Woodland Care Ltd

Woodland Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 29 January 2018 which was unannounced. This meant the provider, registered manager, staff and people using the service did not know that we would be carrying out an inspection of the service. We returned for a second day of inspection on 5 February 2018 which was announced because we needed access to records in the registered manager's office.

Woodlands care home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Woodlands care is an established building which has been adapted to become a care home. People had their own room with access to three communal areas and an outside courtyard. The service can accommodate up to 15 working age adults and older people living with a mental health condition or learning disability who require personal care. It is not registered to provide nursing care. At the time of the inspection, there were 13 people using the service.

The registered manager has been registered with the Care Quality Commission since 1 October 2010. 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.

At the last inspection of the service on 30 July 2016. We rated the service to be Requires Improvement. We asked the provider to make improvements to become a Good rated service.

At that inspection, we found that people did not always receive care and support in line with their individual needs, wishes and preferences. Staff knowledge of fortified diets for people with diabetes was limited. As a result staff did not provide the support for people with diabetes which was outlined in the care plans. Bi-monthly meetings with people were not person-centred and goal orientated as stated in the providers Philosophy of Care Policy and Statement of Purpose. People did not have the opportunity to be involved in activities of daily living, such as the preparation and cooking of food. There were no funds in place for activities and as a result, the provision of activities was limited. People were encouraged to attend events in the community; however this was because they were free rather than centred around people's preferences.

We also identified that an ineffective auditing system was in place. The provider did not carry out their own quality monitoring of the service. This meant that areas for improvement had not been identified. The refurbishment plan lacked detail and we found that improvements were not made in a timely manner.

At this inspection, we found the required improvements had not taken place.

Safeguarding alerts had been made when needed, however risks had not been fully assessed and care plans updated as a result. There was no evidence of procedures in place to ensure lessons had been learned. Risk assessments for behaviours which challenge were not in place and care plans did not contain the detail needed to provide safe care and support. Medicines were not safely managed.

Robust procedures were not in place for staff at night to ensure they remained safe from behaviours which challenge. Ineffective procedures were in place to cover staff absence. This meant the deputy manager worked additional hours, six days per week and was on-call every night.

Unsafe water temperatures were in place, increasing the risk of potential harm to people and staff. Doors to equipment such as the gas boiler and electrical switches, which needed to be locked for safety and prevent misuse, had been left open. All areas of the service needed to be cleaned. No colour coding system was in place for cleaning equipment

The registered manager and deputy manager had not received supervision or appraisal. Training for all staff was not up to date. Some training had been undertaken by the registered manager but they did not hold appropriate training qualifications to complete this, which meant the training received by staff was not valid. This included moving and handling, infection control and food hygiene.

People who needed a specialist diet because of diabetes or high cholesterol did not receive one. People were not involved in menu planning and menus did not reflect their choices. Consistent choices are mealtimes were not provided. All aspects of the service needed updating. This included paintwork and plasterwork, torn furniture and mattresses, broken furniture and worn flooring.

People are supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service do support this practice. Staff did work in line with the Mental Capacity Act 2005. However staff knowledge on the Mental Capacity Act 2005 was limited.

People told us they were happy at the service and received good care from staff who knew them well. However minutes of staff meetings and feedback from surveys showed some staff were unkind to people. In feedback respondents thought some staff could be more compassionate to people and treat people the same. No evidence was available to show that thorough action had been taken to address this.

Some staff practices meant that people's privacy and dignity was not always protected. Records did not show if people were routinely involved in planning and reviewing their own care. Staff did support people to maintain meaningful relationships.

People did not have access to regular meaningful activities. There was no evidence of innovation or use of technology to encourage people to participate in activities. Staff missed opportunities to provide activities to people at the service and in the community.

Care records lacked detail about how to provider person-centred care to people. We identified records did not reflect current needs. There were gaps in many of the records looked at. There were no systems in place to archive records.

People were aware of how to make a complaint and told us they would speak with staff or the deputy manager if they needed to. However, in meeting minutes and surveys people had raised concerns and there were no robust measures in place which showed these concerns had been listened to and action taken to

resolve them.

The provider and registered manager did not have adequate oversight of the service. An ineffective auditing system was in place. Information from meeting minutes and surveys did not result in action plans and had not been used to drive improvement at the service.

People and staff told us the provider and registered manager were not visible and were no responsive to them when concerns were raised about their care or aspects relating to the service. There was no evidence to show the service was integrated in the local community and no evidence to show how equality and diversity was embedded into the service or what the goals for these were for the next year.

No improvements to the service have been made since the last inspection. There was evidence of further deterioration at this inspection. Robust systems and adequate oversight had not been put in place to support the service to provide and deliver a good service to people.

Registered managers and providers are required to notify the Commission of specific events which take place at the service without delay. When notifications were submitted, some were sent late. Some incidents such as police incidents or safeguarding incidents had not been reported to the Commission. This will be dealt with outside of inspection.

We found seven breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, dignity, safe care and treatment, meeting nutritional needs, the premises, good governance and staffing. We identified one breach of the Care Quality Commission (Registration) Regulations 2009 in relation to submitting notifications.

"The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Care plans had not been updated when incidents occurred. Risk assessments did not show the actions taken to reduce risk. Robust measures were not in place to protect staff at night from the risk of harm.

Hot water exceeded safe temperature limits and put people at risk of potential harm from burns and scalding. People were also at risk of harm because necessary repairs had not been carried out.

Ineffective systems were in place to manage sickness. The deputy manager was on-call every night. Staff were supporting people with behaviours which challenge without the training to do so.

Procedures to manage medicines needed to be improved. The cleanliness of the service needed to be significantly improved.

Is the service effective?

Inadequate

The service was not effective.

The registered manager and deputy manager had not received supervision or appraisals. Poor staff practices and concerns regarding the service and safety of people and staff had not been discussed in supervision.

Training for all staff was not up to date. Staff had not undertaken training in supporting people living with a learning disability. Staff knowledge of the Mental Capacity Act was limited. The registered manager was training staff without the necessary qualifications.

People who needed specialist diets did not receive them. Staff knowledge of specialist diets was poor. People were not routinely offered a choice at mealtimes and were not involved in menu planning.

The service was in need of updating and repair. There was a lack

of signage throughout the service. No action plan was in place to make improvements.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they received safe care and support from staff. However minutes from staff meetings showed people were not always treated kindly. There was a lack of robust evidence to show what the provider had taken to address this.

Improvements were needed to ensure people's privacy and dignity at all times. This included when people received their medicines and the quality of the environment.

From our observations we could see staff knew people well and timely support was given when people experienced deterioration in their mental health.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not always reflect current needs. There was no evidence to show that people were routinely involved in making decisions about their care.

People did not have access to meaningful activities. People were supported to maintain meaningful relationships and visitors were welcomed into the service.

People were aware of how to make a complaint. Records were in place to show that complaints had been dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have adequate oversight of the service. Ineffective quality assurance procedures were in place. Improvements had not been made since the last inspection.

Appropriate support and resources had not been put in place during the registered managers planned absence. This meant there was a lack of oversight at the service.

People and staff were not involved in the development of the service. Although views and feedback were sought, it was not used to drive improvement.

Required notifications were not submitted. Where notifications were submitted, they were not always done so in a timely manner.

Woodland Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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.

We carried out a comprehensive inspection of this service on 29 January 2018 and 5 February 2018. One adult social care inspector and one expert by experience visited the service for an unannounced inspection on 29 January 2018. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, the expert by experience had experience of working or caring for people with a mental health condition. One adult social care inspector returned for an announced visit on 5 February 2018.

Woodlands care home is registered to accommodate 15 people. At the time of inspection there were 13 people using the service who were supported by the registered manager, deputy manager, eight care staff, one chef and one domestic member of staff. The service provided support to working age adults and older people with a mental health condition or learning disability.

Before our inspection we reviewed all the information we held about the service. We examined the notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with Durham local authority contracts and commissioning team, Health Watch, and Durham fire service. We used this feedback as part of our inspection planning process.

The provider was asked to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

During the inspection we spoke with seven people. We also spoke with the provider, deputy manager, five care staff and the chef. The registered manager answered questions via email.

We reviewed three care records in detail and the supplementary records (medicines administration records, hospital passports and dietary records) of a further four people. We reviewed two recruitment and induction records and six supervision and appraisal records. We reviewed the training summary records for all staff. We also reviewed records relating to the day to day running of the service.

We looked around the service and went into some people's bedrooms (with their permission) and visited the communal areas. We carried out observations of practice.

Inadequate

Is the service safe?

Our findings

We checked the water temperatures in all communal areas (sinks, shower and baths) which people had access to. All temperatures checked exceed 50 degrees Celsius. This increased the risk of potential harm through scalds and burns to people. One person told us, "The water in my bath this morning was red hot." No signage was in place to warn of the hot water. No water temperature checks had been carried out by staff. Health and Safety in Care Homes guidance states 2014 (Second edition) 10.2 states that bathing above 44 degrees Celsius can cause increased risk of serious injury or fatality. Where large areas of the body are exposed to high temperatures, scalds can be very serious and lead to fatalities. We asked the deputy manager to take immediate action to address this. On the second day of inspection, water temperatures were found to be within safe temperature limits.

Doors required to be kept locked were found open. No action had been taken to ensure people did not have access to hazardous areas. An electric cupboard located above the sink in the dining room was open and unlocked. We asked staff to go to the shop to purchase a suitable lock which they did and this was fitted immediately. People had access to the laundry room because it was unlocked; we saw that the gas meter was located in this room. The deputy manager started to make improvements following feedback and kept us updated with this progress.

Six sockets leading from an electrical supply where positioned at eye-level. Although these sockets could not be used by people or staff, we found they could be hazardous if people chose to tamper with them. No action had been taken to fit blank socket plates or box in this area to make it inaccessible to people. No risk assessment was in place for a boiler positioned on the wall in the dining room above head height. This meant the provider had not considered the risk that people may tamper with the boiler creating a hazard or had considered whether the boiler needed boxing in or relocating to a more suitable area.

The fire risk assessment stated that weekly checks of the fire alarm would be carried out. Records in place showed these were completed monthly. The risk assessment also stated that monthly fire drills would be carried out. From the records, we identified only five out of 12 staff had completed between one and two fire drills during the last year. No fire drills had taken place at night. One staff member told us that the evacuation procedure was for all staff to evacuate the building without checking whether people had left or needed assistance to leave. The provider told us this was not the correct procedure.

Robust procedures were not in place to ensure the safety of staff at night. One waking member of staff and one 'sleep over' member of staff were on duty at night. However there was no system in place for the waking member of staff to alert the sleep over member of staff that they needed assistance. A member of staff told us they were concerned that they could be attacked at night and hadn't undertaken training yet. We identified that the waking member of night staff did not have any way of calling for assistance if they were struggling to deal with people who have behaviours which may challenge or if they were at risk of harm. For example, the waking night member of staff did not carry an alarm to alert the sleep over member of staff. One fixed alarm was in place in the staff office. We also noted five staff were working night duty without having received training around how to manage behaviour which challenge. This meant staff were put at

risk of potential harm.

One staff member told us about a recent incident where one person had displayed behaviours which may challenge and they had to leave the situation to avoid further escalation. Although the staff member had received the required training, they felt that this was the best course of action to ensure their safety because they had not been able to raise the alarm for assistance. This incident had not been reported or recorded.

Care plans for behaviours which challenge contained limited information. No detailed information had been provided about the types of behaviours which could be shown, signs that behaviours may occur, action staff needed to take or de-escalation techniques which should be used. Associated risk assessment did not detail how to reduce the risks to people and staff. Incidents involving people who display behaviours which challenge were not routinely reported or recorded.

Safeguarding alerts had been made when incidents took place, however risks from safeguarding incidents had not been reviewed. This included updating care plans and putting risk assessments in place. For example, one person was at risk of unwanted attention from another person. No risk assessment was in place for either person to make sure the risk of occurrence was minimal and that staff had safely considered the risks and had put measures in place to maintain safety. A serious incident had occurred between two people. Actions had been put in place by the local authority to reduce the risk of reoccurrence following the outcome of a safeguarding alert. However care records did not contain the information needed to direct staff about how to manage this risk. Monitoring records had not been fully completed to show active monitoring had taken place. We also noted that the provider and registered manager had not considered whether safeguarding alerts had needed to be made when they received feedback via staff meetings and surveys about the conduct of staff towards people.

Systems in place to manage people's medicines safely needed to be improved. Two people were prescribed topical creams. No topical cream records were in place to detail when and where on the body topical creams needed to be applied and if they had been applied. This information had not been recorded onto an information card in the medicines folder where information about each person's medicines was recorded. Not all topical creams reviewed contained a date of opening and prescription labels were not legible. This meant we did not know if people were receiving their topical creams as prescribed.

One person was prescribed Lorazepam as a regular medicine and as an 'as and when required' medicine. Staff had completed the MAR in a way that showed the person had been given too much, however we could see this was a recording issue. We noted that staff were following instructions for giving the dosage of medicines from a consultant doctor, however no records were in place to support this dosage, such as a prescription or letter. We asked the deputy manager to take immediate action to address this. No 'as and when' required protocol was in place for this medicine.

Other 'as and when required' protocols did not contain the detail needed to determine whether medicines were needed. For example, a protocol for another person for Lorazepam did not provide information about how the person may present if they needed this medicine and what supportive measures staff should carry out before medicine was offered. 'As and when required' protocols had not been updated for over a year. This meant we did not know if the protocols remained relevant.

A handwritten medicine administration record (MAR) was in place for one person. This record had not been checked to make sure the information was accurate. We reviewed this record and found the frequency of two medicines had not been recorded. Another medicine did not show the times it needed to be given. 'As and when required' medicines for Movicol and Paracetamol for one person had not been correctly recorded

on the MARs. We noted no stock checks were available for Paracetamol. Although we could count the number of tablets, there were no records to show how many tablets they should have been because stocks had not been carried forward on the MAR.

There were gaps in recruitment records. Gaps in recruitment had not always been investigated. The registered manager had only obtained one reference for a staff member and this had been from a relative.

The cleanliness of the service was not in line with the provider statement of purpose which stated, "[We will] ensure that the premises are kept clean, hygienic and free from unpleasant odours, with systems in place to control the spread of infection." We saw communal areas, the kitchen, bathrooms, toilets and the shower room were all in need of attention. We asked the deputy manager to take immediate action to address this which they did.

Hand wash basins were not clean and not all sink areas had liquid hand wash. This meant people and staff could not clean their hands appropriately. Foot operated pedal bins were not in use and bins did not have a disposable bag in each of them.

Yellow mop buckets were in use at the service. A variety of mops were observed throughout the service. We found them stored head down in the laundry area and on the landing. A colour coding system was not in place to prevent cross contamination. The prevention and control of infection in care homes (National Patient Safety Agency, 2010) recommends that care homes adopt colour coding for cleaning materials. Therefore cleaning materials such as mops and buckets should be different for bathrooms, general areas and bedrooms.

Seven of the mattresses checked did not have a mattress protector on them. One mattress we looked at was damaged and we could see the internal filling and springs. Another mattress was heavily stained.

Training in infection prevention and control and food hygiene was not up to date. No competency checks had been carried out for staff who had completed training. Cleaning records were in place but were not always completed. Checks of cleaning had not always been carried out.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The shower room and both bathrooms contained pink mould, specifically on tiles, seals and in jugs found at the side of baths. This type of mould can cause risks to physical health. The shower curtain contained black mould. Fridges in the staff room, dining room and kitchen contained dried spillages. We observed black mould in the corner of a window in one person's bedroom.

Seals between kitchen worktops and tiles had worn or was missing. This had led to a build-up of dirt. A seal between the floor to the kitchen step and adjacent wall was missing. This area contained compacted dirt and food debris. The flooring in the kitchen area stopped under the fridge. This meant the floor had lifted in the gap between the cupboard and the fridge. We also noticed a build us of dirt and debris in this area too.

Laminate flooring in the hallway, small lounge and in one person's bedroom was worn and had started to lift. Flooring in the kitchen, dining area and office had started to lift. Seals on the floor had started to break down. An area of one communal toilet door was worn. This meant the paint had worn aware and bare wood was visible. Carpets in two rooms were damaged and heavily stained. We noted a malodour in two bedrooms and in the hallway on the second floor.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no systems in place to manage staff sickness and annual leave effectively. The service did not use agency staff. Only one member of bank staff was recruited and the hours they could work was limited. The deputy manager worked care shifts when they were unable to find sufficient cover. This was on top of hours already worked in their capacity as deputy manager and overseeing the registered manager's role during their absence. The deputy manager was also required to be on-call seven nights per week. This meant the deputy manager worked six to seven days per week. The provider and registered manager had not recognised this and had not considered whether changes to staff rotas, staff working hours or recruitment needed to take place.

Only one senior member of staff was employed on a part time basis, working four days per week from 08:00 to 15:00. This meant there was no senior on duty on an afternoon, evening, at night or at weekend. This had led to staff contacting the on-call frequently for support. No competency assessments were in place to show whether care staff were capable of being in charge of the service and ensure its smooth running in the absence of the management team. The provider had not considered whether more senior care worker roles were needed.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality assurance systems in place had failed to show that the service was unsafe. A health and safety audit had not included checks of hot water. These checks would have shown that the hot water was set at unsafe limits. People and staff told us the water was too hot for them; however no action had been taken to address these concerns. Medicine audits had not highlighted the errors above despite the regular checks in place.

Infection and prevention control audits were in place, yet they had not identified any of the concerns highlighted in this report about the cleanliness of the service. A domestic member of staff was employed to work two hours per day, five days per week. We could see this was not sufficient time to carry out the duties expected of them. Daily cleaning records were in place which showed the cleaning tasks which needed to be carried out. We noted that a member of management team was required to sign these records to show they were satisfied with the work completed. These records were not regularly signed. In the week prior to inspection, two dates had been signed to show the management team was happy with the standard of work. Our findings about the cleanliness of the building would not support these records.

Audits of accidents and incidents included a list of dates and the type of accident or incident but information had not been analysed to check for patterns and trends. No unannounced visits had taken place at night to review staffing levels and to determine if staff were safe at night. Health and safety checks of people were not completed regularly. These records did not clearly show when one person was out of the building and when they had returned or when the second person did not require checks. Checks had not been routinely carried out at night. Times of checks had been pre-populated and did not give an accurate view of the time the check was carried out.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy living at the service and felt safe. One person told us, "I am happy. I get

support with everything. They [staff] do really well with it." Recruitment records were in place which included a current Disclosure and Barring Service (DBS) check. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. Up to date health and safety checks had been carried out and up to date certificates were in place.

No-one at the service self-medicated or received covert medicines. Information leaflets and a homely remedies policy was in place. People had sufficient stocks of their medicines. Medicine competency checks for staff were up to date. Good procedures were in place for managing controlled medicines.

Inadequate

Is the service effective?

Our findings

Staff received regular supervision and appraisal. However we saw the deputy manager had not had an appraisal since 2013 or supervision since 2014. There was no evidence to show that the registered manager had received any supervision or appraisal. Training was not up to date in all areas, this included fire safety, mental health, behaviours that challenge and equality and diversity. We noted staff had not received any training to support people living with a learning disability. The registered manager had been training staff in areas such as moving and handling, fire safety, food hygiene, infection prevention and control and mental health without the necessary qualifications to do so. This meant we could not be sure if training was valid.

The providers induction policy stated that staff would receive a structured induction programme within six weeks of their employment and that staff would complete the Care Standards training which is now outdated. Induction records stated the activities staff needed to carry out within a two-week period and that they were on probation for three months. This was not in-line with the provider's induction policy.

The induction policy did not identify what activities new staff needed to undertake during their induction and what reviews and probationary meetings were needed to support staff and determine whether additional support was needed. No records were available to show that staff had participated in regular reviews during their probationary period to identify any additional support that they may need. No records were in place to show whether staff had successfully completed their probationary period.

The induction policy did not refer to the Care Certificate which two staff were currently undertaking. The Care Certificate is a set of minimum standards that should be covered as part of induction training. Of two staff undertaking this certificate, one staff file had been regularly checked and another had not been checked. There was no evidence to show a further member of staff employed recently had undertaken this certificate.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive support with their nutritional intake when they required a specialist diet or when menus were not in line with individual needs, wishes and preferences. Four people lived with diabetes and one of these people also had high cholesterol. These people did not receive foods suitable to their health conditions. Staff knowledge of fortified diets for people with diabetes was limited. As a result staff did not provide the support for diabetes which was outlined in the care plans. Staff could not tell us what suitable alternatives were available to people.

This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they were 'bored' of the menus in place at the service and that they were not involved in menu planning. One person told us, "They [staff] give you more or less the same choices week in, week out.

Not much variation." Another person told us the menu "Could be much better, with more [and] different food on the menus." One staff member told us that the [registered] manager devised the menu. Another member of staff told us, "The same [four-week] rota [for menus] has been in place for years. It's just repeated choice all year round." Menus did not reflect people's choices and requests. We asked staff what would happen if people decided they wanted to have a curry for their evening meal at the weekend. Would the menu be changed as a result? The staff member told us, "Residents would have to go out and buy their own."

We reviewed the four week rolling menu which was in place. We found that two choices were not always available to people at meal times. For example, for one week the menu for Sunday lunch was roast chicken and for another week it was roast pork. On both these days an alternative to these Sunday lunches had not been planned. We noted that one person did not like pork and they received a Yorkshire pudding and vegetables. On other days, the choices included the same type of food. For example, on one day the choice was fish fingers or fishcake and on another day it was sausage and mash or toad in the hole with sausage.

Care records did not contain up to date information about people's dietary intake. One person's records stated they required support with their hydration, however there was no information about the support needed or the volume of liquid they needed to consume each day. No fluid balance records had been completed. Dietary records stated that the person needed to have nutritional supplements; however we found these were no longer needed. The deputy manager told us this person was not currently at risk of dehydration or weight loss and therefore the care plan was not relevant. The care plan also stated that the person needed to be weighed weekly and monthly. Records showed that staff had not weighed this person as needed.

The providers standard operating procedure stated they, "Provided meals which enable residents as far as possible to decide for themselves where, when and with whom they consume food and drink of their choice."

The registered provider, registered manager and staff had not recognised that these practices had caused people to experience discrimination and that practices were not in line with the Equality Act 2010 under the protected characteristic of disability. People using this service were living with a mental health condition and required support with their nutritional intake. This included menu planning, shopping, preparing and cooking foods.

This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Aspects of the service were in need of repair and updating. These had not been highlighted by the provider and registered manager and no improvement plan was in place to show the improvements needed. One staff member told us, "The environment is not good. Everything needs to be updated."

Repairs were not carried out in a timely manner. A toilet had been out of use for one month and no action had been taken to repair it. The floor boards outside of one bedroom moved downwards when we stood on them. We saw the floor boards in this area were not level. Door stops in all communal areas had stopped working and these doors were wedged open with chairs or with folded paper.

Plaster work was needed in some communal areas where damage to walls had occurred. Plaster board was removed from a section of wall in the dining area to access pipes. We noted that this plasterboard had been screwed back onto the wall but had not been sealed or painted. Doors, radiators, skirting boards and the

banister needed repainting.

We saw a hatch on the ceiling of the shower room had been removed and not replaced correctly. A grey wire was visible from the hatch. A cupboard door located under the stairs did not have a lock or a hinge. We saw staff had to wedge the door in to keep it closed. The material on one sofa was torn and some furniture needed replacing because it was broken.

One person required the assistance of two staff to shower. We could see the shower room was not big enough to safely accommodate three people safely. Furniture not in use and equipment was not appropriately stored away. Hoovers were stored in hallways outside of people's bedrooms. Ladders were stored in a fire exit and wheelchairs were stored in a lounge area.

There was a lack of signage in use at the service. It was not clear whether doors to rooms were bedrooms, bathrooms or the shower room. Some bedrooms did not have a number on them. A door separated two sides of the building on the first floor. The door had no window. We saw that when the door opened there was a step immediately as you walked through the door. No sign was in place to warn of this step. We saw that this lack of signage increased the risk of potential harm to people through slips, trips and falls.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection there were three people subject to DoLS.

From our discussion with staff, we determined that staff knowledge of the MCA and DoLS was limited. We also identified that information relating to current DoLS authorisations had not been included into people's care plans.

We recommend the provider takes action to ensure staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Staff supported people to attend their healthcare appointments. They also supported people to make informed choices about their healthcare by making sure people understood the information provided to them. Staff supported people with their health and well-being and supported people with their day to day needs. When people experienced deterioration in their mental health, staff sought assistance from the appropriate services.

When one person was not following the treatment outlined by health professionals, staff liaised with health and social care professionals and put procedures in place under their guidance to ensure effective monitoring was in place. Where the person failed to follow these actions, staff took timely action to keep

these health and social care professionals up to date.

Requires Improvement

Is the service caring?

Our findings

People told us staff supported them with their health and well-being needs and their privacy and dignity was maintained and respected. People told us staff gave them the time they needed and were not rushed. However from our observations and reviews of records, we determined that people's privacy and dignity was not always maintained and respected. We found the system in place for dispensing medicines to people was not dignified.

People had to queue in line in the hallway at the office hatch. Staff dispensed medicines through this hatch. We found this practice did not allow people privacy, did not allow people the time they needed because other people were waiting behind them and did not allow personal conversations to take place. People and staff interacted with each other about their health and well-being but this did not take place in a dignified manner. This practice meant that people's confidentiality was not always maintained.

People's rights had not been considered under the Equality Act 2010 when scheduling staff. We noted frequent occurrences where the waking night staff and the sleep over member of staff were of the same gender. This meant people did not always have a choice about receiving care from their preferred gender. From speaking with staff, we understood that one person liked assistance with personal care from female staff. Care records did not state people's preferred gender of staff where they needed assistance with personal care. The provider and registered manager had not considered that the processes in place at the service did not always allow people to have the option of seeking support from a preferred gender.

People were encouraged to be independent with their personal care; however the practices in place at the service did not allow people to be independent in all aspects of their lives. At the time of inspection ten people had capacity to make their own decisions, yet no assessments had taken place with people to determine whether they could be responsible for and manage their own medicines. People did not have the opportunity to be involved in shopping for groceries, preparing and cooking food. This is an area of concern which we raised at the last inspection with the provider.

This was a breach of regulation 10 (Respecting and maintaining privacy and dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider gave staff time to participate in training to ensure they could provide safe and compassionate care to people. However we found that they did not routinely monitor whether training was taking place. Concerns had been raised in staff meeting minutes and survey feedback from people, relatives and staff about the way some people were treated. In the records reviewed, we read comments that staff did not spend enough time with people, that some staff demonstrated a lack of empathy and respect toward people and that everyone should be treated the same. An audit of surveys had highlighted feedback about staff attitudes but there was no evidence of the staff involved, specific details about these attitudes and what the impact upon people had been.

We spoke with the deputy manager to understand the actions that had been taken to address this.

Discussions had taken place in staff meetings, but no monitoring was in place to determine whether people had continued to experience any issues with staff practices of behaviour. No observations of staff practices had taken place and no further discussion with staff had taken place to obtain feedback. The provider and registered manager had not considered whether it was appropriate to make safeguarding alerts in respect of the feedback obtained. We spoke with the provider and deputy manager during inspection and asked them to take immediate action to address this. This included speaking with people and staff to determine whether these behaviours were still occurring, consider whether safeguarding alerts were needed and taking robust action to address this with staff responsible.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they were happy with the care and support which they received from staff. We observed positive interactions between people and staff throughout inspection. We saw conversation was relaxed and we could see that staff knew people well from the questions asked and discussions which took place. Staff displayed good knowledge of people's mental health conditions and the signs and symptoms they needed to look out when people became unwell. This meant staff could respond quickly when people need support from health professionals Staff knew people's individual routines and life histories.

Staff supported people in their day to day lives. They were aware of people's communication needs and took them time to support people to read letters and discuss any actions needed from letters, such as making appointments. Information about local advocacy services was on display. This is a means of accessing independent advice and support to aid with decision making.

Staff supported people to develop and maintain relationships with people important to them. People could have visitors when they wanted and we observed this to be the case during inspection. Staff supported one person to maintain their relationship and allowed them privacy when they received a visitor. Staff supported another person to keep in telephone and email contact with their relative each month. One person told us, "My daughter likes coming to see me."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in July 2016 we raised concerns that there were no funds in place for activities and as a result, the provision of activities was limited. People were encouraged to attend events in the community; however this was because they were free rather than centred around people's preferences.

At this inspection, we found the provision of activities needed to be improved and an activities budget was still not in place. We understood from speaking with staff that they had found it difficult to engage people in activities. There was no evidence of innovation with regards to activities. For example, technology was not used to deliver activities; there was no information on display about upcoming events in the local community. People were not able to watch a film because the service did not have access to a DVD player. People told us during inspection they would like a DVD player to watch films but they were not allowed to have one because this required a special licence.

There were no opportunities to have themed evenings around food, such as trying a curry, Chinese, pizza night or tasting foods unfamiliar to them. Activities were not centred on people's individual preferences and people therefore chose not to participate. External activities, such as singers and visiting Pantomimes were not considered because of the cost.

One staff member told us that people liked to go to South Shields or to Redcar. But they needed to go by taxi. In order to do this at least five people needed to go to share the cost, at around twenty pounds each. The provider and registered manager had not considered more accessible and cost effective ways of providing activities to people in the community. For example, going to the local library, leisure centre or cinema.

Two people had wanted to go on holiday to Blackpool to see the illuminations. They agreed to pay for this trip including support from staff, however they were unable to go on this holiday because the provider told them that their insurance would not allow this. The provider had sought advice and had not considered how people could go on holidays they wanted to.

This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although feedback about activities had been sought from people, relatives and staff, no action had been taken to engage people in the activities they requested. A common theme in feedback was the quality of activities. Comments included, "Activities could be better, [Person's name] tells me they are bored." And, "More time should be dedicated to activities." Comments from the staff survey included, "More outings for residents," And, "More activities needed." Minutes from residents meetings about activities stated that people had wanted to try fishing, trips out in the community and games nights. There was no evidence to show that people had been able to participate in these activities.

No action plan had been developed from this feedback. The surveys had not been thoroughly analysed,

however did have a handwritten comment by the registered manager which stated, "The provider cannot afford an activities budget." Results had not been disseminated and had not been used to improve the quality of the service. An audit of residents meetings had not picked up any themes. From our review of these minutes, activities had been highlighted as a continual theme.

The provider's statement of purpose stated they offered, "A range of activities which enables each resident to express themselves as a unique individual." And, "Offering residents a wide range of leisure activities from which to choose."

This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to people about their care plans and most people were not aware of them. Care records did not show if people were involved in planning and reviewing their care. This meant we did not know if the care provided met people's needs, wishes and preferences. Care plans were not person-centred because the information contained within them was not always accurate or up to date. For example, risks identified in care plans and support needed was no longer relevant. Information relating to preferences, likes and dislikes had changed and the information no longer accurate.

Care plans did not fully reflect people's physical, mental, emotional and social needs. Care plans did not provide detailed information about physical treatments people were receiving including the actions the person needed to carry out for their own self-care. Limited information was available about how to manage people's well-being and behaviours when they were experiencing a bad day or their mental health had started to deteriorate. Records stated that people liked to participate in swimming for example, however staff confirmed that they did not go anymore. Records had not been updated to reflect these changes.

Records had not been kept up to date. For example, hospital passports where completed, had not been updated for over a year. These passports are used when people go into hospital. As they had not been reviewed, it was difficult to know where the information contained within them remained relevant. Some hospital passports looked at were incomplete and key information regarding people's mental health, the approach needed and difficulties people may experience had not been completed.

Some records were in place regardless of need. For example, everyone had a 'urine sample record' stored in their medicines records. Although no-one had needed this record at the time of inspection. Staff had not recognised that these records could be stored away and completed if people ever required one.

Daily notes had been regularly completed but lacked information about people's overall health and wellbeing. Records stated that people had taken their medicines, had eaten and whether they had participated in activities. Records did not include information about people's mental health and whether they had experienced any difficulties. This practice did not allow staff to fully monitor people's health and well-being needs.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A small number of complaints had been made and records were in place to show they had been dealt with appropriately. However concerns raised during meetings and in surveys had not always been responded to robustly.

One formal complaint had been made by one person and we could see they had been happy with the outcome. People knew how to make a complaint and told us that they felt able to raise any concerns with staff. One person told us, "I'd tell them [staff], if I wasn't happy."

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2016 we determined that an ineffective auditing system was in place and that the provider did not carry out their own quality monitoring of the service. Audits had not highlighted where improvements needed to be made. Improvements to the service had not been carried out in a timely manner and the refurbishment plan in place lacked detail.

At this inspection we found that improvements to the service still needed to be made. There was some evidence that measures had been put in place to improve the quality monitoring of the service, however we found that these remained ineffective. At this inspection we found the service had declined further since the last inspection and further concerns had been identified.

A variety of audits had been carried out, but they had failed to identify any of the concerns highlighted during this inspection. There were gaps in audits, for example, physical checks of water temperatures had not occurred. Audits had not identified omissions and inaccuracies in medicines records, recruitment records and training records. Audits contained inaccurate information; for example, an infection control audit stated they were no shower curtains in use at the service, yet we observed one in place in the shower room.

We could see that the provider checked the registered managers audit records but had not picked up any errors in those audits and they had not carried out their own checks of the service to make their own informed decision as to whether a good service was being provided. The purpose of the audits in place was unclear, for example, the maintenance audit only showed the repairs that had been carried out. The audit did not include any repairs which were needed or if repairs carried out had been done so to a good standard. Care plan audits did not show what checks were being carried out and didn't show which people's care records had been audited. Audits of staff meetings had picked up key themes; however no action had been taken to address them.

The service did not have links with the local community. The provider's records stated, "Residents should be involved in the local community as much as possible, taking advantage of the integrated network of services and opportunity for development which it provides." We found this was not the case. Staff were not aware of events occurring in the local community which people could attend. Religious and cultural organisations were not invited to the service and there were no links with local schools.

Policies required updating. We identified gaps in policies reviewed. They did not contain the information needed to assist staff and did not provide correct guidance. For example, the induction policy did not set out standards which staff were expected to achieve and the reviews that they would need to participate in to monitor their progress. The provider's policies, service user guide and statement of purpose referred to care standards and national minimum standards. These are outdated regulations and 'Fundamental standards of quality and care' are now in place. Audits of policies carried out by the registered manager determined that all policies were up to date. This meant we could not be sure if the people auditing policies were competent to do so.

A quality management policy referred to Commission for Social Care Inspection, an organisation no longer running. The policy stated staff will be paid for three days training per year, yet the training and development policy states this is five days per year. The emergency response file had not been updated to reflect staff who had left their employment and new staff. The file directed staff to contact NHS direct, a service no longer in use.

Many records, particularly those associated with the day to day running of the service needed to be archived. At the time of inspection, no systems were in place to support this.

The registered manager and staff lacked knowledge about how they embedded equality, diversity and human rights into the service on a daily basis. The registered managers knowledge was limited and they could not tell how us how they embedded it into the service, how it was used to drive improvement and what the priorities for equality, diversity and human rights was over the next six months. This report has highlighted where people have not been protected by the provider and the registered manager under the Equality Act 2010. This lack of knowledge demonstrated that people continued to be at risk of the service failing to protect their rights under the protected characteristics of this Act.

The registered manager submitted a notification on 3 January 2018 to tell us about a planned absence from the service which would last four to six weeks. In this notification, we were told that the deputy manager would carry out the role of the registered manager. Although the deputy manager was suitably qualified to undertake this role, the provider had not ensured appropriate support and resources were in place for the deputy manager to undertake this role.

When we attended for inspection we identified that the deputy manager worked 28 hours and was expected to carry out their own role and the role of the registered manager. No formal written agreement was in place to discuss working hours or flexibility to increase their hours to meet the needs of the service. No consideration had been given to arrangements that needed to be in place to cover the deputy manager should they need to be off sick. We saw that the deputy manager was at work on their non-working days and working additional hours to keep up with the duties expected of them. We also noted that the deputy manager was in work on their non-working day to allocate people's money to them and to complete an on-line shopping order. We saw that no other member of staff had the training or necessary permissions to do this.

Where notifications had been submitted, they had not always been done in a timely manner.

This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC of deaths and other important events that happen in the service in the form of a 'notification'. The registered manager had not always informed CQC of significant events, such as one police incidents and four safeguarding incidents by submitting the required notifications. This meant we could not always check that appropriate action had been taken.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of this inspection to address this. We will report on any actions once they have been completed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect (1) Service users must be treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs (1) The nutritional and hydration needs of service users must be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be (a) clean, (b) secure, (c) suitable for the purpose for which they are being used, (d) properly used (e) properly maintained, and (f) appropriately located for the purpose for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care (1) The care and treatment of service users must (a) be appropriate, (b) meet their needs, and (c) reflect their preferences.

The enforcement action we took:

We imposed conditions upon the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part

The enforcement action we took:

We imposed conditions upon the providers registration.