Keslaw Limited

Woodcot Lodge Care Home

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?	**Requires improvement**

Overall summary

This inspection was unannounced and took place on the 30 September, 1 October and 6 October 2015. Woodcot Lodge is a nursing home which offers personal and nursing care to 85 older people, some of whom live with dementia. The home has three floors, with a lift providing access to all floors. The second floor accommodates people living with dementia and the first floor accommodates people with nursing care needs. The ground floor is referred to as 'residential' and accommodates older people who do not fall into the other two categories. At the time of our inspection 52 people were living at the home.

The home did not have a registered manager. 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 home had an acting manager who in this report is referred to as the manager. They advised us they would be applying to the Commission to become the registered manager.

Summary of findings

There had been a history of non–compliance with the regulations at this service since September 2013. Following the last inspection on 4, 5 and 12 March 2015 we rated the service as inadequate. We found breaches in relation to staffing recruitment, staffing levels, skills, training and supervision. We identified breaches with medicines, complaints not being investigated and recorded. Breaches also related to poor records, food and nutrition and a poor quality assurance system. Breaches over peoples care and welfare remained, people were not being treated with dignity, privacy and their choices were not being promoted. People had poor personal risk assessments and care records were not personalised.

At this inspection we found improvements had been made, the attitude of the majority of staff was caring and the atmosphere of the home was calm. However whilst improvements had been made the service still needed to make sure it continued to improve as it had still not reached compliance with all previously breached regulations

We found risk assessments had been completed but these did not look at the overall risk or take into account the person's changing needs. This was a repeated breach from the previous inspection. Staffing levels were adequate to meet the needs of people, which was an improved picture since the last inspection. We found staff were receiving supervision and felt supported in their role and were receiving training to carry out their roles, which was an improvement on the last inspection. Staff understood safeguarding protocols and knew who to report concerns to. Medicines had improved but a few errors were still occurring.

The principles of the Mental Capacity Act 2005 were not always being applied as people did not always have capacity assessments, and best interest decisions were not always made, which was a breach of regulation. We found a repeated breach relating to the poor nutritional and hydration needs of people as staff did not always know people's nutritional needs. We found people had access to a range of health professionals.

Staff had a caring attitude and knew people as individuals. People had their privacy respected and were treated with dignity some of the time. This was an improvement from the last inspection. At times there was a lack of attention to detail when supporting people with care.

People were not involved with their care planning. The care planning did not result in all people being provided with personalised care which met their needs. This was a repeated breach.

Complaints were being recorded, logged and investigated. This was an improvement on the last inspection.

Whilst the quality assurance system had improved it was still not adequate to ensure lessons were being learnt to prevent further events and this was a repeated breach.

Records were still not being adequately maintained to ensure they reflected people's needs were being met. This was a repeated breach.

We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Risk assessments had been completed but these did not always take into account when the person's needs changed.

Staffing levels were adequate to meet the needs of people, but there was concern these would not be adequate if people's needs increased or there was an emergency situation.

Staff understood safeguarding procedures and referrals were made appropriately.

Medicines practices were improved, although a few errors were still taking place.

Is the service effective?

Requires improvement

The service was not always effective

Staff were receiving adequate support and training to ensure they could meet people's needs.

The principles of the Mental Capacity Act 2005 had not always been applied to ensure any restrictions to people were made with the proper authorisation

People's nutritional needs were not always being met or monitored closely enough.

People had access to a range of health professionals.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were caring and treated people as individuals. At times there was a lack of attention to detail when providing care.

People were given privacy but not always treated in a respectful manner.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans did not include the involvement of the people they related to.

The detail of information in care records varied but they were not personalised and did not result in people having their needs met at all times.

Complaints were being logged and there was evidence these were being addressed.

Summary of findings

Is the service well-led?

The service was not always well-led.

The quality assurance system was not adequate to ensure lessons could be learnt from analysis of information.

Record keeping was not adequate to ensure records reflected all care was been given to keep people safe and healthy.

Requires improvement

Woodcot Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 30 September, 1 & 6 October 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in the care of frail older people, especially people living with dementia and those with end of life care needs, 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. The expert had experience of caring for people who have dementia. The lead inspector and the specialist advisor visited on three days, one inspector for two days and the expert for one day.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, safeguarding meeting minutes and notifications. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spent time talking to two regional managers, the manager, 15 people, six relatives, 12 members of staff and one GP. We looked at minutes of staff meetings, residents meetings, policies and procedures, monthly reports by the regional manager and the complaints log. We looked at eight staff recruitment files, training and supervision records and the care records of 14 people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff.

Requires improvement

Is the service safe?

Our findings

The relative of a person told us, "She is definitely safe here. The staff have always been brilliant. Sometimes we have to wait several minutes if she wants to go to the toilet. They do ask about things and keep us informed: For example, if the doctor's been out." Another relative told us, "They always seem short staffed especially at weekends and often I see people I don't recognise. You get a sense they're stretched".

At the last inspection in March 2015 we found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010) which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of risk assessments in place to ensure the safety and welfare of people. During this inspection we found the use of risk assessments had improved but there was no overview of people's care to ensure their whole care provision was being monitored and risk assessed.

People had risk assessments in their care folders, which related to the sections of their care plans. These had been reviewed on a monthly basis. However, there was concern this was more of a paperwork exercise and did not join up the overview of the risks for each person. For example we could see from the incident logs dated August 2015 – September 2015, there were three medicines errors, six incidents where there had been physical aggression between people, one person had absconded and at least nine people had fallen. Three of these people had fallen on more than one occasion, but this information had not been included in monthly reviews of people's risks. In another example a care plan detailed a person had behaviours which may affect other people, but the risk assessment did not detail how this was to be managed. The risk assessment did not detail how many incidents there had been that month and if the risk assessment was still appropriate and effective. In another example the 'nutrition' care plan detailed a person had a poor fluid intake. However whilst the intake was being recorded on most days, the outcome was not reflected in the monthly risk assessment. In another person's 'mobility' care plan which identified the person had 'high' needs in this area it indicated the person needed a stick when mobilising. During the inspection we saw this person walk without a stick over three days. Staff had not taken action to reduce the risk for this person. In another example 'daily notes' referred to the person exhibiting inappropriate behaviour in June 2015 in the 'continence' care plan. However this had not been picked up or added to the relevant risk assessment. In the 'hygiene' care plan there was another mention of inappropriate behaviour, but this had not been added to the relevant risk assessment. In September 2015 following another incident of inappropriate behaviour the risk assessment was updated and the person was put on a fifteen minute observation. However there had been incidents during this time, which may have been prevented if the possible risks had been identified and managed. Risk assessments had been carried out on the environment and improvements had been made. The fire risk assessment dated May 2014, identified high risk areas. It was noted one of these raised concerns over staffing levels at night, in the event of a fire.

The lack of effective risk assessments in place to ensure the safety and welfare of people meant there was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate steps had not been taken to ensure there was always sufficient numbers of staff with the relevant skills to meet the needs of people. During this inspection we found the staffing levels were adequate to meet the needs of people but there was concern what would happen in an emergency or if people's needs increased.

The service used a tool called Care Home Equation Safety Staffing (CHESS) to determine the staffing levels needed to support people. We were advised this was completed monthly and included a review of each person's individual needs. The manager told us the tool identified at the present time the home was overstaffed. The regional manager demonstrated to us how environmental factors and people who were deemed to have extra support needs were taken into account using the tool. However it was agreed the tool calculation for the top floor would not have provided enough staff to meet the needs of the people on that floor. The regional manager advised it was only a guide for staffing levels and there were extra staff on each floor to what the tool suggested. Agency nurses and agency care

Requires improvement

Is the service safe?

staff were still covering shifts in the home, but continuity was being maintained by the home using the same agency staff to cover shifts where possible. The majority of staff told us there was enough staff at the present time to meet people's needs. Some spoke of being rushed at times and two felt they were unable to offer personalised care. Night staff on two floors told us there was enough staff to meet people's needs as long as all went to plan. They advised if people's needs increased or people were not well, or there was an emergency situation this would a create problem of not being able to meet people's needs. One night staff member explained there were two people on their floor which required the support of two staff with personal care, which sometimes increased to three people. They advised they had one person who liked to walk on a regular basis at night, which meant if two staff were providing personal support there were no other staff to respond to people. A night staff member on another floor where there was three staff on duty explained there were at times difficulties meeting people's needs. They advised there were eight people who needed the support of two people for personal care, one person was on a fifteen minute observation if they left their room and there should always be a member of staff in the lounge if people were up. They advised people were up on a regular basis during the night.

At the last inspection we found a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of appropriate recruitment checks before people started work in the home which meant people were at risk of receiving care from people who were not suitable to work with adults at risk. We found recruitment checks had improved but there was still room for improvement.

Appropriate pre-employment checks had been undertaken to ensure staff were of good character; and nursing staff had the qualifications, skills and experience necessary for the work to be performed, including registration with the nursing and midwifery council (NMC). Four of the eight records we viewed did not contain interview notes. One member of staff's records recorded the staff member had left their previous job due to a 'disciplinary' issue. There was no evidence in the staff member's record to demonstrate this had been discussed or investigated and that the home had satisfied themselves about the staff member's suitability. We discussed this with the administrator. They told us, "This member of staff has been here for over five months. They are really good. We haven't had a problem with them." Agency staff profiles included photos of the agency staff member; a CV; a record of the agency staff member's qualifications and dates the agency staff member had updated their training.

Staff were aware of what constituted abuse and knew how to report any concerns. The service had worked closely with the local authority when it had identified safeguarding concerns. Staff were aware of where to find policies regarding safeguarding and felt confident any concerns would be passed on to the relevant authorities.

At the last inspection we found inadequate practices in the administration, recording and storage of medicines which was a breach Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Since the last inspection we had continued to receive notifications from the service regarding medication errors but during this inspection we found an overall improved picture. On the final day of our inspection there was a medicines error regarding covert medicines.

There was an effective system for the ordering of medicines at the home. The disposal of medicines was in line with best practice and records were made of all medicines which required disposal. We checked the controlled drugs (CD) management processes and we found CD's were stored safely. The records relating to CDs were good. Good information was provided for staff about different types of medicines, their risks and contraindications which was available to staff. There was a system of recording the temperature of the room and the refrigerators in line with best practice. As and when necessary (prn) protocols had been introduced and these had been applied to almost all of the medicines prescribed as prn. We reviewed all of the Medical Administration Records (MARS) of people living at the home and found they were in order and had been audited regularly and recently. We identified two omissions on these MARs, which we discussed with staff, who were already aware of these gaps and appropriate action had been taken.

Requires improvement

Is the service effective?

Our findings

People told us, "They (staff) do have training and I think they're good at what they do, yes". "You can just tell they're knowledgeable, they've got their heads screwed on and they talk sense" People confirmed they had access to a range of health professionals. "Yes I had to have the doctor I had pneumonia and they got a Doctor". People also spoke of having their hair done, chiropody, and eye tests. "It's all done here", was a quote from one person who felt all their health needs were met.

At the last inspection in March 2015 we found the principles of the Mental Capacity Act 2005 had been incorporated into people's care provision. On this inspection we found there were inconsistencies regarding the incorporation of the Act

There were differences in the detail in people's care plans regarding assessing people's capacity and the recording of best interest decisions. In some care plans there were very clear capacity assessments for separate decisions relating to areas of the person's care, followed by best interest decisions. For example there were clear capacity assessments and best interest decisions where bed rails were being used. However in other parts of care plans there was no detail regarding the person's capacity and no best interest decisions. For example, one person who was deemed not to have capacity had been moved to another room and they had a movement sensor in their room identifying when they left their room. Whilst these were quite clear restrictions on the person a mental capacity assessment and best interest decision had not been made. The manager had made standard Deprivation of Liberty (DoLs) safeguarding applications appropriately where people were being deprived of their freedom of movement in terms of the building being locked at all times. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority to protect the person from harm. These had been put into people's care plans to ensure staff were aware of them. However we were not assured all staff had a good understanding of the Mental Capacity Act 2005. A nurse told us "I don't understand the Mental Capacity Act. I am doing more training next week". On another floor we saw a person walking in the corridor and trying the exit doors. A care staff member spoke with the person and led them by the hand back to the lounge area. When the care staff member was asked if the person had a DoLS in place they told us, "I don't know." We asked the nurse on the unit if the person had a DoLS, they replied, "I am relatively new. I am not sure." This meant we could not be assured all staff understood the Mental Capacity Act and treated people within the principles of the Act.

The lack of consideration and understanding regarding people's mental capacity and best interest decisions at all times was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found staff had not received regular formal supervision or adequate training to ensure they could meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found staff felt supported and had engaged in training.

The manager published a weekly report on staff who required training updates, which was given to the heads of each floor. We were told, "There are 105 staff employed here. This week we had 92% compliance with mandatory training across the board. The figures are skewed as the system is still carrying a course that is discontinued and we have two staff included in the figure that are on maternity leave. The real figure is closer to 100%." Mandatory training and rates of completion included: basic life support 91%; medicine administration 100%; safeguarding children 90%; safeguarding adults 96%; COSHH (Control of Substances Harmful to Health) 96%; equality and diversity 94%; fire safety 96%; food safety 93%; health and safety 94%; infection control 96%; information governance 88%; mental capacity act 89%; moving and handling 43%; allergen awareness 95%. The organisation's own dementia services team was providing on-going training to staff. This included observations of staff practice and one to ones with staff about skills and managing behaviour. Training had also been provided from the Alzheimer's society. We saw six staff had attended training with the Alzheimer's society.

The manager had a grid of when supervisions had happened and when they were next due. Staff received individual supervision bi-monthly and reflective practice sessions. The records from the reflective practice group

Requires improvement

Is the service effective?

supervision on 24 September 2015 from the top floor were viewed and this had involved a case study and staff discussion of reporting incidents, "Without delay." This had taken place following an incident on that floor.

At the last inspection we found people were not protected from the risks of inadequate nutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found people were still not being supported in a manner which meant they had their nutritional needs met.

Care plans relating to people's nutrition needs were variable. For example one person was identified as a high risk of choking and their care plan identified 'Grade 1 thickened fluids' or Grade 2 if coughing. However this person was identified as having a low fluid intake target of 500mls and was at a high risk of dehydration and on a food and fluid intake chart. Despite the risk the fluid charts had not been totalled. In another person's nutrition care plan we found confusing information in their care plan. We looked at their care plan as it appeared they were choking at a lunch time we observed. We saw the GP had prescribed thickeners and written a prescription of "Thick and Easy". The choking risk assessment was not clear as it identified a 'medium' risk; however it was also recorded elsewhere as 'High'. We found no information why the risk had increased from medium to high in a month. There was no referral to SALT (speech and language therapist) and there was no clear guidance about how staff should support the person to eat and drink. There were no records of a high choking risk in the person's room care plans.

Views of the meals served varied. Some people told us they enjoyed their meals, whilst others told us the "Food is not great". The meal times we observed showed us a mixed picture of how people experienced meal times, which seemed to depend on who was on duty rather than the floor people were on. During one lunchtime we observed people being given choices, regarding the music, drinks, where people wanted to sit and support was given in a timely and respectful manner. However the next day the lunch time on the same floor was not the same experience for people. The music was intrusive and not the choice of people, it took thirty minutes before more appropriate music was put on. One person sat at the table for 25 minutes with their meal in front of them before anyone had the opportunity to support them. This was due to the needs of people needing support across the floor and call bells needing attention. The person was supported by a care staff member sitting perched on a chair arm and leaning over the person. We observed three people having two different care staff to assist with their meal whilst another had three different care staff. One person was given a plastic beaker with a lid; there was no detail about this in their 'nutrition' care plan. Another staff member replaced this with a cup. This did not provide adequate and quality support to ensure people enjoyed their meals.

People did not have their nutritional and hydration needs and associated risks met which was a repeated breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Details of people's health assessments and on-going health needs were recorded in people's care plans. We could see professionals were called in and made entries into people's care records. Relatives informed us they were kept up to date with people's changing needs.

Requires improvement

Is the service caring?

Our findings

Comments from people were positive about the relationship they had with staff members. Comments included, "I really quite enjoy it here, they get me up in the morning and leave me to it which I like and I go off to the shops when I like". Another person told us, "This one here (referring to the nurse coming into room) she's the light of my life I've never seen her without a smile. The biggest part of them are smiling". A relative told us, "It's much better now but my confidence in them has been knocked. I still feel I should come in everyday and I still worry when I'm not here. They are more attentive and committed now".

At the last inspection in March 2015 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always supported by staff who recognised their needs and demonstrated respect for people's privacy, choice and dignity. At this inspection we found the staff interactions on the whole had improved.

The majority of interactions we observed between people demonstrated staff had developed caring relationships with people. Staff in the main addressed people with their preferred name. We observed staff getting down to people's level before communicating with them. Staff had a good relationship with people's relatives and we noticed a pleasant banter between people, their relatives and staff. One staff member supported a person to contact their relative who lived abroad using skype as the home had wi - fi. Staff interacted with people in a kind and compassionate manner. There were a considerable amount of warm and friendly exchanges between staff and people which were, when people were able, reciprocated in the same way. The staff were cheerful and the atmosphere at the home was relaxed

Observations showed us for the majority of time people were listened to and were involved in daily decisions regarding their care. An activity took place in one large lounge which included people from each floor. People were asked if they wanted to join in and those who did not had their choices respected. Where people needed to move or be moved to accommodate more people, this was done in a respectful manner. On several occasions we did note the music being played in various areas was not the obvious choice of people and the choice of staff and on one occasion this was changed by the manager when they entered the area.

People's right to privacy was respected. Staff were aware of the need to ensure people received personal care in private and to support people who were more mobile with their privacy. Whilst most people were treated in a dignified manner there were some observations where this could have been promoted more. For example, one person was walking out of the dining room and was ordered by staff to "Sit down" on several occasions. A different care staff member approached the person in a different manner and the person was immediately reassured and happily sat down and then went on to eat their meal. Several care staff did not engage in conversation with people they were supporting, and discussed staff issues with each other. People were told, "Eat your meal x" and conversations from staff were held about people and their food and fluid intake. For example, "She's a soft" or "She's a normal" was called across the room in reference to presentation of meals for individuals. These examples demonstrated people were not always treated in a dignified manner.

Whilst staff were caring in nature there was at times a lack of attention to detail when caring for people. For example on numerous occasions we saw two people who were identified as high risks of falling with footwear which did not fit them correctly. For one person their slippers were not on their feet correctly and they were pressing the back of the slipper down with their heels. On other occasions we saw two people enter the lounge room without any footwear on. On both occasions staff followed later and put these people's footwear on their feet. On one occasion we found one person resting on the bed of another service user who was the opposite sex who was asleep in their chair. This could have posed risks for this person and we alerted staff who encouraged the person to leave the room, however this had not been noticed by staff. During our evening visit one person was walking with an unsteady gait. We had to call the staff to support the person when they went into another person's room and went into a corner and could not back out of it and they let go of their walking frame. Another person who was restless later came to speak to us and it was noticed they had a strong faecal

Requires improvement

Is the service caring?

aroma which could have caused or contributed to their restlessness. We mentioned the situation to the nurse in charge who diverted the two carers away from another person to assist.

Requires improvement

Is the service responsive?

Our findings

People told us they were happy and comfortable with their rooms and rooms were personalised with possessions, photos, and memorabilia. One person had a budgie in their room, which gave them pleasure. Another person told us, "We do all sorts. Have you seen the garden it's marvellous, just beautiful". A relative told us, "Last week when I came in they had some old fashioned pictures and they had to remember and talk about them. It was so good and even I enjoyed it".

At the last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations as there was a lack of care planning and information did not support people to receive personalised care to meet their needs. Whilst we have noted some improvements during this inspection, care planning was not personalised to meet the needs of individuals.

Since the last inspection in March 2015 the care planning record system had been changed and was in general an improvement. However we found some records had not been updated to reflect changes in people's needs. People had care plans which were split into 16 sections. Each section was reviewed on a monthly basis and this determined if the person had low, moderate or high needs in this area. Where necessary relevant risk assessments were completed at the end of each section. People also had daily records to be completed if needed, for example food and fluid charts, daily journals and "my choices" booklet, which were all kept in people's rooms. The daily journals tended to give basic information and include information on whether the person had had a good or bad day, with little more detail. The "my choices" journal included information on people's preferences and what was important to them and included what a good and bad day looked like for the person. However the information was not detailed and included basic information, for example on what time the person went to bed and got up in the morning. Not all sections had been completed in all the journals we viewed. We noted for one person it was recorded what a good day would look like. However a complaint had been made by a relative, which demonstrated staff had not taken this information into consideration. The complaint related to providing care in a particular way to ensure the person was having a good day.

The information recorded in all these documents tended to vary in the detail for each person. In some records we noted the dependency level had been circled for two levels not making it clear what the dependency needs were for the person. The monthly reviews in these situations did also not make it clear when the person's dependency level had changed. People's behaviour was not detailed sufficiently to know what behaviour to expect from people. In some examples we saw ABC (Activity Behaviour Chart) charts recording person's behaviour, but this was not detailed in their care records. It was not always clear how the person's behaviour should be managed, which meant staff did not have clear guidance on how they should support people

People did not always receive care which was personalised to meet their needs. Care plans were not personalised and it was not possible to ascertain people had been involved with their records. For example on one floor two people had recently moved rooms. When looking in one of these people's records there was no information explaining why they had moved or of the involvement of the person. When asked, staff were aware of the reason why. However, when we asked the person about the move, they told us, "I didn't change it; they (staff) changed it". This reflected, as did their records, that the person had not been involved in the decision to move their room. We could not be assured this person had not been moved for the convenience of staff rather than the needs of the person. In another example a third person had moved floors for specific reasons; however the care plans gave no detail of the move or the specific reasons why the person had moved. This information was important in relation to the history of the person living in this home. We observed a person known to be anxious call out, being moved with the use of a hoist. The person needed a lot of reassurance and was in mid-air calling with their arms stretched out. Care staff did respond to this, but there was a long few moments where the care staff were distracted about staffing across the floor and not acknowledging the persons cry for help. After the movement was completed a care staff member said, "Here's some juice so you're all sorted". Shortly after this the manager came and sat with this person and was calm, gentle and comforting and they chatted quietly together holding hands. The person became visibly relaxed. When

Requires improvement

Is the service responsive?

we arrived on our second day we heard some calling out and upset from their room. We found their call bell was not in reach. On a further three visits to this person over the next four hours they did not have their call bell in reach.

All staff did not see peoples care records and they told us they tended to use the daily journals and the choices document kept in people's rooms. However these documents did not reflect a picture of people's overall needs, risks and ways to minimise the risks. An agency nurse when asked what the care folders were in the cupboard stated they were not sure. They advised us they had received a good verbal handover from the nurse on the previous shift although they were still new and on their probation period. When giving the handover the agency nurse reported a person had been shouting out and was unsure if this was the person's usual behaviour. Permanent staff reported this was the usual pattern for this person. However this made it clear the agency nurse had not known the person's normal pattern of behaviour. On another floor we asked the senior in charge to explain two parts of the care plan, it was clear this was not familiar to them and they had to read the instructions to understand both parts of the care plans. They explained it was only the unit managers and nurse who tended to use the care plans. This made it difficult to establish how care plans were used to ensure they reflected and informed how people would like and receive their care and treatment.

The care and treatment of people was not always person centred and did not always meet people's needs in an appropriate way. This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were invitations for relatives to attend informal meetings with their relatives living in the home to share feedback on their experiences or raise any concerns around the home. We were advised these had reduced recently but had been well attended in the last few months. Minutes had been taken of relatives meetings. Details of the complaints procedure were available in the home and relatives felt they would be comfortable complaining to the manager and that they would act on their complaint. Details of the complaints made were seen and we could see complaints were being investigated thoroughly. There was a computer in the home's reception, which was used to gather feedback from residents and their visitors. We found response rates were low with four people having provided feedback in August 2015.

Requires improvement

Is the service well-led?

Our findings

People said they would speak up about any issues or concerns and the staff and the manager were approachable. Relatives said that they were always made to feel welcome when they visited and one relative knew who the manager was by name. A relative said "As far as I'm concerned it's pretty well organised here" and "I've recommended it to people."

At the last inspection we found the service did not have a robust quality assurance system which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 Regulations which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the quality assurance systems had improved but this still needed to improve further.

The atmosphere in the home was positive and had improved over the last six months. The majority of staff felt listened to and advised they could raise concerns which would be appropriately received. There was an improved picture regarding the caring attitudes of staff however some staff still needed to remember the basic skills of treating people with dignity and respect.

The service did not have a registered manager but the manager in post was being supported by two regional managers and an operations director. The staffing structure had changed and there was a unit manager on each floor, who were supermumery to staffing levels. During our inspection there was no unit manager on the top floor. Managers were aware of the home's last CQC report and were working on the action plan. They all felt they had made progress but were also aware of some of the shortfalls. When concerns had been raised appropriate notifications had been sent to us and safeguarding referrals had been made appropriately to the local authority. The local authority have been supporting the home to make improvements and felt progress was being made but still had concerns regarding the service.

The manager had introduced more audits to try and improve the service offered to people. Audits consisting of daily walkabouts by managers were seen, which looked at care being given and a random selection of records. Feedback was given to staff at the time of the walkabout.

Surveys had been carried out with staff, professionals, and residents between March and September 2015. The results had been analysed and pie charts had been developed to show the results.

Whilst more analytical work was being carried out at the service this was still not adequate to ensure all patterns were being picked up and improvements made as necessary. For example despite the service saying they were 100% compliant with medication training, serious errors were still occurring, which put people at risk. A serious medication error occurred on the night of our inspection; this was the second error of this kind in a matter of months. This involved covert medication being given to the wrong person. The manager showed us some analysis of incidents in the period of August and September 2015 and of the falls in a twelve month period. However it was clear the analysis of this information had not been used to ensure necessary changes had been made to people's records. We noted for two people the incidents recorded in the months of August and September both had four falls. However this had not been picked up and the information had not been transferred to people's care plans. It was also noted there had been various physical incidents between people which had not been analysed. The falls audit for the year only gave basic information so it again made it difficult to take any learning from the analysis already done.

The quality assurance system whilst improved was not adequate to ensure all learning was taken from events happening in the service. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found a lack of accurate record keeping which was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there was still concern over the record keeping in the home.

Record keeping in the home had not improved. We saw gaps in people's food and fluid charts, which were essential records to ensure people were receiving the care and support they needed. For example one person had a very low fluid intake, but their fluid intake had not been totalled. In a period of seven consecutive days they had only reached and passed this total once. In another eight

Requires improvement

Is the service well-led?

consecutive days the person had only reached and passed this target on two days and on three days the total amount had been below 200mls. Whilst care plans had been updated on a monthly basis, they did not always reflect the necessary changes or identify the risks to people. Care records did not provide a clear and complete picture of the life of people. When reviewing one person's care folder we found in a ten week period a record of 21 adverse events. Records of these events were recorded in different parts of the care plan, but there had been no overview of the records to identify these events. We reviewed one person's food records and found they recorded the person had eaten their lunch on the day of the inspection. We observed the person at lunch and knew they had only eaten their pudding, but records showed the person had eaten a third of their main meal. This showed that the record was not an accurate reflection of the care and support given to the person

The lack of accurate records being maintained was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.