Woodchurch House Limited

Woodchurch House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 9, 10 and 11 May 2017 and was unannounced. Woodchurch House provides accommodation, nursing and/or personal care in purpose built premises. There were two people receiving accommodation and nursing/personal care when we inspected. It also provides a personal and /or nursing care service to people who hold tenancy agreements on their accommodation within Woodchurch House. 50 people were tenants and received personal and/or nursing care in leased accommodation suites. There were 52 people in total using the service during our inspection; of which 46 were receiving nursing care. The service is divided into two floors with the ground floor dedicated to nursing care and the first floor to people living with dementia; some of whom also require nursing care.

It is a requirement of this service's registration with the Care Quality Commission, that there is a registered manager in place. 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. The manager at Woodchurch House had become registered immediately prior to our inspection.

Woodchurch House was last inspected on 5 and 6 November 2016, following information of concern we received about the service. They were rated as inadequate overall at that inspection and placed into Special Measures. Prior to this they had been inspected in September 2016 when they were rated as requires improvement overall but inadequate for Safe, and January 2016 when they were rated as Inadequate overall.

At this inspection there had not been sufficient, sustained improvement and we continued to have concerns about the safety and well-being of some people, despite having made the issues clear in our previous reports. There had been inadequate management and provider oversight to ensure that risks were addressed and quality and safety made better.

Known risks to people such as from choking, from skin wounds, from dehydration, certain equipment or from being unable to use call bells had neither been properly assessed nor were actions to minimise the risks put into place. Staff were still not suitably deployed so that people received prompt and appropriate attention, and training and knowledge remained lacking in some areas. Most recruitment files had been improved but there remained an issue over unexplained gaps in employment history even though this had been specifically highlighted at past inspections.

Systems to protect people from abuse had not been operated effectively and incident reports had not been completed by staff when unexplained bruising, cuts and skin tears were noticed.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) had not been consistently applied to ensure staff were always acting in people's best interests or with their consent.

People's dignity was not preserved if they became incontinent when there were delays in call bells being answered. Independence was not consistently promoted when people needed support to carry out exercises recommended by physiotherapy. End of life care records needed more work to include people's personal preferences.

Complaints were recorded well but actions taken in response to them were not always robust or effective. Feedback was sought from people and relatives via surveys and meetings but again this was not always acted upon.

Care plans held person-centred information but this did not always match with other records and created the opportunity for error and confusion. Some records were neither accessible nor made available to us during the inspection. Auditing had been largely ineffective and was sometimes based on flawed data.

Medicines had been well-managed and the computerised administration system supported staff to give and record medicines safely.

Maintenance of the premises had been routinely undertaken and records about it were complete. Fire safety tests had been carried out and fire equipment safety-checked.

People and relatives told us staff were kind, considerate and caring and we observed staff treating people with gentleness and patience throughout the inspection. Records about people were stored securely and staff were mindful of people's confidentiality and privacy.

There was a varied activities programme in place which had been improved to include many outings. People were seen to enjoy baking, games and musical entertainment and relatives commented on how much it meant to their loved ones to be involved socially.

Actions taken following our last inspection had not been sufficient to ensure people's safety and well-being. We remained concerned that people were not consistently receiving appropriate standards of care. CQC is now considering the appropriate regulatory response to resolve the problems we found.

We found a number of breaches of Regulation.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The deployment of staff was not always effective in meeting needs promptly.

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

Not all equipment was properly safety-checked.

Unexplained injuries had not been brought to the registered manager's attention and had therefore not been considered for investigation or discussion with the local safeguarding authority.

Recruitment processes continued to be insufficiently robust.

Medicines were managed safely but prescribed creams were not always applied in line with the prescriber's directions.

Environmental and fire equipment safety checks had been regularly undertaken and the premises were well-maintained.

Is the service effective?

Inadequate

The service was not always effective.

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

Wound care was not consistently effective.

Staff training and supervision had not always been effective in equipping staff for their roles.

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

Catheter care had improved and was better managed. People had access to GPs, chiropodists, dentists and opticians.

Is the service caring?

Requires Improvement

The service was not consistently caring.
Some people waited too long for call bells to be answered, which affected their dignity.

People's needs were not always met appropriately.

End of life care records did not reflect what happened in practice.

Staff interactions with people were kind, caring and gentle.

People and relatives mostly felt involved in care decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Actions in response to complaints were not always robust or effective.

Care plans were written in a person-centred way but different records about care were conflicting or inaccessible.

There was a wide range of activities available to all people using the service.

Is the service well-led?

Inadequate

The service was not well-led and had received inadequate ratings at each of our last four inspections.

Many of the issues highlighted in our previous inspections had not been fully addressed.

Assessment and monitoring of risks to people had not been successful in a number of areas.

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

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

Most people and staff felt the manager was approachable and would listen to any concerns.

Woodchurch House

Detailed findings

Background to this inspection

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

This inspection took place on 9, 10 and 11 May 2017 and was unannounced. The inspection was carried out by two inspectors, two specialist nurse advisors and two experts by experience. The specialist advisors had clinical experience and knowledge of care in settings for older people and those living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience had personal experience of older people and people living with dementia.

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

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

We pathway tracked nine of the people living at the home. This is when we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

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

procedures.

Inadequate

Is the service safe?

Our findings

People and relatives told us that they felt the service was safe. One person told us "I am safe because I have nothing to worry about- no one is unkind or makes me do anything I don't want to". A relative commented "I can safely say that I come away feeling Dad is really safe". However, we received mixed feedback from people and their relatives about whether their needs were consistently met. Similar issues were raised in our inspections of January, September and November 2016 and this area had not been adequately addressed at this inspection.

One person told us "It's not too bad at the moment. I think they have one carer to four residents which isn't bad if there are no problems". A relative said "I've noticed there are more staff in the lounge" and another commented "Big improvement in staff numbers and that improvement has impacted on all staff; they are no longer stressed". However, three people told us that they sometimes had to wait "Too long" for staff to respond to call bells and this occasionally caused them to be incontinent. One person went on to say "Sometimes when you ring, staff come and say they will be back right away but then it can be 10 minutes, which isn't good if you're waiting desperately for a commode." Another person said "It's irritating when staff tell you they'll be with you in 10 and are then 20 to 30 minutes". In a survey of residents and relatives carried out in February 2017 one comment read 'Our relative can be left in the lounge badly soiled, when we speak to the staff they say they are short staffed. This is more evident at the weekend'. This situation was undignified for people and had not improved sufficiently from our previous inspections.

At our inspections in January, September and November 2016 there had been insufficient experienced, skilled and competent staff deployed. At this inspection staffing numbers had again been increased. The registered manager told us a dependency tool was no longer used to calculate staffing levels but the registered manager told us they made their own assessment of staff requirements by speaking with staff and constantly reviewing people's care needs. The registered manager told us that there were always more staff on duty than indicated as necessary by their assessments.

Our observations showed that, while lunchtime on the ground floor was pleasant and relaxed for people, those living on the first floor had a different experience. The mealtime was chaotic and staff were unable to keep track of which people had received their lunch, despite using checklists for this purpose. For example; one person was becoming agitated when most others had received their meals. Staff had placed this person's meal on a covered plate on the worktop in the dining area. We asked staff if this person had eaten and two staff confirmed they had, until we pointed out the covered and plated meal on the side. The meal was cold by this point and another portion had to be sought from the kitchen, which caused a further delay. One staff member told us "So many people need assistance; we're very busy and could do with more staff".

People were served with their meals one by one as staff needed to support most people in the lounge and in their own rooms to eat. This meant that those who were waiting their turn in the lounge were sitting watching others eating for up to 40 minutes before they received their own meal. People were not generally sitting at the dining tables but remained seated in armchairs with a clear view of those who were eating, which was not considerate of them possibly feeling hungry. A relative told us "There are not enough staff on

over lunch because they're busy feeding and can't be doing everything".

One person complained repeatedly of discomfort when sitting in their wheelchair in the morning and was observed leaning over the side of it. They needed the support of two staff to assist them to move to an armchair with a hoist but staff were busy helping other people to get up and dressed at the time. There were two staff in the lounge but one of these was supposed to be providing one to one care to a person there. In order to be able to support the person to move from their wheelchair, care staff had to ask an activities coordinator to sit with the person receiving one to once care, so they could assist a colleague with the hoist transfer. There were not enough care staff deployed to meet people's needs promptly.

Some people said that "Communication is difficult" with staff for whom English is not their first language. One person told us that this sometimes meant they could not make their needs understood and caused them "Huge frustration". This communication difficulty created a risk that some staff may not understand people's needs or requests for assistance. Following the inspection the provider informed us that all staff are assessed before being employed to ensure they have a good command of English language. However, interview records for a recently appointed staff member showed that they had a very poor command and understanding of English and they had no previous experience in social care. For example, they were asked 'What would you do if you saw a staff member pushing a resident'? To which they had replied 'Ok no problem'. Other questions about working in a care setting had been replied to with 'Not understanding'. None of the interview questions had been answered satisfactorily but the registered manager told us they had employed the applicant because "They're lovely with a nice personality". They also said that English lessons would be provided for the staff member. One person's response to the February 2017 survey read 'I and a relative often have trouble understanding the accents of staff. We would prefer more emphasis put on knowledge/ability to make themselves understood when employing staff'.

The failure to ensure competent and experienced staff were deployed effectively is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection, choking risks to people had not been properly assessed or minimised. At this inspection the situation had not improved sufficiently and some people remained at risk. One person had a serious choking episode a few days before our inspection and had received hospital treatment following it. On their return to the service the person had been placed on a soft diet and a referral had been made to speech and language therapy (SaLT) for advice about their swallowing. However, there was no specific assessment in place to document the risks to this person and to give guidance to staff about how to deal with a choking incident.

Care plans for another three people showed they were at risk of choking, but again there were no assessments about how to reduce the likelihood of it happening and no information for staff about managing people if they choked. One of these people had been assessed by SaLT who had advised that thickened drinks should be given in non-spouted cups without straws. This person had two un-thickened drinks on their over-bed table when we visited them; both in spouted beakers with straws in them. Staff told us that this person chose to ignore the SaLT advice; which they were at liberty to do. However, there had been no assessment about the increased risks to them of drinking un-thickened fluids against professional advice. The failure to follow SaLT advice and/or having risk assessments in place about it was specifically raised at our last inspection in November 2016.

Staff were not clear about correct actions to take if people choked. One nurse told us they would give back slaps "But not too hard because I'm afraid to do that" and another said that they would sweep people's mouths with their fingers to clear any obstacles. Back slaps need to be firm enough to remove obstructions

so that people can breathe, and moving fingers around people's mouths can cause any blockage to be pushed further into the throat. Care staff gave better responses to questions about choking actions but also added that they would call a nurse to deal with any choking anyway. We immediately made the registered manager aware of our concerns and they printed off and displayed a guidance sheet about treating people who are choking; from the St John Ambulance website. However, this information was intended for the general public and not nursing home staff who may need to assist people in bed, in wheelchairs and with other medical conditions to consider.

At our last inspection, regular checks had not been made on one person in line with their care plan directions. At this inspection there remained confusion amongst staff about how frequently these checks should be made. Some staff said the checks were every 30 minutes and others told us they were hourly. The care plan stated checks should be each 30 minutes during the day and hourly at night. This had not always happened and records for the day before our inspection showed they had been checked hourly during the day and night. On one day of our inspection at 2:35pm the last record of a check made on this person was at 1pm. Staff were not sure where the person was but we located them sitting alone in their bedroom. At 2:40pm we looked at the recording sheet again and saw that entries for 1:30pm, 2pm and 2:30pm had been made by staff retrospectively. There had been no record made of this person's whereabouts for an hour and a half so staff could not be sure they were safe and well during that period. The registered manager said that staff held pocket books and sometimes recorded in these when they had made checks on people, and then transposed the records to the check sheet later on. When we spoke to staff about recording checks on people, none mentioned the use of pocket books or showed them to Inspectors.

At our last inspection people who were unable to use call bells were calling out frequently. At this inspection that situation had improved and we did not hear people shouting for staff assistance. However, staff told us that people who were unable to summon assistance with call bells would be checked every 30 minutes. Records for the two people we reviewed showed that checks were generally made hourly, but that there were some occasions when gaps between checks were longer. For example; there were gaps of two, three and five hours for one person. Confusion amongst staff about how often people should be checked meant this did not always happen in line with care plans designed to keep people safe.

At our inspections in January and September 2016 we highlighted that people's creams had not always been applied in line with prescriber's directions or that there was limited information for staff about where to apply them. At this inspection similar issues were found. For example, there were no instructions to show where one person's cream should be applied and it had only been applied once a day rather than twice as prescribed on three days out of the previous seven days. This person had a current skin wound. Another person whose care plan showed them to be at risk of skin breakdowns had their prescribed cream applied once daily instead of twice daily on five days out of the previous seven. People had not received the full benefit of the creams that were designed to protect their skin.

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

Other assessments of risks to people were more detailed and listed preventative actions to be taken by staff in case of, for example, falls. One person had experienced a number of falls and as a result their bed had been lowered to reduce the likelihood of serious injury if they fell out of bed. Alarm mats were in place to alert staff if people were moving around their rooms and might be at increased risk of falling and care plans reminded staff to check alarm mats were in good working order each day.

At our last inspection some people had walked into other people's rooms uninvited and removed their

personal property. At this inspection door alarms had been activated to make staff aware when people were in others' rooms.

At our last inspection equipment had not always been properly used or maintained. At this inspection air mattresses had been replaced with automatically inflating ones to prevent them being set at incorrect levels for people at risk of skin breakdowns. However, one person had been injured by a different piece of equipment, which had resulted in them requiring treatment in hospital. An incident report made by staff documented that the equipment mechanism had caused the injury and was 'Not safe'. During the inspection this person continued to use the same piece of equipment. The registered manager told us that they had visually checked it over and could not see how the injury had occurred. Following the inspection we were told that maintenence staff had also checked the chair and cleared it for use .However, we were informed that the injury to this person had been unwitnessed and an incorrect assumption had been made that the injury was caused by the chair. Incident reports and care records for this person documented that staff had been present at the time of the injury and therefore knew how it had been caused

The failure to ensure equipment is safe is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Injuries to people such as unexplained skin tears and bruising had been documented onto body maps by staff. Some records showed 'Massive bruising' or bruising to both forearms at the same time. There were a large number of completed body maps seen during the inspection. Most of these injuries had not been reported by staff on incident or accident forms. The registered manager told us that because of this, they had been unaware of many of the documented injuries. Similar issues had been highlighted at our inspection in January 2016 but had improved by our inspection of September 2016. However, our findings at this inspection showed the improvement had not been sustained and people were at risk because of it.

Staff told us that their responsibility ended once they had reported the injuries to nursing staff, but nurses said that incident reports should have been completed. We tried to case track some of the injuries to see what staff did next but found that daily notes made by staff rarely mentioned the initial injury or any treatment or follow-up action. There had been no conversations between the registered manager and the local safeguarding authority about some of the unexplained bruises, to determine whether investigations should be carried out to establish how and why they had occurred; and to prevent further incidences.

All staff had received safeguarding training and those we spoke with could describe different forms of abuse and how this might present. However, none of those staff had made the connection between unexplained bruising and other injuries and their responsibility to keep people safe. There had not been a robust and effective safeguarding process in operation at the service.

The failure to appropriately protect people from potential abuse or neglect is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our inspections in January and September 2016 recruitment systems were not adequate to ensure that only suitable staff were employed. One area highlighted in September 2016 was a long gap in the former employment details of a staff member; which had not been explored by the manager. At this inspection there was again an unexplained gap of seven years on a newly-recruited staff member's application form. This had not been addressed to establish what they had been doing during that period and meant the provider could not be sure of the staff member's background before making the decision to employ them.

The failure to properly and consistently operate a robust recruitment procedure is a continued breach of

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

All other checks and documentation in relation to staff recruitment were complete. Proof of identity; including recent photos had been retained and Disclosure and Barring Service (DBS) clearance had been sought in all cases to provide some assurance about staffs' character and suitability for their roles.

At our previous inspections in January, September and November 2016, medicines had not been consistently managed safely. At this inspection medicines were observed to be administered correctly, with staff checking the right people received the right medicines. The service operated a computerised system which helped to significantly reduce the possibility of errors and records showed people had been provided with their medicines consistently.

Medicines about which there are special legal requirements were stored securely and had been checked daily and weekly to ensure stocks were correct and that safe practices were followed. The medicines rooms and fridges were maintained at suitable temperatures and these were recorded daily. Where some people received their medicines covertly or without their knowledge, there were proper authorisations and best interest decisions documented.

The premises were in a good state of repair throughout. Staff and visitors were invited to write any maintenance issues into a book and these were promptly actioned by maintenance staff. Environmental safety checks had been regularly undertaken .These included emergency lighting, fire alarms and extinguishers. Personal emergency evacuation plans (PEEPs) were in place to provide guidance to staff if it became necessary to evacuate the premises. Water temperatures were tested and documented to make sure they were within safe and appropriate levels. Routine servicing had been carried out by a professional contractor on hoists and other equipment such as special baths. The passenger lift had a service history and had been maintained to prevent the possibility of breakdowns.

Inadequate

Is the service effective?

Our findings

At our previous inspections in January, September and November 2016 people had not always been protected from the risks of poor nutrition and/or hydration. At this inspection food recording charts had generally improved but we continued to have concerns about how much people were drinking.

One person's care plan stated that staff should encourage fluids to help prevent any skin breakdowns. There was no individual target amount documented to show staff how much would be reasonable for this person to drink and staff gave varying responses from one to two litres per day. Fluid charts showed that on the first day of our inspection this person's last drink of the day was 'one sip' at 3:30pm; although records made up to 7:20pm showed they had either refused drinks or tipped them over. There was nothing to show that the spilled drink was replaced. The next fluid intake for this person was not documented until 11:05am the following day; a gap of more than 19 hours between drinks.

Another person's fluid chart showed exactly 200mls had been drunk on 13 occasions from late morning until early evening at intervals of between 20 minutes to an hour, with a total of 2770mls throughout the day. This was an unusually high fluid intake for an older person weighing around 40kgs and it would be unlikely that a person would drink exactly 200mls each time, especially given the short gaps between some drinks. According to the fluid input and output recordings, this person had only one wet pad between 3:30pm that day and 4:15am the following morning, despite the fluid charts documenting they had drunk 1600mls between those times. This would indicate that they had not actually drunk as much as was shown on the charts. There was a gap of more than 18 hours between documented drinks for this person on other days, with the last recorded fluid taken at 5:10pm one day and the next not until 11:40am the following one. The registered manager said that people were given ice pops to encourage fluid intake but there was no record of these being provided for any of the people we reviewed.

The registered manager assured us that people were receiving enough to drink. However some of the fluid charts we reviewed showed people had not had a drink for long periods. Although drinks were visible in most people's rooms and beside them in lounges throughout the inspection, one relative told us "[Person's name] keeps getting water infections-they leave drinks on the table in his room that he can't reach, so I'm not sure if he's drinking enough". Comments from the February 2017 survey included ' Morning and afternoon drinks are not always taken to residents in rooms' and 'We have requested an hourly tea for our mother as she is unable to make her needs know, but this does not happen'.

At our last inspection, fluid intake for people with urinary catheters was highlighted as a concern. Although catheter management overall had improved at this inspection, one person's care plan recorded that they should drink 'Six to seven cups a day'. No fluid chart was being kept for this person and when we asked staff how they would know if this person had drunk this amount they replied "We would just know" and could not elaborate. This was not a reliable or effective way of ensuring healthy hydration.

At our inspection in September 2016 people had not always been referred to a dietician in a timely way if they lost weight. At this inspection people had been referred for professional input, but there had still been

some delay in this happening, which could place people at increased risk to their health. For example, one person had lost 4.1kgs between December 2016 and mid-February 2017 but was not referred to a dietician until mid-March. The registered manager told us that a new system for identifying weight loss had been introduced in March 2017 and accepted that this person should have been referred for professional advice sooner. At the time of our inspection the person had lost 5.2kgs in total and the dietician had yet to visit to assess them due to high demand on their services. Interim advice had been provided by the dietetic service and this was generally being followed but there was one occasion in the week prior to our inspection when the person had been asleep at breakfast time and nothing else was offered until lunch. On another day that week, there was no record of any lunch or mid-afternoon snack. Charts did not evidence that the person had been given a pint of full cream milk each day, as recommended by the dietician, but they had a milkshake or smoothie on some days. There was a lack of consistency in ensuring this person received good nutrition while awaiting the dietician assessment and staff had not updated the kitchen with the dietician's interim advice, even though this had been received by the service on 23 March 2017.

The failure to mitigate risks to people from poor hydration and nutrition is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspections, recording of what people had eaten was not consistently detailed enough to show nutritional content. At this inspection most food charts were well-completed to detail the types and amounts people ate. However, there were still occasions when staff entered 'Puree meal' or 'Pudding' without noting what the meals consisted of. This is an area for further improvement so that the nutritional make up of meals can be assessed to ensure people are receiving adequate input from all food groups.

We received mixed feedback about the food offering with some people saying it was "Excellent" and others that it was "Adequate" or "Just OK". One person told us that "Fish is like a bit of cardboard" while a relative commented "Quality and variety of food is really good-they will try to tempt her with things she likes when she is not eating well". The lunchtime experience differed greatly between floors, with downstairs tables being laid with cloths and flowers and a hand-written menu. People chatted together and lunch was a sociable occasion. On the first floor none of the tables were laid for lunch on the first day of our inspection but were on the second day. Staff were rushing around to try to support the many people who needed support to eat and as a result there was a chaotic atmosphere with some people waiting 40 minutes to be served, while others around them ate.

People were given a choice of meals, which looked appetising. Pureed meals were served with each component separate on the plate so that people could enjoy different tastes. Staff were kind and attentive when supporting people to eat and made eye contact and conversation throughout. Fresh fruit smoothies were offered to people and snacks and biscuits were given out at regular intervals.

At our last inspection skin wounds had not always been well-managed. At this inspection we continued to have concerns in this area. Staff told us one person had a pressure wound that was "Getting better". It is good practice to photograph skin wounds to map their progress but there were limited, blurred photos of this person's wound. Nursing staff were unable to find more recent photos for us to see and had to telephone an off-duty colleague to find out where they were. They were eventually located but we were unable to gain assurance from these that the wound was improving. Staff took a new photo of the wound when they next provided the person with personal care. This showed that the wound had deteriorated and was not getting better as staff had said. Staff had not recognised that the wound had become worse until we asked for the up to date photo, which posed a risk that the person may not receive appropriate treatment. A referral was made to the specialist Tissue Viability Nurse (TVN) during the inspection.

Records about this person's skin showed that they had two separate wounds but these became confused within notes made by staff and it was difficult for us to work out exactly what had happened with each. Nursing staff assured us that one wound had healed, but records were conflicting and posed a risk that staff would not know to which was being referred. Another person had a wound on their leg and photos of this showed the person wearing odd socks with clear and deep indentations where the elastic on them had made imprints on their legs. This can cause restricted blood flow which may delay healing, but had not been recognised by nurses managing the wound.

There was no specific care plan for a person with a condition which required individual equipment to be used. There were no directions for staff about cleaning parts of the equipment which was important for maintaining the person's well-being. Nursing staff said that one part of the equipment was changed every three months but did not understand that a cleaning regime should be operated in between. This person's condition meant that good mouth care was necessary but there were no records to show if and when they had been supported with this. Another person was noted to have poor oral hygiene and there were no records or notes to document when their teeth had been cleaned. Staff said that teeth brushing was part of "Normal personal care" and was not separately written into daily notes of care given. However, this person's teeth were heavily plaqued and dirty and their breath was not fresh following their morning personal care.

There was no person-specific guidance for staff about managing high or low blood glucose levels for people living with diabetes. Staff showed us a generic printout of information from the internet which was aimed at diabetic patients rather than nursing home staff. There were no specific diabetes care plans in place for people to include foot and eye care and dietary needs. There was a risk that staff would not know how to treat individual people appropriately.

People's health risks had not been appropriately assessed and minimised which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person's skin wounds had been properly managed, with advice being sought from the TVN and followed by staff. The wound had healed completely and regular photos tracked the healing process clearly. People had access to opticians, chiropodists and dentists; and appointments and outcomes were documented in peoples' care records.

There were clear urinary catheter care instructions in place; including when they were due to be changed, the size and type of catheter. All staff we spoke with knew how to clean equipment and catheter sites appropriately and to check that urine was draining correctly. Staff had received catheter care training from a specialist nurse and were confident in their knowledge of how to manage catheters effectively.

At our inspections in January, September and November 2016, training had not been effective and staff had not received regular supervision. At this inspection, staff said they received regular supervision sessions and had received more training in a wide range of subjects. Our findings showed that not all staff training had been effective in equipping staff to carry out their roles, and that supervision had not picked up on this.

For example; some nursing staff were unclear on correct actions to take if people choked, safeguarding training had not been sufficient to alert staff to the potential for abuse when people had unexplained bruising, fluid monitoring and recording was still inadequate despite training and not all staff were able to recognise deterioration in skin wounds or knew how to prevent restricted blood flow from people wearing tight socks.

The failure to ensure staff received adequate training is a continued breach of Regulation 18 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us "Most of the nurses are well-trained and efficient" and a relative commented "On the whole they seem to be well trained". New staff completed the Care Certificate within 12 weeks of starting work in the service. The Care Certificate is an agreed set of standards that health and social care staff follow in their daily working life. Inductions included a day of shadowing experienced staff. One staff told us "A day's shadowing is not enough for new staff". They explained that there was too much to learn in this short period and that they felt staff would benefit from a longer and more detailed induction. This is an area for improvement.

The principles of the Mental Capacity Act (MCA) 2005 had not always been followed in practice. The 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People's capacity to make their own decisions had been assessed and was properly documented in most cases. However, one person was using equipment which effectively restricted them from mobilising freely. No MCA assessment had been made specifically about the use of this and there were no records of a best interest decision to show that less restrictive alternatives had been considered. The registered manager told us that the equipment was in use for the person's comfort and that they were not being restricted. However, daily staff notes made a number of references on different days to the person becoming agitated and expressing that they wished to move from it.

The failure to work within the principles of the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed offering people straightforward choices and seeking their verbal consent when giving care. For example; staff showed people two meals and supported them to make their selection. People were asked gently and politely whether they would like to wear a food protector while eating their lunch and staff listened to people's responses. Reminders for staff about the principles of the MCA were on display at nurses stations. Appropriate MCA assessment and best interest decision documentation was in place where people received covert medicines.

Requires Improvement

Is the service caring?

Our findings

We received mainly positive feedback from people and relatives about staff. One person said "You cannot fault them on care- they are all kind and friendly". Another person told us "The care here is very good, improved I think in the last few months; everything seems better and they're more compassionate". A relative commented "I love the atmosphere, it is very friendly and they obviously care about the residents". Other people said that staff did their best but were very busy. For example; "I think carers work very hard. They haven't time to sit and chat because they have so much to do".

At our inspections in January and September 2016, people's needs were not always met promptly. At this inspection we continued to hear from people that call bells were not always answered quickly enough to prevent them being incontinent. Although call bell analysis data provided to us showed almost all call bells were answered within a maximum of 15 minutes, several people told us that staff cancelled bells and went away without assisting them due to more urgent tasks. One person had made formal complaints about call bell response times and data showed they had waited one hour and 56 minutes on one occasion. This was not considerate of people's dignity and had not been fully addressed despite having been previously highlighted as a concern in our reports.

People's dignity was not consistently preserved which is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had no other concerns about people being treated with respect. Staff addressed people in the way they preferred and people were dressed appropriately and comfortably. When people were supported to move with hoisting equipment, bare legs were covered and staff reassured people throughout. Staff knocked on doors and called out to people to let them know they were there or ask permission to enter. One person said "They [Staff] always knock before they come in" and a relative told us "I came unannounced one day and listened outside [Person's name] room and heard the carers talking during personal care. They were instructing [Person's name] on everything they were doing and covered them discreetly with a towel". Another relative commented "They always shut the curtains during personal care for dignity". People's confidential information was stored securely and staff were mindful of people's privacy when speaking with them. Staff were discreet when reminding people to use the toilet and when speaking with each other about care tasks to be completed.

Our observations showed that staff were kind and courteous to people throughout the inspection but that other needs were not always met in the most appropriate way. For example; one person complained of a specific pain. Their relative told us that the GP had prescribed a cream specifically for pain in that area. Staff did not apply the cream when this person said they were in pain but gave them Paracetemol instead. Staff told us that the cream had been prescribed at three times daily and was applied at breakfast, tea and bedtime. However, no consideration was given by staff to the fact that this person could have had an application of the cream in the early afternoon when they were in pain instead of waiting until teatime and providing a non-specific pain relief in the interim. The prescriber's instructions were three times daily and there was a much longer gap between breakfast and tea than tea and bedtime. Although the person

received pain relief, it was not the most appropriate for them and staff had acted in a task-orientated way rather than responding to the person's needs.

Another person had been assessed by a physiotherapist who left instructions for staff to support the person with exercises, to help them remain independent for as long as possible. There was no record to show that this had happened and in fact there were notes from the physiotherapist to say that the person reported that they had not often done the exercises with staff. Nursing staff told us that the person did not need support from staff, but this contradicted the instructions from the physiotherapist. Identified needs had not consistently been met.

The failure to appropriately meet people's needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans about people's end of life care contained little information about personal preferences. Details mainly centred on whether there was a Do Not Attempt Resuscitation (DNAR) order in place and funeral arrangements, in those we reviewed. Although there was general guidance for staff in some cases about offering reassurance and chatting to the person and family, there was no information about the people and things that might be important or comforting to them. One person was reaching the end of their life during our inspection. Their care plan made no reference to how often they should be checked or guidance to staff about how to respond if they expressed fear or distress.

The registered manager told us about the care provided to a recently deceased person and their family. They said staff had received training from a specialist nurse and would recognise the signs that a person might be reaching the end. The registered manager said a new more comfortable bed had been sourced for the dying person and that a member of staff had stayed with them at all times. Music and hand massages had been used to help the person relax and staff had ensured the person left for their final journey in their favourite outfit. However, this level of input and detail was not reflected in care plans or notes and is an area for improvement. A relative told us "The staff are very tuned in to family's needs. They spoke to us very caringly and gently about end of life care and put us at ease with a very difficult subject".

People and relatives generally felt that they were kept informed about care decisions. One relative told us "Having the information file in the room is excellent; it's a mine of information for family members". Another family member said "It is good to be able to look at the daily notes on-line; especially if you are on holiday or unable to visit-it puts your mind at rest". A relative said "They ring me if there are any significant changes or needs". However one relative said they were not consulted about a decision to move their loved one to a different room and a person told us "I don't always get told what's going on, which can be annoying".

The accents of staff for whom English was not their first language caused some people and relatives difficulty. This was raised in our previous inspection reports. At this inspection some people said they could not always make their needs understood and one relative told us " The home phoned me to tell me Mum had had a fall, however I couldn't understand the member of staff which caused me some anxiety at first until I realised she was fine". Communication is therefore an area for improvement and following the inspection the provider informed us that all staff are assessed before being employed to ensure they have a good command of English language. .

Staff were gentle and considerate when interacting with people during the inspection. One staff gave a person living with dementia a baby doll when they became agitated and spoke soothingly to them to help them relax. Another staff had cheerful banter with a person who clearly enjoyed the attention. People appeared comfortable with staff, were well-presented and some ladies had been supported to wear a little

make up. A relative told us "It's important to Mum to be turned out nicely; it's a reminder of who she was and she holds on to that". Another person did not have English as their first language and relatives had provided a glossary of words for staff to use. They commented to us that staff often used them and that "They do listen. They make suggestions and usually we're on the same wave-length". A staff member told us "I see people here as my family.

Requires Improvement

Is the service responsive?

Our findings

At our inspections in January and September 2016, complaints had not been properly managed in line with the provider's own policy. At this inspection, there had been improvements in the documenting of complaints but actions taken in response to them were not always robust or effective. For example; we read complaints about poor call bell response times where the actions were recorded as 'Staff instructed to respond ASAP' and 'Discussion with carer re; more rapid response to buzzers'. These actions did not establish the root cause for the delays and the problems still continued during our inspection.

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

People and relatives said they knew how to complain and one person told us they felt complaints were now handled "More generously" than previously. During the inspection relatives complained to the manager about an issue with their loved one's property but told us "It was a lack of communication and I'm confident it will now be resolved. The manager is very approachable and listens".

Care plans had been written in a person-centred way and documented people's likes and dislikes along with detailed information about their care needs. However, information in care plans did not always agree with various other records in use in the service. Care plans were maintained on a computerised system called Residata but alongside these records there were, for example; folders containing food and fluid charts, body maps and other paperwork kept in people's rooms, paper care files, wound records, weights books, pain charts, clipboards containing rooms check sheets, meals lists, whiteboard information and kitchen files. This created opportunities for mismatched information that could lead to inappropriate care.

For example; one person's room folder contained a laminated notice reminding staff to 'Strictly' adhere to SaLT directions that the person should have thickened fluids. This person was drinking un-thickened fluids during the inspection and nursing staff told us they had discussed this with SaLT by telephone. However, they were unable to produce any records about the conversations, even after they made contact with SaLT during the inspection. We asked to see SaLT advice for 19 people but only received it for three people after spending three days at the inspection. Dietary sheets for some people had not been updated for kitchen staff so they were unaware of the latest advice and there was a risk it might not be followed in practice.

Another person's care plan stated that they must not sleep in their armchair but other records noted that they had done so on a number of occasions. Fluid charts for a further person were missing for a whole week despite care plan instructions that drinks should be documented. The registered manager told us that one person was completely immobile but notes made by staff less than two weeks before the inspection recorded that they had been 'Walking about'. We noticed that a line was added to this person's care plan about mobility on the last day of our inspection to state' Able to walk a few steps'. A relative responded to a recent survey by saying 'The Resilink facility [Allows family to access records remotely] is a good tool BUT the reports are not always accurate, which is disturbing'. Another respondent said 'What is on the Resilink is different from what we find'.

Records about two separate skin wounds for one person had become mixed up and created a confused picture of the current position. Nurses gave us differing accounts of the status of the wounds and it took two days of inspection to clarify that one wound had healed. Nurses had told Inspectors that the second wound was improving, but we were able to establish that it had in fact deteriorated. The conflicting notes and confusion amongst staff had led to this deterioration being overlooked.

Pain assessment tools were in use but when a person was given Paracetamol after they complained of pain the assessment tool was not completed immediately. Staff told us that they completed the pain scale information at the end of their shift; but this practice gave rise to the possibility of errors occurring and was not helpful in providing a way of monitoring any improvement or decline in people's well-being.

The poor use of English in some care plans made them difficult to understand or muddled. For example; one person's care plan about incontinence stated 'Staff to support her during this embarrassing period which she feels ashamed and unworthy' [sic]. Another said 'Enjoys a large breakfast' in one sentence and in another 'Eats small meals' and a further care plan had the wrong person's name written in the section about communication. All of these issues provided the potential for people to receive inappropriate care and treatment.

There were many occasions during the inspection when staff and the registered manager were unable to provide us with the information we requested or there were long delays while staff searched for relevant records. There were many body maps showing skin tears, bruises and other minor bodily soreness or irritation in people's room folders. The registered manager and staff were unable to provide any further information in most cases about what had happened next. For example, one person had a sore and bleeding navel and this was recorded in nursing notes to be monitored daily. There were no further records or mention about the navel at all. In other instances where staff had noted skin or body issues there were no further records about them whatsoever, so there was nothing to evidence any actions taken by staff to treat them. The registered manager told us that people had received appropriate support and treatment but was unable to provide records that supported this.

The failure to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were treated as individuals and staff were able to tell us about people's different personalities and preferences. For example; staff knew that one person enjoyed bird watching so helped them to position themselves to have a clear view of the garden. Another person became agitated and staff knew that they could be distracted by offering them dusters and a chance to "Help out" and staff told us how a further person referred to their favourite drink. A relative told us that staff had gone out of their way to find a picture for their loved one's door which depicted what they had done as their profession. Some people said that agency staff were not so good at knowing them. One person told us "They don't know my routines or my needs" but the registered manager confirmed that agency staff usage had decreased significantly and recruitment of permanent staff was on-going.

There was a wide range of activities on offer to all people using the service. Staff showed great patience when supporting people living with dementia to make biscuits during the inspection. People enjoyed the activity and those who were not directly involved watched and laughed when staff's hands became covered in the sticky mixture. Another staff member took a large sea shell to individual people and invited them to "Hear the sea" which then prompted lively conversations about trips to the seaside.

Activities coordinators were employed full-time on both floors and the service subscribed to 'Ladder to the

Moon'. This is a scheme which provides monthly conversation boxes and prompt cards, together with training for staff to help them make the best of the equipment. A varied programme of activities was advertised and included; music sessions, chair exercises and memory games. A rock and roll singer entertained people during our inspection. The music was very loud but people really seemed to enjoy it and were dancing or tapping their feet throughout.

Some people preferred to stay in their rooms rather than join in with organised activities. Coordinators regularly visited those people to provide conversation and stimulation and played board games or puzzles with individuals. One person told us "I don't have much to do with the other people that live here; I'm quite a private person, but I'm happy with the service". Church services took place within the service for those who wished to attend and birthdays were celebrated. One person had a birthday during the inspection and staff brought out a homemade cake and sang while the person opened presents with their family.

A number of outings had taken place and more were planned. These included fish and chips at Dungeness, a garden picnic, a pub outing and a trip to the seaside. There were caged rabbits and chickens in the garden and people were observed talking to the animals and enjoying feeding them. The garden was enclosed and attractive and people sat in it or walked with care staff for a change of scene, if they were less interested in the pets. Staff told us how they were now managing to take some people living with dementia out of the service for bowling and other activities. One person had recently visited a garden centre and their relative wrote to the registered manager to say 'It is my wish to express my sincere thanks to all those members of staff that were responsible for [Person's name] recent outing to the Tenterden Garden Centre: that was indeed some achievement. I commend your entire care team, well done and thank you.'

Inadequate

Is the service well-led?

Our findings

The service was not well-led. Woodchurch House has been inspected four times since January 2016. It was rated as inadequate overall in January and November 2016 and May 2017. In January 2016 the service was placed into special measures and we served eight warning notices on the provider. At the September 2016 inspection there had been some improvements but these were not sufficient to meet all the warning notices and the service was rated as inadequate for safety and remained in special measures. Following the September 2016 inspection we received information of concern about people's safety and well-being at the service and we carried out a focussed inspection in November 2016. This resulted in the overall rating for Woodchurch House being reduced to inadequate because any improvement had not been sustained and we remained worried about people's safety and the management of the service. The service has been in special measures therefore since January 2016 and has been monitored by the CQC, local authority, Clinical Commissioning Group and other professionals. The provider attended regular meetings and provided action plans which stated that improvements had been made in the areas we highlighted during our inspections.

There had been insufficient management oversight to ensure that all the issues we had previously reported on had been properly resolved. At this inspection the registered manager had been in place since January 2017 and told us that they and staff had worked extremely hard to bring about change for the better. They said that they needed more time to make all the improvements needed but was determined to do so. Feedback we received from professionals prior to this inspection indicated that Woodchurch House was gradually improving; but our findings did not always agree with this.

Although the general management of medicines had been improved, people's prescribed creams were still not being applied in line with the prescriber's instructions. These people were at risk of, or already had skin breakdowns and the lack of regular application of their creams meant they had not received consistent benefit from them. People were no longer observed to be calling out or being passed by, but records of regular checks on people to keep them safe were inconsistent and sometimes completed retrospectively.

Risks to people from choking, for example, had still not been properly addressed, despite this area specifically featuring in our previous inspection reports. Staff continued to be deployed in such a way that people on the ground floor had a different mealtime experience from those living with dementia on the first floor, and some people stated again that delays in call bell responses left them incontinent at times. Similar situations had been reported by us following our former inspections, but robust action had not been taken to resolve the issues.

New concerns also emerged at this inspection. Staff reports about injuries and bruising to people had not been escalated and the registered manager said they were unaware of them. There had been a breakdown in communication which left people exposed to risk of harm. The provider contracted a Group Quality Auditor to make regular checks on the service but they had not picked up on the issues with these injuries because they told us they did not include reviewing body maps in room folders as part of their audit. They relied on information about bruising and skin tears to be completed on incident forms and uploaded into Residata, but this had not happened so their report to the provider about incidents and accidents was

based on flawed data.

The failure to assess, monitor and mitigate risks is a continued breach of Regulation 17 (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The risk to people from poor catheter management had been addressed and staff were now confident and competent in this area.

Quality assurance processes had not been successful in recognising that fluid charts showed some people were not drinking for long periods at times. The registered manager told us that certain staff were allocated to check charts every day and take action if there were any problems, but this had not worked consistently and left some people still at risk or poor hydration.

Poor staff training and understanding had not been picked up through supervision, this was evident in the management of some people's wounds, one of which had deteriorated and not been recognised by staff. Some people continued to tell us that a lack of a good command of English in some staff adversely affected their experience of life at the service, but the registered manager had recently recruited care staff who clearly had very little understanding of the language.

Records were kept in many different places, were sometimes inaccurate and others were not made available to us at all despite repeated requests. This situation created opportunities for confusion and error but had not been identified or remedied through quality assurance checks.

The failure to assess, monitor and improve the quality and safety of the service is a continued breach of Regulation 17 (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Feedback had been sought from people and their relatives by way of a survey and meetings. However, our findings at this inspection showed that this feedback had not always been acted upon. For example, minutes of a relative meeting in January 2017 showed that the inaccuracy of Residata information was raised. This continued to be a problem during our inspection three months later. Call bell response times were mooted as a concern but we continued to hear complaints about long waits.

Responses to the survey issued in February 2017 showed that some relatives queried whether people received enough drinks. We found that there were long gaps between fluid intake for some people, so this point had not been adequately resolved.

The failure to act on feedback is a breach of Regulation 17(e) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were some occasions however when actions had been taken in response to feedback. One person told us that they had been given a new mattress but that this was proving uncomfortable for them. They had told staff about this and a replacement was being sought during our inspection. Another person said "I approached the manager three times to change rooms- now I have this lovely one".

There was a friendly atmosphere in the service and staff told us they enjoyed working there. One staff said "The staff are happier now and we all get on well". Another said "I know we've had bad reports in the past but I've always been proud to work here". Although staff tried to be helpful and cooperative during the inspection, there was a lack of accountability and confidence which meant that they frequently referred us to other staff for answers to our queries or went to collect documents we had requested and then did not

return. One staff told us "We had made loads of improvements but now it's slipping-some staff have got lazy and complacent and records aren't being completed properly or kept up to date". Other staff felt things were much better overall.

Staff said that they attended regular meetings and felt able to voice anything they wished with the registered manager. They said they had confidence in them to make the necessary improvements at Woodchurch House. One staff said "I think a lot of the problems in the past were because we had so many new managers but now we are more stable". Most people and relatives told us they found the registered manager approachable. One person said "The new manager has introduced herself and I'd have no problem complaining to her if I had to". A relative said "You can come any day, anytime and you're always made welcome, If you've got any little problems they're sorted straight away".

Links with the local community had been fostered through weekly visits from church ministers and with schools whose children provided entertainment for people on occasions. The service's activities programme had been extended to include trips to local pubs and restaurants which also gave people opportunities to spend time with others in the community and in a different setting.