistent.

Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. For example, the service manager told us agency staff were provided with a summary of people's care needs prior to working with people. However, we found that these profiles were only available in the agency file for four of the seven people living at the home. In addition, records of care and support, such as food records, were not fully completed. The failure to ensure complete and contemporaneous records meant we were unable to identify if people had received the care and support they required.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection, the service manager was open, honest and was responsive to our feedback. They told us they were aware of many of the issues we raised and assured us they were committed to improving the quality and safety of the home.

The service manager told us they kept up to date with best practice in a number of ways. The provider shared regular updates on national and local developments. The service manager met regularly with other local managers employed by the provider to share good practice and problem solve. They also used the internet and received updates from nationally recognised organisations to ensure they stayed up to date. The service manager was involved in a provider wide group aimed at reducing the use of restrictive physical interventions, they told us this group reviewed and analysed incidents to try to better understand people's behaviour and improve the support people received.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the MCA were not always respected. Regulation 11 (1)