Larchwood Care Homes (North) Limited

Alwoodleigh

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 30 March 2016 and was unannounced. The service had previously been inspected in February 2015 and was found to be in breach of the Health and Social Care Act 2008 Regulations in relation to record keeping and staffing. At this inspection we checked to see whether improvements had been made and sustained and found the service was still not meeting the regulations around record keeping and staffing. We also found the service was in breach of regulations around consent, person centred care and good governance.

Alwoodleigh is registered to provide nursing and personal care for up to 40 people. There were 33 people staying there at the time of our inspection. The home mainly provides support for older people some of whom are living with dementia. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The nursing unit is based on the upper floor and the residential unit on the ground floor.

There was a registered manager in post on the day of our inspection who had been registered since 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The 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.

All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against

abuse and they knew the procedure to follow to report any incidents.

We found that the assessment of risk was inadequate. There were no personal emergency evacuation plans and missing risk assessments for identified risk. We found no moving and handling care plans in five out of the nine care plans we reviewed. This meant staff were moving and handling people without clear guidance and although we did not evidence any poor practice during our inspection, the service was not able to evidence it had complied with the legal requirements to ensure the safe moving and handling of people.

There was no robust system in place for determining staffing levels. The service had recently taken on a high number of people with end of life care needs, requiring intense support from staff. This meant staff were only able to focus on care tasks, and they neglected to complete care plans and engage with people in a meaningful social way.

The ordering, storing and administration of medicines was safe , Staff had had an annual medication management competency check and regular audits were undertaken.

We found the environment to be clean and with minor exceptions, we observed good infection control practices in place.

We found not all staff had received training in assessing mental capacity or the Deprivation of Liberty Safeguards. Decision specific capacity assessments had not been undertaken and capacity assessments had not led to recorded best interest decisions, when a person had been assessed as lacking capacity. Staff were able to advise us how they would act in the person's best interests whilst providing care.

We found consent for care and treatment had not always been recorded in people's care plans.

People told us how much they enjoyed the food. We saw people being supported with their food and drink. However, the recording of what some people had eaten and drank was intermittent which meant the service could not confidently evidence people's nutritional intake.

Staff told us they "loved the home" or they were a "caring person" and continued to enjoy their work. They told us they could tell they were providing good care from the positive feedback from relatives but also from the people using the service either verbally or through their body language.
We saw evidence that staff protected people's privacy during person care delivery.

We found that people who had been admitted recently had either partial or no care plans in place and inadequate assessments in relation to their care and support needs. Consequently people were providing task centred care based on mainly personal hygiene care. Those people who had been living at the home longer, had care plans in place but they also lacked the detail to provide all the care they required. They did have some evaluations that reflected a response to changes in their conditions. But the level of detail was not consistent in all the files we reviewed. The home is to transition to new care plans following the takeover of management services.

We found there had been a lack of leadership at the service. The registered manager did not have a clear vision for the home in terms of improving the service for the people living there and supporting staff. Although we found issues at our previous inspections, actions to improve the quality of the service had not

been sustained. Auditing of the areas of concerns had not happened and there were insufficient checks and balances in place to quickly identify where systems were failing.

The registered provider had employed a new operating company to take over the management of the service in January 2016. They had undertaken a whole service audit and although this had not been shared with the home found similar issues to those found at inspection. The registered manager left the week following the inspection. A temporary support structure had been put in place following the departure of the registered manager by the operating company, with management oversight from the regional manager to ensure immediate improvements in the service provided at Alwoodleigh.

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 always been assessed and recorded in relation to the use of assistive equipment, moving and handling needs and pressure care management.

There was no adequate system in place for determining staffing levels. This meant staff were put under pressure as the service had accepted a high level of dependent people on the nursing unit without an increase in staffing over the previous few months.

On the day of our inspection there was no hot water in the kitchen which meant staff were carrying hot water in pans to wash up.

The ordering, storing and administration of medicines was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

We found a lack of compliance with the Mental Capacity Act 2005 and capacity assessments when undertaken were not decision specific. We found a lack of evidence of recorded best interest decisions.

There was a lack of evidence people had consented to their care and treatment.

We found staff had received recent supervision but not all training was up to date. The regional manager acted on this information immediately to ensure staff training and development was prioritised.

People told us they enjoyed the food at the service but monitoring of weights in relation to nutritional needs was not accurate

Is the service caring?

Requires Improvement

The service was not always caring

We observed some very kind, caring and compassionate interactions on the day of our inspection but this was not consistent amongst all staff.

Staff were observant in protecting people's privacy during personal care provision.

Staff had been recognised by relatives for the support they provided during end of life care provision.

Is the service responsive?

Requires Improvement

The service was not always responsive

There was missing and out of date information in people's care files which could have a detrimental impact on their care if followed.

In the absence of the activities coordinator there was a lack of meaningful activities as staff did not have the time to support people with activities.

Complaints were not always recognised or recorded although all the people we spoke with told us they knew who to report complaints to and were confident these would be acted upon.

Is the service well-led?

Inadequate

The service was not well led.

The service had not been adequately monitored to improve the quality of care provided at the home.

Audits and systems had not been robust at home level.

There was no effective leadership at the service.

Alwoodleigh

Detailed findings

Background to this inspection

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

This inspection took place on 30 March 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provided had not been asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. Before our inspection, we reviewed the information we held about the home. We reviewed all the intelligence we had about the service including the statutory notifications, enquiries and safeguarding referrals. We contacted the commissioners of the service and the local authority safeguarding team. We also contacted Healthwatch who sent us the most recent "Enter and View" visit they had undertaken in 2014. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We observed the lunchtime experience in the dining room in the residential and nursing unit and also for those people who chose to eat in their rooms. We spoke with 14 people who used the service and eight visitors. We also spoke with the cook, the laundry person, four care staff, the deputy manager and the registered manager. We inspected the laundry facilities and the kitchen.

We reviewed nine care records, and the monitoring records for four people cared for in bed and we observed the administration of medicines to the people living at the home. We also reviewed all the available records relating to audits and maintenance of the home.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found there were not enough staff on duty to meet the assessed support needs of people living there. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made in relation to staffing levels mainly due to the high level of dependency of people on the nursing unit and with no adequate system in place for determining staffing levels.

We could see from the rota that staffing varied from day to day and there were regularly seven staff on the rota each morning but occasionally six and on occasions eight with no rationale for the variance. Staffing at night was low with three care staff and one nurse with the rota showing there were two days when only two night care staff and one nurse was on shift. Staffing levels were having an impact on people using the service. For example, we observed one person in the residential communal lounge had to wait for the carer administering medicines before being transferred from their wheelchair to a comfortable chair. We asked people using the service and visitors about staffing arrangements. One relative said "staff turnover is a problem" A person who lived there told us "Sometimes it's just agency staff and they don't know the building and they don't know the people." We observed call bells were not always answered in a timely fashion and one person told us "They don't come straight away."

Staff told us there were staffing issues within the home and they did not always have adequate staffing levels. The recent increasing workload associated with the high turnover of people in the latter stages of end of life care who had been admitted to the home had been of particular concern to staff. In addition the families' of these people also required additional care and attention to support them at this time. We were told that currently there was only one permanent nurse at the service which meant bank and agency nurses were often required. On the day of our inspection there was a bank nurse and carer on the nursing floor. We were told that 50% of people required two carers to hoist and care for them and that the majority of people required assistance with eating and drinking. Low staffing levels also meant staff were only able to focus on care tasks, leaving little opportunity to engage with people in a meaningful social way.

We asked the registered manager how they determined staffing levels and whether they used a dependency tool to determine levels. They told us they currently were not using a dependency tool and they worked out staffing levels with the deputy manager. However, they provided no evidence they based staffing levels on people's level of dependency but instead based this on the numbers of people staying. The registered manager told us there were enough staff to meet the needs of the people there and they still had the same staff levels as they did when they had 40 people there. They told us they worked on a base staffing level of five care staff on the nursing unit with two qualified nurses and two care staff downstairs with one senior. They also told us the new management company was forthcoming in providing additional staff if required, and all they needed to do was to telephone the regional manager if they required agency staffing. They had been permitted to employ a further four permanent staff but a recent recruitment drive had not been effective.

We asked the registered manager how agency staff were introduced into the service and what information they were given before commencing work. They told us they were given an induction sheet and details of the emergency exits by the senior person on duty. When we asked if they were confident this was happening, the registered manager told us "I doubt it." When asked further how agency staff were able to care for the people living there, we were told "Agency staff would be told the information on the handover sheets." When we advised the registered manager we had seen the handover sheet, and this did not contain the required information they told us "I have not checked the handover sheet. It's probably because [name of employee] is new and that sort of thing was done by [Name of previous employee]". The registered manager could not confidently assure us temporary staff received an introduction into the service to enable them to provide a safe service to the people living at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with who could voice their opinion told us they felt safe at Alwoodleigh. Staff also told us people were safe at the service. We asked staff about their understanding of safeguarding. They demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They were able to give examples of how they would identify abuse. Staff also knew the principles of whistleblowing and assured us they would not hesitate to report any concerns. The registered manager could not advise us on the day of our inspection which staff had undergone safeguarding training, and we requested this information was sent to us following our inspection. This information was sent to us following our inspection which showed that not all staff were up to date with safeguarding training.

In the nine care plans we examined we found missing risk assessments for identified risks. For example, we found no moving and handling care plans in five out of the nine care plans we reviewed for people we had identified as having moving and handling requirements. This meant staff were moving and handling people without clear guidance and although we did not evidence any poor practice during our inspection, the service was not able to evidence it had complied with the legal requirements to ensure the safe moving of people.

We found risk around the use of assistive equipment had not been assessed. For example, people using assistive equipment such as shower chairs, bed rails or wheelchairs did not always have an assessment in place for this equipment. We also noted people had bed rails and although they were audited monthly they were not checked when people received all their care in bed. We brought this to the attention of both the deputy and the registered manager as requiring immediate attention to ensure people were protected from risk.

There were no personal evacuation plans (PEEPS) in place which meant staff would not know how to support individual people in the event of an emergency. The service had undertaken some stimulated evacuations with staff so they understood their responsibilities but not all staff had yet undergone this training. We examined the records and saw evidence of fire alarm testing and training but also found that there was evidence of emergency lighting repairs having to be repeatedly reported.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) checks, reviews of people's employment history and that two references had been received for each person. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

During our visit to the home the senior carer and two nurses were observed completing a scheduled

medication round. All medication was supplied by a local pharmacy and transferred to the three medication trolleys; one for the residential unit and two for the nursing unit. The prescribed drugs were dispensed by a local Pharmacy in colour coded blister packs and non-scheduled solutions or tablets were kept on the trolley shelves. We found stock control was accurate throughout the home and that there were effective processes in place for checking the Controlled Drugs. There was a list of staff signatures and consistent monitoring of the room and drug fridge temperatures.

There was a medicine management policy and procedures in place and we saw evidence that staff had had an annual medication management competency check and that regular audits were undertaken. Whilst the administration of all medication was in line with best practice we had some minor concerns. We observed the Do Not Disturb Tabard supplied for the medicines administrator was not worn and we witnessed the registered manager interrupting the senior carer during the medicine round in order for them to take an external phone call when they could have taken a message. We also noted that the registered manager left the mobile phone with the expectation of the carer answering further calls which meant they were at risk of constant interruptions at a time they should not have been disturbed to enable them to safely administer medicines.

The MAR charts had peoples' details and most had an ID photograph. We saw no protocols for non-scheduled "as required" medication and no risk assessments for those people who lacked capacity. We were told that the care plans contained this information, however when we tracked four care plans this information was either not available or not in specific detail. We also found that some staff were not aware of all the drugs' effects or of people's medical conditions. We found that the boxed medicines for pain or anxiety control and laxatives were recorded on the MAR chart and a chart for running totals maintained on a separate chart. However we found some running total charts were missing for new people and that some charts had not been maintained.

Records showed accidents and incidents were not always recorded and the registered manager told us they were not up to date with their accident analysis. We found poor analysis of accidents, meant that changes were not made to the service as a result of these.

We found a number of Health and Safety Issues of concern during our visit. These were most notably in the kitchen where the repair of essential equipment for the running of the home had not been expedited. The dish washer was broken as well as the hot water boiler system supplying the kitchen. We found staff boiling pans of hot water which they were transporting in jugs to rinse crockery which was highly dangerous. We checked the first aid box to find no supplies to deal with burns should an accident occur. This was discussed with the registered manager who was not aware of the situation even though this equipment had been out of use for some time which demonstrated the reporting system was not robust. Staff did not know when to expect that they would be repaired.

We observed the home was clean with sufficient automatic sanitation and soap dispensers and staff had access to plentiful supplies of protective aprons and gloves. We did note that there were no arrangements in place for ensuring hand hygiene during medication rounds and discussed this with the registered manager who advised us that this would be rectified. In addition there was one lapse of good practice when one member of the care staff put dirty linen on the floor instead of using the dirty linen skip provided by the home. People did not all have individual moving and handling slings and slide sheets which poses an infection control hazard and this was raised with the registered manager.

The above examples demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

We asked the registered manager how new staff were supported to develop into their role. The registered manager told us all new staff would be completing the Care Certificate as part of their induction and the registered manager would be the accredited assessor for this. Staff had been completing the previous management company's induction up to the recent changeover of the management of the home.

As part of our inspection we asked the registered manager whether staff had received training to enable them to have the knowledge and skills to perform in their role. The registered manager told us training was not up to date as a result of the changeover in management and they did not have a printed training matrix or a record of individual staff training. They told us they could access training information from the computer and provided us with some information on the day of our inspection. We requested the registered manager sent us the information following the inspection and this information was provided by the regional manager which confirmed not all training was up to date but the new management company had put in plans to ensure essential staff training was provided without delay.

The staff we spoke to on the day of our inspection told us they had either up to date professional or nationally recognised care qualifications. In addition they had completed their required essential training to ensure they maintained their skills in order to provide safe services to the people who lived at the home.

We saw evidence that staff had regular supervision. However, on review of supervision records we found no evidence supervision was supporting staff to develop in their roles as it did not review gaps in knowledge and skills or look specifically at staff training requirements. The registered manager showed us a reflective log they were intending to use at future supervisions sessions so that staff could reflect on their practice to ensure the people at the service were provided with the highest standard of care. They told us they were planning to change supervision to ensure the nurses were supervised by the registered manager or deputy manager, the seniors by the nursing staff and the care staff by the senior staff.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had three authorisations in place and was waiting the outcome of a further request they had made to the local authority for an authorisation.

We found the legal two stage capacity assessment in one care file which was not decision specific (although the provider's form stated "a separate test is required for each decision"). Although this person was found to lack capacity to make decisions, there was no best interest decision recorded to enable the care staff to lawfully carry out the activity which meant the registered provider was not meeting the requirements of the Mental Capacity Act 2005.

We found not all staff had received training in assessing mental capacity or DoLS and some staff who had received training could not remember they had undertaken this training. Staff were able to advise us how they would act in the person's best interests whilst providing care. Staff understanding of DoLS was still around safeguarding people who were requesting to leave with no consideration of the recent changes in the interpretation of the legislation which widened the scope of the safeguards to include those people who were under constant supervision and control and were not free to leave, whether or not they were asking to leave the home.

We found consent for care and treatment had not always been recorded in people's care plans and the lack of adherence to the Mental Capacity Act 2005 meant the service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were told that there were handovers at the beginning of each shift but the handover information we saw in use on the day of our inspection contained very basic information. It was described as "not very good" by one temporary member of staff who told us it did not provide the information they needed to be able to provide the delivery of effective care services.

We observed the dining experience in the main communal dining room on the ground floor and the small dining area on the nursing unit. Tables were laid with table cloths and condiments. We observed people were not offered a cold drink or juice at lunch time although a member of staff came round with a hot drink during the meal. Some people requested a cold drink and this was provided. People were observed to be enjoying the food and we heard comments such as "That was very nice" and "I really enjoyed that" One relative we spoke with told us "The food must be good [relative] has put weight on since they came here" Another person who ate in their room told us they liked the food and we saw evidence in their care plan that their weight was regularly monitored and they had put on weight since they had arrived at the service.

There was a small dining room on the second floor but it was only used by three people as most people ate in their room. We saw people being supported with their food and drink. A number of people had their food and drink monitored but we found recordings to be intermittent and we were unable to be confident about their nutritional intake. For example, we found one highly dependent person's daily records were not consistent with the recorded information. Their care plan was incomplete even though nutrition had been identified as of concern. We discussed this with the deputy manager who had undertaken the care assessment. We pointed out the inadequacy of the monitoring and recording as it indicated the person had lost a significant amount of weight since the pre- admission assessment. However, this could not have been accurate due to the amount of weight loss recorded which meant the records must have been wrong initially. This poor recording was evidence of a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that most people's weights were being monitored monthly but that was problematic as the weighing chair had been broken for some time. Although there was a set of weighing scales attached to the hoist for those people who were hoisted, not everyone had been assessed for the use of the hoist. Staff did not know when they could expect a replacement for the broken weighing chair.

We inspected the kitchen and found a modern stainless steel facility. It had a five star food hygiene rating and apart from the health and safety concerns we reported on earlier in this report, we found it to be was a well-stocked, organised and controlled with competent trained staff.

We saw evidence in people's care records that they had access to other healthcare professionals including G.P, occupational therapy, community psychiatric nurse, dietician and chiropodist. We saw evidence of partnership working with community health teams to assist in the management of people with complex needs.

Alwoodleigh is a converted Victorian property with a double storey extension. Bedrooms for people with residential care needs were on the ground floor and nursing care was provided on the second floor accessed by a staircase and a lift. Most bedrooms were laid out appropriately to meet people's needs with en-suite facilities. There was a well-equipped laundry in the basement.

Requires Improvement

Is the service caring?

Our findings

We asked people using the service whether staff were kind and caring. Most of the people we spoke with were very positive about the staff, particularly those people who had lived at the service for a long time. One person said "Oh it's very good here, everything is done for you". Another said "They are very kind to me even when I'm a bit naughty". This person's relative told us "[Relative] can be demanding and agitated at times but they are very kind and understanding with [relative]". However, one person we spoke with who had only been at the service for a short time was not happy and said "They don't do 'owt to help you. One or two are alright. They could vastly improve."

Staff told us they "loved the home" or they were a "caring person" and continued to enjoy their work. They told us they could tell they were providing good care from the positive feedback from relatives but also from the people using the service either verbally or through their body language.

We saw some evidence of friendly and warm interactions between staff and people who lived at the home and their relatives. All relatives and friends we spoke with reported being able to visit without restriction and families told us they were encouraged to be involved. A recently bereaved relative told us that staff had been "fantastic".

Staff told us they respected people's dignity and privacy by closing doors when undertaking care, closing curtains and covering people when undertaking personal care. However one person told us care staff had not treated them with dignity when showering which we reported to the regional manager.

While most care staff were observed to be caring and interacted with residents in a respectful and dignified way, they did not challenge or react to other staff when they were less so. For example, we heard the following as lunchtime approached. One carer said in the communal area "Can we start to get people ready for lunch?" Another carer pointed to a resident who was in the room and asked "Is she coming as well?' They then approached this person, stood at their side, gently shook their hand and said "Hello, wake up it's time for lunch" At this point another carer called this carer away. They placed a walking aid in front of the person and without explanation or further conversation walked off. A short time later, another carer came into the room and approached the person, stroked their hand and crouched down to eye level saying "Hi (name used) are you coming for lunch? The person replied "No not just yet". The carer replied "OK, I'll come back in a minute". They then stroked the residents hand and left the room.

Staff told us how they encouraged people to remain independent whilst at the service and those people who could get themselves washed and dressed were encouraged to do so, or do the parts they could manage without support.

We saw evidence the service used advocates when appropriate to support people who required assistance to ensure their rights were protected.

The nursing unit had difficulty maintaining confidentiality as this floor had no office or place to store

confidential documents. They had a desk and filing cabinet for care plans on the landing which meant they had difficulties ensuring their conversations with relatives and other staff remained private. We were told that a room was being converted and it had been on-going for approximately six months and was almost complete.

We were told that the home had had a high turnover of people recently admitted for end of life care but we did not see end of life care plans in all the files we reviewed although relatives told us how they had been supported by staff with compassion at this time.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection the service was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation17 (2)d of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had failed to protect people against the risks of unsafe or inappropriate care because up to date and accurate records had not been maintained. At this inspection we found the service had not made improvements in this area and some records were still incomplete which meant that the service was still in breach of this regulation.

We examined nine care plans and tracked the care people were receiving. We found that people who had been admitted recently had either partial or no care plans in place and inadequate assessments in relation to their care and support needs. Consequently people were providing task centred care based on mainly personal hygiene care. Those people who had been living at the home longer, had care plans in place but they also lacked the detail to provide all the care they required. They did have some evaluations that reflected a response to changes in their conditions but the level of detail was not consistent in all the files we reviewed.

The lack of recording included incomplete life histories which meant it would be difficult to tailor care to meet the person's needs based on past life experiences, preferences and previous choices. Yet for people who had been living there for some time we saw life histories had been completed giving staff the detail required to provide more personalised care. One relative we spoke with told us "I was asked to fill in a MY LIFE booklet when [relative] first came in the home, I thought that was very good" When asked whether they had seen evidence of the information being used by staff in the care of their relative they replied "No, I pinned a copy up in their room but [relative] keeps taking it down".

We asked people using the service and their relative if they were offered choice in their daily lives. One person told us "My [relative] did not want his lunch at lunch time so they arranged for them to have it later in their room" We observed in the communal dining area that people could choose where they preferred to sit for lunch and one person who wished to dine alone was accommodated on their own table. People were offered a choice of two main meals and puddings, and we observed an alternative to the menu pudding being provided for two people who did not want the choice on offer.

Despite these examples of choice we found that there was a lack of recorded evidence in the care files we reviewed that people were offered choice in designing their support plans including what time they wanted to get up and go to bed, food preferences, whether they wanted support to be provided by a male or female carer, and how they wanted this support to be undertaken.

Staff told us the service employed an activities co-ordinator Monday to Friday from 9 am to 3.30 pm. They were on leave at the time of our inspection and we saw no evidence of any meaningful activities on the day we visited and there were no arrangements in place to provide activities when the coordinator was not in

work.. We were told by staff that there were activities on offer such as group activities which varied from a film afternoon on a Friday, biscuit decorating in conjunction with kitchen staff, shopping with some people and attending football matches with others. The home also employed a company once a month to undertake chair based exercises. We reviewed the activities file and records for some people included "visited by son", or "had hair done at the hairdressers." There was a lack of recording of any meaningful activities undertaken on a daily basis in people's care plans and a lack of recording of people's wishes preferences in this area in the majority of care records we reviewed. This was a breach in Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found the garden area was well maintained with adequate seating and people we spoke with who accessed the garden told us they enjoyed having this facility and they could go out when they liked for their daily walk. They told us "I go out for my constitutional round the block whenever I want"

We asked people who used the service and their relatives if they were able to raise concerns or complaints at the service. They all told us they would have no worries about bringing issues to the attention of management. One person said "I'd tell the manager if I had any worries but I haven't"
A friend of a person living there said "I've raised the issue of the room being small, [the manager] said they would look at alternatives if one became available."

The home had a complaints policy and procedure. Whilst staff were clear about reporting any concerns to senior staff and understood about safeguarding they did not report or record all complaints. We were told that they would resolve the complaints they received from relatives or people who lived at the home which they described as minor rather than record them. The registered manager told us they had received no complaints. As the CQC had referred three complaints to the registered manager, this was not accurate. When asked how the service learnt from mistakes, they told us issues were discussed with staff at supervision. Failure by staff and the registered manager to record these complaints meant the home did not learn from repeated problems or from their mistakes.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post who had been registered for 12 months. They had been absent for a period of time in 2015 and left the service shortly after this inspection took place. The registered provider had employed a new operating company to take over from the previous company in January 2016. They had undertaken a whole service audit and although this had not been shared with the service found similar issues to those found at inspection. A temporary support structure had been put in place following the departure of the registered manager by the operating company, with management oversight from the regional manager to ensure immediate improvements in the service provided at Alwoodleigh.

We found there had been a lack of leadership at the service. The registered manager did not have a clear vision for the home in terms of improving the service for the people living there and supporting staff. One member of staff told us the deputy manager was approachable and supportive and without them they would have left long ago. Another member of staff told us the registered manager was often absent, but they could always get hold of them by telephone if required. They told us they could make suggestions for improvement but these were not always acted upon. The permanent staff were dedicated to the service and told us they enjoyed working there. There had been a high turnover of staffing with a high usage of temporary staff and a lack of stability in management at the service.
We found staff meetings had been held and recorded. The registered manager told us meetings with staff were held every three months but told us the attendance of staff was poor at these meetings as they could not make staff attend as they did not get paid to attend. They told us they ensured staff were given a copy of the minutes from the meetings. Staff told us these meetings were not an opportunity to contribute to the improvement of the services but were used to inform staff of relevant information. We reviewed the staff meeting minutes for October 2015 and January 2016 which confirmed these were a forum to cascade information to staff. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service

We also found systems for ensuring staff had the skills and knowledge to meet people's needs were not always in place. For example, we found at this inspection there was no robust monitoring of staff training needs by the registered manager, which we also found at the previous inspection. We found that all supervisions had been completed, but supervision was not used to identify gaps in knowledge and areas on the supervision record form to detail future development needs had been left blank. Consequently there were no actions to discuss progress from one supervision to the next. The registered manager showed us a reflective log they intended to use in future supervisions, and also how they intended to delegate supervision between staff groups.

We found there was no systematic approach to auditing service user care plans and daily records. The registered manager had not undertaken an audit of care plans since May 2015. This was an issue raised at the previous inspection when we were told 10% of care files would be audited each month. Poor recording had also been an issue raised during a recent safeguarding investigation. This demonstrated the registered manager was not monitoring the quality of service provision to monitor improvements for deficits already

identified.

The registered manager was unable to provide us with evidence on the day of our inspection that they were holding relatives and residents meeting nor could they provide us with information from the resident and relative questionnaires and they had agreed to send this to us following the inspection but this information was not sent on. Therefore they could not evidence that feedback was being monitored or analysed for trends or concerns which may require further action.

At our last inspection we saw the registered provider completed a quality monitoring report every month and undertook a thorough audit of the service provided. This included an audit of the environment, medicines, care plans, the kitchen and maintenance files. Any actions required were passed to the manager to complete. We asked the registered manager if we could see a copy of the audits carried out by the registered provider since our previous inspection. We were not provided with any. We did not see any evidence the registered manager had audited the service against the CQC fundamental standards of care to evidence they were monitoring the quality of their service and to show they were making improvements from our last inspection.

We found that the service did not recognise complaints as opportunities for learning which could have a positive effect on the service in terms of identifying patterns and themes to enable the service to improve. We found that the lack of reporting of both complaints and accidents and incidents meant the service was not able to analyse or learn from mistakes and put actions in place to prevent a reoccurrence.

These examples evidenced a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was meeting its registration requirements in terms of statutory notifications sent to CQC. We examined the facilities certificates such as insurance, gas electric, lift servicing and water testing were all in order and maintenance audits were all up to date.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of meaningful activities for people at the service. Views and preferences of people requiring support had not always been recorded to enable staff to care for them in their preferred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent had not been evidenced for those people with and without capacity to consent.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There had been a failure to ensure care and treatment was provided in a safe way, as the service had not adequately assessed and mitigated risks to people using the service.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There had been a lack of leadership at the service which meant the quality of the service had not improved from the previous inspection.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was no adequate system in place for determining staffing levels to meet the needs of the people at Alwoodleigh. There was inadequate information and support for agency staff to enable them to provide appropriate support for people at the service.

The enforcement action we took:

Warning notice