Woodchurch House Limited

Woodchurch House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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**

Summary of findings

Overall summary

This inspection took place on 31 August and 1 and 2 September 2016; and was unannounced. Woodchurch House provides accommodation, nursing and personal care in purpose built premises. It also provides a personal care service to people who rent or buy their accommodation within Woodchurch House. There were 70 people using the service during our inspection; of which 51 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.

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. There had not been a registered manager at Woodchurch House for almost a year at the time of our visit; however the manager had applied to become registered.

Woodchurch House was last inspected on 7, 8 and 11 January 2016.They were rated as inadequate overall at that inspection and placed into Special Measures. We took enforcement action and required the provider to make significant improvements in a number of areas by 15 March 2016. The provider sent us regular information and records about actions taken to make improvements following our inspection and the enforcement action.

At this inspection we found that improvements had been made in some areas. In others, however, the changes made had not addressed the issues; leaving some people exposed to risk of harm.

Assessments about individual risks had not always been followed through into practice; meaning that the risks to people had not been properly reduced. Medicines management had improved overall but there were still areas that needed attention to make them safe. Recruitment practices required further input to ensure that all staff employed were suitable for their roles.

Staffing numbers had increased following our last inspection, but the organisation of staff sometimes meant people's needs were not met promptly. Training needs had been met for mandatory subjects, but staff would benefit from further instruction in some subjects. Supervisions had taken place and had resulted in actions being taken by the manager.

Some people's needs in relation to eating and drinking were not consistently or properly managed. People enjoyed their meals and there was a good choice available. Healthcare had generally improved in areas such as wound care, but catheter management required attention. End of life care plans met National Institute of Clinical Excellence (NICE) guidelines.

The principles of the Mental Capacity Act (MCA) 2005 had been applied and people's consent had been

appropriately obtained.

Auditing carried out for the purpose of identifying shortfalls in the quality and safety of the service had been extended and was more in-depth, but needed reviewing to ensure it was wholly effective. Feedback about the service was sought from a variety of sources and had been acted upon.

Incidents and accidents had been properly documented and preventative actions were considered. Referrals were made promptly to the local authority safeguarding team when necessary and staff understood the importance of raising concerns so that they could be independently investigated. Statutory notifications required by the CQC had been submitted in a timely and appropriate way.

People's safety had been protected through robust maintenance of the premises. Fire safety checks had been routinely undertaken and equipment had been serviced regularly.

People and their relatives gave mostly positive feedback about staff and we observed many kind and caring interactions. Some staff had however become desensitised to people who constantly called out for help. Activities had been developed and much improved so that people living with dementia could be involved and enjoy them.

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.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures and we found a number of breaches of Regulation.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

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

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

Medicines management had improved by there were still areas which required addressing.

Accidents and incidents were properly documented and referrals made to local authority safeguarding teams where necessary.

Environmental and equipment safety checks had been regularly undertaken.

Is the service effective?

Requires Improvement

The service was not always effective.

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

Health care had generally improved but catheter management required further training input.

Staff training and supervision had mostly been improved. Staff completed the Care Certificate within 12 weeks of commencing employment.

The principles of the mental Capacity Act 2005 (MCA) had been followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff did not react promptly to people calling for their help.

People's privacy and dignity was mostly protected but needed

further review.

Staff interactions with people were mostly kind, caring and gentle. People were encouraged to be independent where possible.

End of life care met National Institute of Clinical Excellence (NICE) guidelines.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints had not been managed in line with the provider's policy.

Care plans lacked detail in some cases; while others were informative.

There was much improvement to the activity programme on offer and was more suitable for people living with dementia.

Is the service well-led?

Requires Improvement

The service had not been consistently well-led.

There had not been a registered manager at the service for almost a year.

Not all of the issues highlighted in our last inspection had been fully addressed.

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, and had 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 31 August and 1 and 2 September 2016 and was unannounced. The inspection was carried out by two inspectors, a pharmacy inspector, two specialist nurse advisors and an expert 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 expert 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 twenty-three 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 eight care workers; including three registered nurses, kitchen staff, seven relatives, the provider and the manager.

We pathway tracked twelve 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, accidents 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 "If I need somebody I just call them on this [call bell on a pendant].It's a very good place they really look after you well'. A relative said, "X needed bed guards because they'd been having falls-they sorted those out for us". Another person said "My only gripe is there's not enough staff to answer buzzers; and another relative told us "If something happened they'd be here in minutes although some days it does take longer".

Although there had been improvements to some aspects of safety; such as processes for recording incidents and reporting them to the local authority when necessary, and medicines management overall; these had not been sufficient.

At our last inspection, assessments had been made about possible risks to people's health, safety and well-being; but actions to minimise those risks had not always been followed through in practice. At this inspection, the situation had improved in the areas we had highlighted in our last report, but other, known risks were not being appropriately managed. For example; one person had been assessed at very high risk of falls and had a history of previous injuries caused by falling. Their care plan recorded that staff should know this person's whereabouts at all times because of this. However, during the inspection, we had to call staff because this person was found alone in a recess at the end of a corridor, slumped in their chair and about to fall off it. We also noticed that this person was wearing slippers from two different pairs. This mismatched footwear could increase their risk of tripping and falling and had not been corrected by staff.

Another person was repeatedly calling out for help and was unable to use a call bell. We asked staff to attend to the person on several occasions because staff walked by the person's closed bedroom door without checking on them. Staff told us that this person "Always calls out like that". We asked how staff would know when the person genuinely needed assistance and they said that they would not. After we highlighted this, routine staff checks were introduced for the person at thirty minute intervals and these were documented. However, the risks associated with this person being unable to use a call bell had not been properly assessed or minimised.

A further person's care plan stated that they needed a soft diet because of a medical condition, but we saw they had been given toast for their breakfast. Food charts showed that this person had received toast at other times and had also eaten crisps at supper. Information in the care plan recorded that 'Solid, dry foods' were difficult for this person, but action had not been taken to minimise the risks and possible discomfort for them. The manager initially told us that there was no medical reason why this person had been placed on a soft diet; until we referred her to the care plan information. A referral was also made to the Speech and Language Therapist (SALT) during the inspection; as the person had not had a formal swallowing assessment since admission into the service.

We observed another person eating toast while propped at an angle in bed. They were falling asleep between mouthfuls and told us they had not been given their dentures that morning. This meant they could not chew the toast properly and created a choking risk. Their care plan about nutrition recorded that staff

should ensure this person was 'Sitting upright in chair for meals'. The manager told us that there was no reason why this instruction formed part of the care plan, but we read SALT advice from March 2016 which recommended a soft diet for this person. Care notes recorded that they had refused to eat a soft diet with thickened liquids, but this made it more important that the person should have their dentures in and be positioned upright to prevent the potential for choking.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regular checks were being made and documented for another person who had been assessed as requiring monitoring during the day and night. Records evidenced that this person had been checked every 15-30 minutes and a note had been made of their whereabouts, so staff could make sure they were safe.

Following on from our last inspection, pumps for special mattresses used when people were at risk of skin breakdown, were now set at the correct levels for people's weights. Daily checks had been introduced to ensure that staff reviewed the settings when people lost or gained weight and these were documented in reports about people's individual care. People were now being repositioned in line with care plan instructions to help protect their skin from pressure damage. This meant that actions to minimise known risks to people's skin had been properly addressed.

At our last inspection, medicines had not been managed safely. At this inspection improvements had been made overall, but there were still areas which needed to be addressed. For example;
temperature records of medicines refrigerators did not include maximum and minimum measurements. Therefore, we could not be assured that people's medicines had been consistently kept at the correct temperature and were fit for use.

Several people were administered medicines covertly (without their knowledge). Most had the correct documentation and information in place to support this practice. However, we found some of the necessary processes had not been undertaken for one person receiving medicines covertly, which meant the provider could not evidence that proper actions had taken place to ensure that this method of administration was appropriate.

MARs (Medicines Administration Records) we reviewed had generally been completed appropriately. However, stocks of medicines recorded on the home's electronic MAR system did not always match physical stock levels. This made it difficult to undertake a physical check to ensure medicines had been administered safely. A relative made us aware of a tablet found on a person's bedroom floor. We were able to identify the tablet, but the MAR showed that this had been administered on every occasion in the last month. The person's care plan noted that staff must ensure that tablets were swallowed properly as this person sometimes held them in their mouth or spat them out later. The MAR indicated that the person had received all their medicines as prescribed to them, but the tablet found on the floor suggested that they had missed a dose. The differing stock records prevented us from being able to carry out a physical reconciliation to ensure the person had had all their medicines. The manager and provider told us that they would investigate the stock control issue immediately.

This was a breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Medicines were stored securely and were within their expiry dates. Medicines requiring safer storage by law were stored securely, and registers to record their handling were accurately completed. Waste medicines

were disposed of correctly. GPs ensured appropriate monitoring of people's medicines was undertaken.

Arrangements for ordering and receiving people's medicines from both the GP and pharmacy were suitable and systems were in place to ensure medicines safety alerts were received and acted upon. Medicines errors had been recorded, but there was no system in place to document near misses (where an error is identified before it affects a person). This meant staff could not effectively review such events to reduce the risk of similar occurrences.

We recommend that the provider considers introducing a system to record near misses.

Protocols were in place to support staff to administer medicines to people on a 'When required' basis. Separate MARs were in place to support the application of people's creams and ointments; however some of these did not always give enough detail for staff to apply them correctly. This could mean that creams might not be used as the prescriber intended. Regular medicines audits had been undertaken since the previous inspection. Action plans were completed and reviewed on at least a monthly basis to facilitate improvements in practices relating to medicines.
At our last inspection we found that references received for some staff were not adequate. At this inspection proper references had been sought in all the staff files reviewed. However there was a long gap in the former employment details of one staff member; which had not been explored by the manager. This meant the provider could not be sure of the staff member's background .The same staff member had disclosed a former criminal conviction on their application for employment, but no formal assessment had been carried out to document that any potential risks had been assessed and mitigated. However, the manager assured us that this staff member had only worked under the supervision of other staff.

The failure to properly operate a robust recruitment procedure is a breach of Regulation 19(3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

All other checks and documentation in relation to staff recruitment was thorough and 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 assurance about staffs' character and suitability for their roles.

At our last inspection, there were not enough staff to consistently meet people's needs. At this inspection, staffing numbers had been increased and there was now a registered nurse working on each floor at all times, day and night. Nursing staff told us that this change had been very helpful to them in being able to meet people's nursing needs more promptly. People had varying and complex conditions like dementia, stroke, diabetes, Parkinson's and epilepsy. Nursing needs included catheterisation, wound and tracheotomy care. Some people living with dementia showed behaviours that challenged and many people were nursed in bed. There were eight care staff on shift in the morning and seven in the afternoons on the ground floor, and eight care staff all day on the first floor. There were three care staff working on each floor overnight.

Staffing numbers had been determined by assessing people's individual care needs and using this information to calculate the number of staff to deploy; using a dependency tool. The provider's staffing policy, which was publicised on their website, stated that everyone's needs would be classified as 'High' for the purpose of allocating staff numbers, even if some people were more independent and required less staff input. This meant that the number of staff on duty at any time should exceed that indicated by the average level of people's needs.

Although staffing levels had been assessed; and rotas and associated documents showed they had been consistently met; the organisation of those staff was not always effective. We received feedback during and

after the inspection from some people and relatives who said that needs were not consistently being addressed promptly. Other people and their families however, said that they were satisfied with the response from staff and one relative remarked "Things have got better and X has told us that staff come more quickly now". Our observations indicated that sometimes people still waited too long for support with their meals or for staff to attend their needs. For example; on the first day of our inspection, some people waited 45 minutes to receive assistance to eat their lunch. The manager told us that a new way of organising staff was being introduced and on the second and third day of our inspection we saw this in practice and people did have their meals more quickly. We used the call bell to summon help for a person who wanted their dentures to be able to eat their breakfast. We waited for 15 minutes but staff did not respond, and in that time the person's breakfast had gone cold. We made staff aware of this. Another person told us that they had resorted to telephoning the office to request support because response times to call bells were too long for them. They explained that they needed staff help with toileting and delays had sometimes caused them to be wet; which they found distressing.

Some people told us that staff cancelled call bells when they came to their rooms, saying that there was an emergency and they would come back later. We asked the manager about this and she told us that staff were following an instruction to let people know when they could not have immediate assistance. The feedback we received from some people was that this happened quite often; although they also told us that they did not blame the staff in any way for this and that they did their best to come as soon as they could. The manager told us that call bell audits were regularly carried out and that response times had decreased since our last inspection. However, these audits were not a reliable method of checking response times, because many people were unable to use call bells, others preferred to call out for assistance and call bells were being cancelled while staff attended to urgent situations.

The provider had failed to ensure staff were deployed effectively. This impacted on the care and treatment people received. This is a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection, incidents and accidents had not been appropriately recorded. At this inspection we found that detailed information was documented when incidents or accidents happened. This included preventative actions to reduce the likelihood of these events recurring. Staff were able to tell us what actions they should take to record incidents and knew how to escalate any concerns; to ensure that they were investigated and acted upon. Staff handover sheets recorded any particular risks to people; such as whether people had urine infections; which could make them more prone to falling or feeling confused. This gave staff had an up-to-date picture of needs and dependencies; which helped them be aware of important factors in people's care.

At our last inspection, staff lacked knowledge about protecting people from harm and abuse. At this inspection staff were able to describe to us the process for alerting senior staff and the manager to any potential safeguarding matters. They knew how to complete documentation to illustrate any injuries and we saw that this was used in practice. The manager showed us records of any incidents which had been raised as safeguardings, and we read emails to show that the manager promptly sought advice from the local authority about any issues which may need to be referred. This meant that the appropriate body was alerted to situations or events which might require independent investigation; and this helped to protect people.

Fire safety checks had been regularly undertaken by maintenance staff. These included emergency lighting, fire alarms and equipment. An up to date risk assessment had been carried out to make sure that systems and processes were in place to keep people safe in case of fire. Other routine safety checks were made of individual rooms and communal areas to see that they remained in good condition and with no foreseeable

hazards. Water temperatures were tested and recorded to make sure they were within acceptable levels, window restrictors were checked, and bed rails and nurse call systems examined to see that they were safely fitted and working properly. This helped to ensure people's living environment was safe. Personal emergency evacuation plans (PEEPs) had been cross-referenced with mobility care plans and now included information about people's ability to mobilise independently or the equipment needed to support them if it became necessary for staff to assist them to leave the premises. This was an improvement on the PEEPS seen at our last inspection as staff now had more detailed guidance to help them in an emergency situation.

Regular servicing had been undertaken on hoists and other equipment such as special baths; used in people's day to day care. The passenger lift had a service history and had been maintained to prevent the possibility of breakdowns. The provider had a plan in place which detailed arrangements for ensuring continuity of care for people in the event of emergencies resulting in evacuation of the premises. There was a 'Grab bag' available containing crucial information about people's needs; to minimise the impact of any emergency situation on people's care.

Requires Improvement

Is the service effective?

Our findings

There had been some improvements made to the effectiveness of the service since our last inspection; around management of skin wounds, working within the principles of the Mental Capacity Act (MCA) 2005 and some staff training. However, we found that some aspects of people's health; such as their food and fluid intake and catheter management had not been properly addressed, and there continued to be gaps in staff knowledge.

At our last inspection, people had not been protected from the risks of inadequate food and hydration. At this inspection we continued to have concerns that people's dietary needs were not always being properly addressed. People had generally been referred to a dietician when there were concerns about their weight. However this did not always happen promptly. For example; one person had lost almost 7kgs in three months but had not been referred for dietician input. Staff told us that this was because the person's Body Mass Index (BMI) remained within acceptable limits for their height. Staff also told us that this person consistently "Eats very well", but had not considered that there may be an underlying medical condition contributing to the weight loss. Food recording charts had been completed with inconsistent information; for example; some staff measured the amounts eaten in spoonful's, while others used percentages. On most of the charts, staff had not recorded the amount of food offered to start with, so it was difficult to understand exactly how much the person had eaten; and whether they had consumed enough to keep them well. The type of food was not always noted on charts; for example 'Lunch 40%' or 'Pudding'; which was not helpful in assessing the nutritional make- up of the meals eaten. The manager made a dietician referral for this person during the inspection.

Risks to people around their nutrition had not been adequately mitigated; which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health care needs were managed day to day by nursing staff; with support from a local practice nurse, the community matron, a visiting dietician, physio and occupational therapists and GPs. Five people had catheters in place and we looked to see how these were managed. Three catheters had been managed appropriately but two people had a history of blockages. One person had 10 catheter changes since April 2016; nine of which were caused by blockages. Blockages can sometimes be caused if a person does not drink enough, but this person's fluid chart recorded intake in excess of 2000mls on many days. However, we found that part of the drinks recorded as drunk on the charts were still on this person's table when we visited them, so this was not a reliable picture of their intake.

This person's care plan also recorded that their fluid output should be recorded. Nursing staff were not able to tell us why this was happening or what the results might mean. Fluid output records for this person showed that their 24- hour intake exceeded output by significant amounts on a number of occasions. For example: 2050mls input and 650mls output on one day and 2100mls intake and 500mls output on another. This could indicate that the person was retaining urine or that they had not actually drunk the amounts recorded on fluid charts. Staff we spoke with were not aware that a low output compared with intake should be investigated. Nursing staff did tell us that the person's catheter was being flushed frequently to help

avoid blockages but they did not know that there were different flushing solutions available for different causes of blocking. They said that they had received training about catheter care, but they were not knowledgeable about on-going catheter management and this had not been consistently effective.

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.

Catheter bags had been changed in line with good practice and were dated to show when the next change was due. One person with a catheter told us that staff always encouraged them to drink plenty to reduce the risk of developing urine infections. People had access to opticians, chiropodists and dentists; and appointments and outcomes were documented in peoples' care records.

At our last inspection training had not been effective and staff had not received regular supervision and appraisal. At this inspection, there had been an overall improvement in the training staff had received; with the majority having carried out all mandatory sessions. There were still areas however, where we saw gaps in some of the staff knowledge, for example around catheter management; and in the recording of food and fluid intake; which was variable. Nursing staff were unable to explain why people's urine output was recorded when they had a catheter, and why this was important. They had not understood that significant differences between fluid output and intake could indicate a problem which required investigation. Staff had not appreciated the importance of accurate and consistent recording of people's food and drink intake; when there were concerns about appetite or weight loss. Staff had completed charts about fluid intake, output and foods eaten; but had not understood the potential impact on people's health and well-being of the information they were documenting.

The failure to ensure staff received adequate training is a continued breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives said that they had faith in staff knowledge and competency in their roles. One person told us "They're so good and have got much better-I don't have any worries in that department .I feel quite happy that they know what they're doing". A relative said "We're completely confident in staff now; the training is one thing but they also know X so well and how they like things to be done for them". The staff we spoke with were more confident than they had been at our last inspection and they told us they had benefitted from more training and guidance.

Staff had now received regular supervision; which they said was helpful in highlighting areas for improvement and identifying training needs. A specialist in care for people living with dementia had been contracted to work alongside staff to offer training and guidance. We observed the specialist working with staff and that she suggested ways to manage people's behaviours through distraction and engagement. The specialist worked on the floor with staff and this was effective in supporting staff in real time situations.

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. This gave staff a solid foundation on which to develop their knowledge and understanding.

At our last inspection, records about the treatment of skin wounds and pressure sores had not been sufficiently detailed to demonstrate that people received appropriate care. At this inspection records were up-to-date and contained enough detail to ensure that the progress of the wounds could be followed. Dressings were changed regularly and the wounds we tracked had all shown improvement. Advice had been sought from specialist nurses and the community matron; and this had been followed in practice to provide

people with appropriate care and treatment.

People who took blood thinning medicines had been regularly monitored, and blood tests to check levels were routinely taken by the practice nurse. Where people had shown any signs which might indicate a problem with their blood clotting; the GP had been involved, blood re-tested and adjustments made to the blood thinner doses. Staff were aware of the risks associated with blood thinners and told us they looked out for any indication, such as bruising or bleeding which needed urgent action. This helped to ensure that people received prompt attention when necessary.

At our last inspection the principles of the Mental Capacity Act (MCA) 2005 had not always been followed. 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. At this inspection, people's capacity to make their own decisions had been assessed when necessary and was properly documented. Staff had received training about the MCA and were able to tell us how they supported people to make their own choices. For example; we observed staff showing two plated meals to people who were living with dementia. They patiently described each meal; and the visual choice made it easier for people to state their preference and take part in the decision.

People or their representatives had given formal consent to receiving care, and staff routinely sought permission before supporting people. For example; staff asked one person "Is it ok if I help you back to your room for a rest?" and another was observed asking "Can I help you with your buttons?" People were involved in decisions about simple, day to day tasks and choices; which respected their rights.

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).The manager was knowledgeable about DoLS and had sought advice and guidance about making applications where this was deemed necessary.

Signage around the service had been adapted to ensure that it was suitable for people living with dementia. There were clear pictorial and written signs to show communal areas and toilets; which helped people to find their way around and remain as independent as possible.

People and relatives told us that the food choices on offer were good. One person said "Very good food; I can't complain, if you don't like something they ask if you want to try something else". A relative told us "It's great food here; it's so important to have a good, nutritious diet. Mum enjoys her meals and can always have more if she wants". There were choices offered at each mealtime and we observed that some people asked for alternatives and were provided with these. People who had pureed or thickened diets received these and the kitchen retained a record of people who required special diets and any individual likes, dislikes or allergies.

Dining rooms were light and cheerful: with brightly-coloured bunting and paper decorations on the first floor. These made the area an inviting place to sit and eat and provided a distraction for people while they waited to be served or supported with their meals. Tables were laid with coloured cloths, flowers and condiments. These helped to make an occasion of mealtimes and some people told us they looked forward to meeting with others while they ate.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we received mixed reviews about the standard of care provided. At this inspection, we received mostly positive feedback from people and their relatives. One person said "Staff show a lot of care- some more than others". A relative commented "Staff treat X like he's their own flesh and blood" and another said "My relative is always well-groomed and there are no smells". We read thank you cards and letters, one of which said "To all the lovely staff that have been a family to my mum. Thank you from the bottom of my heart for all you have done". Another read "A very big thank you for all your dedicated care and attention".

There had been improvements since our last inspection, but not enough had been done to ensure that the service was consistently caring. Our observations showed that people's experiences of the care given varied; and this needed further work to make it better.

Some people and relatives told us that staff were kind and caring but that needs were not always met promptly. One person said "This place has gone downhill; I know they're busy but it takes ages for them to come sometimes" and another person said "This is a lovely place and I certainly wouldn't want it to close; but the problem lies with some of the employees". This person said that staff could be slow to respond or there were sometimes not enough staff deployed.

Our observations showed that some staff appeared to be desensitised to people's calls for assistance. One person was shouting from their bedroom that they were in pain and needed staff. Their bedroom door was closed and staff told us that this person could not use a call bell to summon help. Different staff walked past this person's door on nine separate occasions without going in to see them, despite them calling out constantly. Although staff said that this person regularly called out in this way, and this was reflected in their care plan; staff conceded that they could not know, without checking, if the person actually needed support.

A nurse attended to this person when we asked them to and they told the person they would bring them some pain relief. This happened at 10:30am. We later checked the MAR and found that this person did not receive pain relief until 12:30pm, although they had already received a dose of one pain medicine at 9:30am. However, staff told us that this person could have another pain medicine in between doses of the first, but this had not happened and it was not kind to leave them waiting for either relief or an explanation of why they could have no more medicine.

The care people received did not consistently meet their needs, which is a continued breach of Regulation 9(1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection, people's privacy and dignity was not always protected by staff. At this inspection, staff were mindful of covering people's bare legs and ensuring people's clothes were suitably arranged for them. Staff knocked on people's doors and waited for a response before entering. One person could be seen lying in bed from the corridor outside their room. Their door was wide open and they were undressed apart from

underwear, as the weather was very hot. We brought this to the attention of the manager but she explained that the person had capacity to make their own choices and had asked to have their door open to see people passing. The manager had suggested placing a screen around the bed, but the person had refused this option.

We recommend that the provider further reviews this situation with the person to ensure that their own and others' dignity is protected.

Although most staff showed kindness and sensitivity when supporting people living with dementia, one person was visibly upset because they had been told that a trip to the beach was planned that day. Staff made sandwiches with people for a packed lunch, but when this person asked when they were leaving, staff explained that the outing was to be "Imaginary". People were then given trays of sand, shells and pebbles; which they enjoyed touching and moulding. The activity had been organised as a way of reminding people of holidays and good times, but not enough thought had been given to how this would be presented to people living with dementia. Staff had not been intentionally unkind but this person was disappointed and confused by the terms used to describe what was happening.

We observed many gentle, kind and affectionate interactions between staff and people. One staff member spent time in describing meal choices to a person. The person was reluctant to eat, but the staff member was patient and thoughtful in using simple language and clear descriptions. Some people carried dolls or soft toys and staff were both sensitive and engaging; asking people, for example "Would baby like some lunch do you think?" This encouraged people to eat and gave staff an opportunity to chat with people about their families. Staff told us that the specialist dementia care advisor had given them lots of tips and guidance for working with people; and we saw this in practice throughout the inspection. Another staff member helped a person to orientate themselves after they had fallen asleep in a chair. They did so by holding their hand, crouching down to make eye contact and slowly and gently reminding them where they were. This type of interaction happened on several occasions and demonstrated that staff were more confident and skilled in supporting people living with dementia.

People were relaxed and appeared comfortable with staff: who spoke in a respectful and caring way about them. One staff member told us "We want everything to be just right, so that residents have lovely days and are happy and well". The service had a calmer atmosphere than the last inspection; with many people on both floors involved in activities. There was a lot of laughter at times and some staff had clearly built a rapport with people. Staff talked to people to reassure them when hoist equipment was being used. They described what was going to happen, step-by-step so that people felt secure. Transfers we observed were carried out professionally and with care. When people were pushed up to tables in wheelchairs, staff checked that there was enough clearance for people's legs to avoid knocking them and gave people choices of where they sat.

People were encouraged to be as independent as possible. Care plans recorded the tasks that people could complete themselves and those for which staff support was needed. Staff gave people the space to feed themselves but were on hand to cut up food or offer encouragement to some people who needed to be prompted to eat. One person told us "I can't do as much as I'd like for myself these days. The staff never make me feel like a burden and they give me time to do what I can".

Although there was no one receiving end of life care at the time of our inspection, the service often provided care for people in their final days. End of life care plans followed National Institute of Clinical Excellence (NICE) guidelines and nursing staff were knowledgeable about the care people should receive at this time. Records of people who were possibly approaching the end of their life showed that people and their families

had been involved in discussions about final wishes. GPs had visited frequently and there was evidence that families had been informed at times when people's condition deteriorated. Medicines had been prescribed and were in place to ensure people had access to adequate pain and symptom relief when needed. Professional pain scales were in use to help staff assess and monitor any changes. People's nutrition had been reviewed so that food and drink was as digestible as possible and skin care was well-documented. Equipment such as pressure-relieving mattresses was in place and appropriately set up; and staff recorded regular repositioning of people; to ensure they remained comfortable in bed. Do not attempt resuscitation (DNAR) orders were in place for some people and these documented discussions with people or their families. Staff knew those people who had DNARs; which helped ensure that people's wishes and rights were respected at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

Although there had been improvements to the responsiveness of the service since our last inspection; there remained areas which still needed attention to ensure consistency in the delivery of care and response to complaints.

At our last inspection, complaints had not been properly managed in line with the provider's own policy. At this inspection, we continued to find that complaints were not being documented appropriately. The provider's complaints policy stated that, on receipt of a complaint, the manager should start a complaint record, document progress on this and attach all relevant correspondence to that record. This had not happened and there were no proper records of investigations or minutes of meetings the manager had had with people or relatives to discuss concerns or outcomes. For example; a relative had made a complaint and the manager had offered a meeting to discuss it. There were no records to show that this meeting had taken place, what was discussed or the outcome. The manager told us that the meeting had happened; but there were no minutes to support this. Handwritten notes had been made by the manager directly onto complaints letters but these did not record which staff had been spoken to about the complaint, nor any actions taken. The manager had responded to complaints but actions taken in response to them were not always clear from the complaints system.

The failure to operate a robust complaints system is a continued breach of Regulation 16(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider's complaints protocol was on display and people and relatives said that they knew how to make complaints. Two people said "I never complain; there's nothing to complain about" but one relative said that they had complained and "Nothing was resolved". However, there was a 'You said, we did' board in the entrance area which showed where comments and complaints had been raised and what had been done about them. For example; 'You said: A staff member was abrupt. We did: We do not tolerate this behaviour, we encourage you to inform us, we have ensured our complaints policy is displayed and we monitor staff communication'. This showed that the provider had sought feedback and had taken action in response to some concerns raised.

At our last inspection, people's preferences around times to get up or go to bed had not always been observed. At this inspection two people told us that this situation had not improved and that they were often later getting up than they wished. The care plan for one person documented the times they preferred to be up, but they told us this information was "Absolutely wrong" and that they had raised the matter with staff and the manager on a number of occasions. The manager told us that some people changed their mind on a regular basis; but care plans did not reflect this. People were out of bed earlier on the second and third days of our inspection, but individual wishes had not always been met.

Care plan information was detailed and well-written but it was not always sufficient to ensure that people received care in an individual way. For example; one person needed dentures to eat and was observed struggling without them. A review of their care plan showed that, while there was plenty of detail about the

person; including that they wore glasses and the way they liked their cup of tea to be prepared; there was no information at all about their dentures. This meant that their need to have them in place could, and had been overlooked.

The failure to appropriately meet people's needs is a continued breach of Regulation 9(1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Other care plans gave clear and full guidance about the way in which care should be delivered, so that it met people's needs and wishes. For example; there was detailed information about effective ways to communicate with a person who had difficulty in expressing their thoughts, and sensitive guidance about another person's preferred bedding.

At our last inspection, there was a lack of meaningful activities for people living with dementia. At this inspection there had been much improvement. The provider had employed specific staff to visit the service once a week and talk with people about their life histories and memories. This information was then used to create individual scrap books which people could read or look through themselves or share with staff and visitors. Families were also able to become involved by bringing in photos and providing stories and favourite memories to contribute to the scrap books. We visited one person who proudly showed us their scrap book and spent time showing us the photos and keepsakes in it. The scrap book created a chance to talk with people about their achievements. One person told us "When you get old, people just see you as an old person; these books are brilliant because I can show everyone who I was and what I did. I love it".

Designated activity staff were employed and had undertaken training and received guidance about the best types of activity for people living with dementia. People were involved in a wide range of activity and we saw them making sandwiches for a reminiscence beach session. People became animated and cheerful when carrying out this task and enjoyed the sandcastle and shell activity which followed. A visiting singer/storyteller conducted a very lively gathering; where people from both floors danced and sang along. Many people were up on their feet and laughter could be heard throughout the ground floor. Efforts had been made to provide visual stimulation in the form of pictures, bunting and colourful paper decorations; which hung from ceilings.

One relative told us that their loved one had been taken out on a short fishing trip, because staff knew they enjoyed this. They had had fish and chips as part of the day out and the person had been delighted by the experience. Another person told us about their particular hobby and that staff had encouraged them to give other people a talk about it. Hens had been introduced in the garden as a way of stimulating some people. We observed that people living with dementia especially, benefitted from this. One person who sometimes showed behaviours that challenged became focussed and involved when seeing the hens. They told staff how the birds should be handled and the hens seemed to have prompted some happy memories for them. The manager told us that an aviary was now being considered. People's individual interests had been considered and catered for.

Care plans all contained information about how people liked to interact socially. Activities staff visited people in their rooms for one-to-one time if they preferred not to be involved in group sessions. Details about activities and one-to one time were documented in each person's notes and gave a full picture of how people had been engaged.

There was a notice board advertising activities and events such as 'Music for Health' sessions, armchair exercises and a musical walkabout There were photos on display which showed pictures of people taking part in different activities such as baking, playing croquet and flower arranging.

There were games, crafts and books arranged in lounges with signs next to them inviting people to use them as they wanted. A monthly newsletter was produced and given to people who used the service. The newsletter advertised various activities and events held both within the service and in the local community. Monthly activity plans included at least one morning and one afternoon activity each day. Activities for August included making bird feeders; pebble painting and having external entertainers visit the service.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in January 2016 the service was rated inadequate in all domains. We took enforcement action and told the provider they needed to make swift improvements to ensure people were safe and were receiving a service which met all of their needs. Although we found that there had been improvements in a number of areas; there had not been enough positive change in others and further work was needed.

Assessments about risks to individual people had not always been minimised, and further work was needed to ensure all medicines were managed appropriately. The deployment of staffing required a thorough review to see that people's needs were being consistently met promptly. In some cases, care and treatment did not meet people's needs because care plans contained insufficient information for staff and in others care plan guidance was not followed through into practice. People remained at risk of not receiving the right care in respect of their eating and drinking, and nursing staff lacked knowledge in key areas such as catheter management. Staff did not always respond to people when they were in pain or needed assistance, and complaints were not always well managed. The provider's action plan stated that these areas had been addressed following our last inspection, but improvements had not been sufficiently wide-spread to protect every person using the service. The manager acted immediately in response to our findings during this inspection, but similar issues had already been brought to the provider's attention and should have been resolved sooner.

At our last inspection, auditing had been ineffective and had not identified the shortfalls highlighted during our inspection. At this inspection more in-depth and varied audits had been carried out by the manager, provider and an external contractor. These audits included assessments of individual staff performance during specific shifts. However, the audit system in place continued not to identify some of the areas of concern we found at this inspection. For example; call bell audits had been carried out, but did not take into consideration the many people who did not, or were unable to use call bells. The audit was not wholly effective therefore in highlighting that some people did not receive prompt attention.

The failure to operate robust quality assurance processes is a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The manager had been in post for seven months at the time of our inspection. The service is required to have a registered manager as part of its conditions of registration with the CQC. There had been no registered manager in post for almost a year; but the manager had applied to become registered. Most people and relatives told us that the manager was approachable and available if they needed to speak with her. One staff member told us "Now the home is moving in the right direction. I'm proud of the work we've done and we'll keep going".

At our last inspection, there had been no recent resident or relative meetings to gain views about the quality of the service. At this inspection we read minutes of group meetings with people and families. These recorded that the manager invited people to speak with her openly at any time with any concerns or

queries. The manager told us that she worked a late night each week; to give working relatives the opportunity to meet with her face to face and in private. Some people had asked at the resident meeting for an improved activity programme and this had been provided. Others requested that the dates of future meetings were publicised in advance and this now happened. There was evidence that action was taken in response to feedback from people and relatives.

Surveys had been completed to measure the opinions of people, their families and staff; and action plans produced to make and monitor any improvements made as a result of these. For example; some people had asked for CCTV cameras to be introduced into communal areas and the manager had fully explored this option. People and their families had been openly invited by the provider and manager to view the action plans submitted in response to the last CQC inspection. One person told us "I know it's not perfect here, but everyone's trying so hard and things are definitely getting better all the time".

Staff told us that they were working hard to improve people's experience of living in the service. Staff said that good teamwork had been crucial in moving forward. We found staff to be more confident in their jobs, with greater clarity about individual roles and responsibilities. As a result, staff were able to provide us with information about people's care without the need to defer to others for input or reassurances. Staff told us that they felt able to speak frankly with the manager with any concerns about the service and understood their responsibility to whistle blow if necessary. Supervision sessions had provided another opportunity for staff to give their opinions and the manager had produced action plans based on comments arising from those meetings. For example; staff had raised the need for more involved training about people living with dementia and in response, a specialist advisor had been brought in.

The manager is a registered nurse and told us how she kept informed about best practice within health and social care through local Care Forum meetings and attending training and development conferences when possible. The provider visited the service at least once each week and carried out monitoring checks. The manager said she felt supported by the provider and able to raise any issues with them openly.

Links with the local community had been fostered; and there were regular visits from churches of different denominations to meet people's spiritual needs. School children made occasional visits to provide a different focus for people; as had cheerleaders and locally-based Morris Men. Volunteers came in regularly from a nearby service for people with learning difficulties; which provided socialising opportunities for both the volunteers and people living at Woodchurch House.