Shires Healthcare (Woodside) Limited

Woodside Nursing and Residential Care Home

Inspection report

The Old Vicarage
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Tel: 01582423646

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22 December 2016

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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

This inspection was carried out on 13 and 22 December 2016 and was unannounced. When we inspected the service in February 2016 we found that the provider had failed to ensure the appropriate management of people's medicines. People's care plans had not been reviewed and were not person centred. The quality assurance system was ineffective, with no actions identified to ensure improvements were made. During this inspection we found that these areas had not been addressed effectively and additional areas requiring improvement were identified.

Woodside Nursing and Residential Home provides care and accommodation for up to 27 people, some of whom are living with dementia. At the time of our inspection there were 20 people living at the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People did not always receive their medicines as they had been prescribed and medicines administration records were not always correctly completed. Stocks of medicines held did not always correspond with the amount recorded. Medicines were not therefore managed in a safe way.

The home had not been cleaned to an acceptable standard to prevent the risk of infection or provide an environment free from unpleasant odours. The underlying causes of some maintenance problems, such as toilets not working, had not been addressed and consequently any improvement that was made was only temporary.

Neither people nor their relatives had been involved in determining their care needs or the way in which their care was to be delivered. Care plans were not person centred, contained inaccurate information and were task orientated. There were insufficient staff to provide care and support to people at times when their needs were at their highest. This did not ensure that people were provided with appropriate care at all times. The staff were, however, kind and caring, treated people with respect and supported people in a way that allowed them to be as independent as possible.

The recruitment and selection processes in place were robust and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. Staff had not received all the training that they needed to ensure that people were supported safely and effectively and could not remember all the training that they had completed. Staff were supported by way of supervisions and appraisals and were encouraged to acquire and maintain relevant professional qualifications.

The quality assurance system was not robust. Documentation was often inaccurate and incomplete. Audits were carried out by members of staff who had responsibility for the areas being audited. Errors and

omissions had not been identified through the auditing processes. The provider organisation had no oversight of the quality of the service provided.

Information was available to people about how they could make a complaint should they need to. People and their relatives were able to make suggestions for the development of the service. People were assisted to access other healthcare services and professionals to maintain their health and well-being.

During this inspection we identified that there were breaches of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive their medicines as they had been prescribed. There were no protocols in place for medicines that had been prescribed on an as needed basis and information was lacking in care records as to the possible side effects of medicines that people took.

An acceptable level of cleanliness was not monitored or maintained and the maintenance of the home was poor. Remedial action had not been taken to address the underlying causes of the persistent problems.

There were insufficient staff to provide the care and support people needed at all times.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were unable to remember training that they had completed and there were gaps in evidence to support that staff had received the training relevant to their roles.

Although appropriate authorisations to deprive people of their liberty were in place staff were unaware of the people to whom these applied.

People's consent was not always requested before care or support was provided.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and caring but did not have time to sit and talk with people about things that were important to them.

People did not always receive personal care in a way that protected their dignity.

People were encouraged to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were not involved in the development and review of care plans to ensure that they were person-centred. Care plans contained information that was incomplete and incorrect.

People were involved in a variety of activities and were supported to maintain their interests and hobbies.

The registered manager responded appropriately to complaints about the service.

Is the service well-led?

Inadequate

The service was not well-led.

Improvements made to the cleanliness and maintenance at the home and the quality systems and processes in 2014 had not been sustained.

The quality assurance system in place was not robust and members of staff with responsibility for an area also had responsibility for auditing that area. As a consequence errors and omissions made had not been identified during the quality audits. there was no oversight of the quality of the service by the provider organisation.

People and their relatives had the opportunity to contribute to the development of the service.

The registered manager was visible and approachable.

Woodside Nursing and Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 22 December 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people and the provision of care to older people in a care home.

Before the inspection, the provider completed 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 also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with nine people and two relatives of people who lived at the home. We also spoke with three care staff, the clinical lead, an activities co-ordinator, the chef, the registered manager and one of the directors of the provider organisation.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments of four people. We also looked at how people's medicines were managed. We looked at three staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Inadequate

Is the service safe?

Our findings

When we inspected the service in February 2016 we found that people did not receive the medicines as they had been prescribed and that stocks of some medicines were not as the records showed they should have been. During this inspection we found that this was still the case. Also, there were no protocols in place for people who had medicines prescribed on an 'as needed' (PRN) basis. We noted that one person who had recently been admitted to the home had been prescribed a medicine to be administered twice daily. When we looked at the medicines administration record (MAR) we saw that it had been administered three times a day for a period in excess of two weeks. We discussed this with the clinical lead and the registered manager. The clinical lead contacted the GP who confirmed that there would be no long term effects of the medicines overdose for the individual, although in the short term it had caused them discomfort and distress.

We saw that care records included a drug profile for each individual which listed all the medicines that they had been prescribed. This profile was to be used to inform staff of the side effects that each medicine could have on the individual. However, the profile merely instructed staff to refer to the British National Formulary (BNF). One person had 15 different medicines listed on their drug profile. We spoke with the clinical lead who agreed that staff could not be expected to look up all fifteen medicines to see if any symptoms the individual displayed could be caused by their medicines. They later updated the drug profiles to include possible symptoms staff should be aware of. We also saw that the latest medication audit had identified that the service did not have the most up to date copy of the BNF and that the individual's drug profile had not been updated when their medicines had been changed.

We found that there were no protocols in place to advise staff when people should be offered their medicines that had been prescribed as PRN or the frequency with which they could be given. We brought this to the attention of the clinical lead. They then developed protocols for each individual who had been prescribed PRN medicines. They told us that they would discuss the protocols with the GP at their next weekly visit to the service and get the GP's agreement to the protocols before they were introduced.

We looked at the medicines administration records (MAR) for three people and found that these had been fully completed. However, when we carried out a reconciliation of the stocks of medicines held for one person we found that there were discrepancies in the stocks of two medicines. There was more stock held of one medicine than the records showed. This indicated that, although the MAR had been signed to signify that the medicine had been administered, it had not been given to the individual.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in February 2016 we initially had concerns about the cleanliness and maintenance of the home but improvements were made during the course of the inspection. Repairs had been carried out, a new cleaner had been employed and new cleaning schedules had been introduced. The Director we spoke with at the time was confident that the new cleaner would be able to maintain an acceptable standard of cleanliness around the home. During this inspection we found that the home was

not cleaned or maintained to an acceptable standard.

Relatives told us that the home was not always clean. One relative said, "The Saturday before last it really smelt in the service, very often the floors are not cleaned, the carpet is heavily stained in the dining room and it does not feel clean. When [relative] was in room [number] my [relative] and I came in and the smell was so bad it made you retch."

We found that carpets on stairs and in the two lounges were dirty. On the ground floor the carpet was heavily soiled and there was a smell of stale urine. The carpet in the first floor lounge was heavily soiled, as were some of the chairs. The communal bathrooms were in a poor state of repair and could not be cleaned effectively. In some bedrooms and en-suite bathrooms rooms the walls were dirty and tiles were chipped. Relatives of people were also concerned about the maintenance of the home. One relative told us, "No, always clean no it isn't but that is not the main problem. Things just don't get fixed. The lift is everlastingly broken down. They can't then get [relative] down to the lounge. The toilet up here [the first floor] does not flush. The toilet downstairs is out of order. They say they are waiting for someone to come. They would be better of employing a maintenance man to do things as they occur. It's not really good enough. They are not really responsive to me because things stay broken for too long." Another relative said, "It takes them far too long to fix things. When [relative] was upstairs the lift was often broken, this caused me many problems with my stick walking up to see [them. They were] not able to be brought downstairs. So I am glad now [they are] downstairs, but the toilet down here is out of order and has been for about three weeks."

In February 2016 three of the four available toilets were not working. During this inspection we found that two were not working on the first day. This was brought to the manager's attention and a maintenance person attended to repair them. On the second day of our inspection these toilets were again not working. This indicated that the underlying causes of the problems had not been resolved. Following the inspection the registered manager told us that repairs had been made and the identified problem with one toilet had been resolved. The first floor bathroom was being changed to a walk in shower room, with the refurbishment scheduled to start on 9 January 2017. They told us that this would resolve the issue with the second toilet.

In the lounge on the first floor the cord on the sash window had broken and the window was propped open by a cushion. One of the doorways to the lounge had been damaged and the wood surrounding it was splintered. This presented a risk of injury to people who lived at the home and their visitors. Although this was repaired immediately after we brought it to the registered manager's attention on the first day of the inspection, we saw that it had again been damaged on our second visit. We also found that the vinyl flooring in one bedroom and in a corridor had wrinkled and presented a trip hazard to the person who lived in the room. The director of the provider organisation had arranged for this to be addressed but on the second day of the inspection, we saw that the wrinkles had not been totally removed from the flooring and the person was still at risk of tripping on it.

There was a stair lift on the main stairs between the first and second floors. This was not clean and did not work. We noted, as we walked around the building on the first day of our inspection, that many of the doors to people's rooms were chipped and had holes in them. We brought this to the registered manager's attention and on the second day of the inspection we noted that the doors had been repainted. However, not all the holes in them had been filled before they were painted and the doors were still unable to be cleaned effectively. This increased the risk of people acquiring an infection.

We saw that the service had gained a level five (the highest possible) from the Environmental Health Agency for food hygiene in July 2016, shortly before the new chef was employed. However, staff we spoke with on

the first day of our inspection told us that the kitchen was not clean. When we looked we found that the cooker and gas hob were encrusted with burnt on grease and food. The hot trolley was also encrusted with grease. Doors to two of the cabinets were damaged and could not be cleaned effectively. Dirty pots were piled in the sink, although the cook had finished for the afternoon. The Director told us that they had identified that the kitchen appliances needed to be cleaned the previous week and had understood that this had been completed. On the second day of the inspection we saw that the cooker, hob and hot trolley had been cleaned, although not all the burnt on grease had been removed. What remained did not present a risk of contamination to the food people were given.

The issues with failing to maintain cleanliness and effective maintenance of the premises were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed opinions as whether there were enough staff to support them effectively at all times. People who were more able and independent felt that there were enough staff but people who were cared for in their rooms did not. One person who was cared for in bed told us that they struggled to get someone to come and assist them when they pressed the call bell. They and their relative both put this down to there not being enough staff. Another person said, "Blimey, you are lucky if someone comes at all." A relative told us, "When I press the bell they come reasonably quickly, turn it off and say [they] will be back in 10 minutes but then doesn't come back. Sometimes it can be an hour, so we press the bell again then someone completely different comes and [provides personal care]. Shortages of staff is the usual problem. They haven't got the time to give 100% to anyone."

At one point during the first day of the inspection 12 people were sat in the lounge. There were no care staff in the lounge to support them, although the activities coordinator was with them. When one person wanted to go to the toilet urgently there was no member of the care staff available to assist them. By the time the activities coordinator had found a member of the care staff it was too late. The person was embarrassed in front of the other people in the room and had found this distressing.

All the staff we spoke with told us that there were not enough staff to provide safe, effective care. One member of staff told us, "In the morning we go in, change their pads and get them breakfast but we have to go back much later to get them up. We have to keep service users waiting to get up. We have agency staff, two to three times a week, but they don't really help because they don't know the residents and they have to double up with us regular staff." Another member of staff said, "The biggest problem is we are pulled in too many directions, for example we have to cook the tea because the chef finishes at 3.00pm. We have to wash up and clear up as well as look after the residents. There are many times when people have to wait for attention because of this."

The registered manager told us that, as there was no kitchen staff after the chef left, the care staff were required to prepare and serve the tea time meals. Care records we looked at showed that many of the people who were living with dementia required more support in the late afternoon and caring for them would take longer at this time. However, this was the very time that the number of care staff was reduced. We spoke with the Director about the impact this had on the people who lived at the home. They agreed that they would consider either employing an additional care worker in the afternoon or a kitchen assistant to undertake the catering duties.

The issues with failing to have enough staff to maintain cleanliness and provide timely support to people were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe at the home for a number of reasons. One person said, "Oh yeah I feel safe, not half definitely. The carers make you feel this is your home and so we feel safe." Another person told us, "I do feel very safe here. It's the staff, they are very good to us, really they are." A third person said, "I feel happy and safe. I have been here a few years, so it is home." A relative told us, "I think [relative] is safe here yes. I have no concerns about that."

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. However, not all staff were able to explain what whistleblowing was. One member of staff told us, "It is talking to someone, who may not be a senior about things that concern me at the home." Information about safeguarding people was displayed within the home. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I have to call the social people and then tell manager." Another member of staff told us, "I would report it to the manager straight away." However, one member of staff said, "I would report it to the manager, but as a senior carer I might talk to the person involved and try to find out by questioning the people concerned what is going on. If it is severe pass it on to the manager. The manager is very good." Our records showed that appropriate referrals had been made to the local authority safeguarding team and notified to CQC.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with the use of bed rails, the risk of people suffering falls, moving and handling, people's risk of developing pressure ulcers and experiencing malnutrition. We saw that in one person's care record there was a risk assessment completed as the person was on oxygen therapy. This covered areas such as the fire hazard presented by the presence of oxygen cylinders, the reduction of space in the person's room and the actions that needed to be taken to reduce the risks. The assessment also included information about actions staff were required to take when the person mobilised around the building or went outside. There was also a risk assessment included for the relief of pressure areas, which included the use of a pressure relieving mattress. Although the risk assessment required staff to check that the mattress was at the correct pressure, it failed to give any information as to what this figure was.

We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of both of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and by talking at shift handovers. This gave staff up to date information and enabled them to reduce the risk of people suffering harm.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included assessments of any hazardous substances on the premises, fire risk assessments and the checking of portable electrical equipment. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. These enabled staff to know how to keep people safe should an emergency occur. However, not all staff were aware of the correct procedures to follow. One member of staff told us that if the fire alarm went, "I would go to the manager and ask if it's a real fire and then make sure the service users are safe." This meant that people could be put at risk of harm because of a delay in taking the correct action. We noted that the contingency plan was last reviewed in January 2016. This document gave the name of the former

clinical lead, who had left the organisation, as the emergency coordinator. This could cause confusion to staff in the event of an emergency occurring.

We looked at the recruitment documentation for three members of staff who had recently started work at the home. This showed that staff employed by the service had been through a thorough recruitment process before they started work to ensure they were suitable and safe to work with people who lived at the home. Records showed that all necessary checks were in place and had been verified by the provider before each member of staff began work. These included Disclosure and Barring Service checks (DBS) and references were completed to confirm that staff were suitable to support people safely. Where staff needed to have been registered with a
regulatory body, for example, nurses, this had been completed and kept under annual review.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that the permanent staff had the skills that were required to care for them, although the agency staff were not so good. One person said, "The casual staff who come most weeks don't know us well, that can be difficult, but the other staff are all very good."

Staff told us that they received the training they required for their roles, although not all staff we spoke with could remember the training that they had done. One member of staff said, "I have done the training package but I am not sure if there is infection control. I think the last package was two to three months ago but I am not really sure what it was." Another member of staff told us, "I am still doing the packs. I admit I am not very good at paper work and doing the training on my own. I am finding it very hard going. It is not very easy for me to do lessons I am alright practically doing things but not learning about it from books. I think we did do infection control here one day after work but I don't know." Another member of staff, who had recently joined the home, was asked about their induction. They said, "I can't remember."

The registered manager told us that training was normally completed as distance learning and was evaluated by an external assessor by way of a written test. When staff achieved the pass mark they were issued with a certificate, which was valid for a period of three years. The registered manager held these certificates in the staff files. There was no other form of validation of the effectiveness of the training that staff had received although there was evidence that training was discussed during staff meetings.

The registered manager showed us the training matrix which was used to monitor staff training. We noted that there were many gaps in this matrix. We discussed these with the registered manager. They told us that they had recently issued a number of staff with the booklets for the training. We highlighted that the clinical lead had considerable gaps in their training. The registered manager told us that they thought the clinical lead had completed the training with another provider prior to joining the home, but could not find the relevant certificates to confirm this. The records showed that the clinical lead had not completed training in person centred care planning but they had the responsibility for the completion and auditing of the care plans for the people in the home. We found that, as a result of their lack of training in this area, people's care plans were not person centred and did not fully reflect their needs.

The failure to ensure that staff were trained effectively to carry out their roles was a further breach or Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed opinions about the food and drink they received and told us that they were not given a choice of food. One person told us, "It's not too bad. You can tell them you don't want it a bit hard because we don't get a menu or choice the day before. They don't tell you what you are getting. There is one main course every day and we never know what is coming for pudding or tea." Another person said, "It's reasonable, it mostly hot. We do get vegetables but we don't know what we are getting especially at tea time. We do seem to get enough to eat." However, another person told us, "Its muck I can't eat it. I rely on my [relative] to bring my food in."

We observed the lunch time experience for people who lived at the home. People's meals had been plated up in the kitchen and were served from a trolley which meant that they did not have to wait for their meal to be served. One person told us, "It is hot." Another person said, "It is generally hot when I get it." People were, however, given their food without any explanation as to what it was. The staff who were serving the food also did not appear to know what they were giving people. When we asked what the pudding being served was, a member of staff told us, "I think it's peach. I am not sure maybe it's apple."

Failure to give people a choice of food was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to eat their meals independently and appropriate equipment, such as plate guards, were used to aid this. Where needed, staff assisted people to eat their meal in a calm and supporting way.

People told us that, rather than ask for permission before they were supported, staff told them what they had come to do. One person said, "Sometimes one carer turns around and says to me, "right bath time, come with me." And you have to go." We saw people sitting at the table being served with snacks by it being put down in front of them without any explanation as to what it was or being asked if they wanted it.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although staff had received training on the requirements of MCA none that we spoke with could recall when this had taken place or tell us of any person for whom a DoLS authorisation was in place. We had, however, received notifications about a number of successful DoLS applications that had been made for people who lived at the home. As staff were unaware of the DoLS they may not have been delivering care in accordance with the requirements of the authorisation and may have been depriving people of their rights.

Care records we looked at showed that, where applicable, assessments of people's mental capacity had been carried out. Decisions had been made on their behalf that were in their best interest following meetings with other health and social care professionals involved in their care and family members. There were formal records of these meetings. Staff told us that decisions made in people's best interests on a day to day basis were recorded in the daily notes within people's care records.

Records we looked at showed that staff had completed supervisions in September 2016 and appraisals had been completed in November 2016. However, one member of staff told us, "I have not had supervision recently, not for 6 months I think. I can't remember when my last appraisal was." Another member of staff said, "I had my supervision and appraisal at the same time last week maybe the week before." The

registered manager told us that staff were supported to discuss any training or development needs they had during these meetings. One member of staff confirmed this and said, "You can progress if you want to, they will support you. They supported me to be a senior carer. I would like to go one more stage to be team leader. They will help me do the training but that is not my strong point."

People were supported to maintain their health and well-being. Their weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake. These charts provided detailed information on what they had consumed. A relative told us, "I am concerned a little about [relative's] so they have started [them] on special shakes this month. [They] are weighed monthly." One member of staff told us, "We weigh people monthly." Another member of staff said, "We give some people those shake drinks to help them." Where needed, referrals had been made to the local dietetic service and the speech and language therapists.

People had access to other healthcare professionals. One person told us, "They will get the GP for me; I have just had some new glasses. The chiropodist visited us last week. I need to see a dentist, not sure when he will come." Another person told us, "If I want to see the G.P. I can ask to see him. There is no need for me to see an optician or a dentist. Funny enough I saw a chiropodist a few weeks ago." The registered manager told us that the community dentist would no longer visit the care home so people had to attend local practices for dental care.

Requires Improvement

Is the service caring?

Our findings

People and the relatives we spoke with told us that the staff were kind and considerate. One person told us, "I can say I am being very well cared for. They are a damn good crowd here for looking after you. They are very kind and patient. I can't fault them at all." Another person said, "The carers are very, very pleasant so far." However, people told us that staff did not have time to sit and talk with them. One person said, "They do chat away when they are giving you care but not at other times." One member of staff told us, "Sometimes we can talk to service users in the afternoons but not always." This indicated that the care that was provided was task orientated not centred on the people who lived at the home and not reflective of a service that was caring.

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. We saw that staff communicated appropriately with people. People told us that without exception staff treated them with dignity and respect. However, one relative told us, "[Relative] says when [they] ask them to take [them] to the toilet, either [they] can't find anyone to take [them] or [they are] told they will come back. [Relative] does not like having to use [their] pad but often has had to do so. I think this has affected [their] dignity." They went on to say, "Generally [relative] is wearing clean clothes and doesn't smell."

Staff told us how they protected people's privacy when assisting them with personal care. One member of staff said, "I shut the door and curtains, make sure that they could cover themselves with a towel and or dressing gown and cover them as much as possible." Another member of staff told us, "We give them a full body wash. We go to the room with the towels. They do have a bath or shower but many don't like it in the winter."

People told us that they were involved in determining how their care was delivered. One person told us, "The girls do seem to listen to me when I ask for things to be done a certain way." However, when we asked how people chose what they wore each day, some staff told us that they asked people what they wanted to wear whilst others told us that they selected something from the person's drawer for them. They did not appear to understand that people should make their own choices wherever possible.

People were encouraged to be as independent as possible. One person told us, "I look after myself. I am just here so I have company." Another person said, "The carers do help me to get washed and dressed. I do as much as I can, I can walk about fine but I can't reach my back. They are very good and help me as much as I want them to." A member of staff told us, "I would let them do what they can for themselves and help where they need me to."

Friends and relatives were able to visit people whenever they wished. We saw that there was information displayed within the reception area about the home and services available within it, including a weekly hairdresser and a chiropody service. Information about weekly visits by a Pet as Therapy (PAT) dog was displayed as well as information on safeguarding and the provider's complaints system, together with an advice leaflet produced by the local council. This provided people and the relatives contact details they

might use if they wanted advice or to raise any concerns outside of the home.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in February 2016, we found no evidence that people or their relatives had been involved in the assessment of their needs or the development of their care plans, nor had the care plans been updated when people's needs had changed. During this inspection we found that people and their relatives were still not fully involved in the development or review of care plans. None of the people we spoke with were able to tell us about their care plan or when it would be reviewed. However, relatives of people told us that they have seen and signed copies of care plans. One relative told us, "I had a talk with them right in the beginning and they wrote a few bits down. I have signed their plan for them but I don't have any input into it. I am not involved in writing it now. The last time I signed it was a little while ago now." Another relative said, "They show me her care plan. I do sign to say I have seen it but I don't have any input into it. They give me it all printed out. The nurse shows me where to sign. I did read it first but I wasn't expected to comment, the nurse made that clear. I am always kept up-to-date with what's going on really." One member of staff told us, "The nurse does the care plans." They were unable to tell us how people's wishes were included in these. Relatives we spoke with told us that they had never seen any member of staff sitting talking to people. One relative said, "Oh good lord no. They don't have time for that." Another relative told us, "No I have never seen anyone sitting talking to [relative] or anyone else for that matter." One member of staff told us, "They can talk to us when we give them care."

We looked at the care records of one person and found that some of the care plans had incorrect surnames on them. We asked for the care records for the people with these surnames and found that the care plans with the incorrect surnames were identical to those in place for the people with those surnames. This included information in the medicines care plan about a medicine that had not been prescribed for the individual. We also found that information about the person, such as their preferred name and marital status, had been found to be incorrect but had not been updated in the records. We discussed these issues with the registered manager and clinical lead and on the second day of the inspection we saw that the care plans had been amended to the correct names and the incorrect information had been removed.

However, the care plans were still not person-centred and were not always followed to address people's needs. We found that people were not assisted to have a bath or shower very often. One person told us, "They will give me a bath if I ask but not very often." Another person said, "I have not had a shower or bath yet but have only been here two weeks." A member of staff told us, "I only work [number] days now, I still bath three to four people on these days but the rest of the week the baths are not happening because they are too short staffed."

The registered manager told us that they had introduced a template for each of the care plans. This template also included information about the service's policies and procedures which did not inform staff as to why and how care was to be provided. We discussed the format of the care plans with the registered manager and the clinical lead. They agreed that the plans were task orientated and gave very little information as to how a person's needs were to be met. We saw that care plans did not address all of people's needs. For example, one person had been identified as using continence pads in both the environmental risk assessment and in their night plan. However, their continence care plan made no

mention of the use of pads.

The failure to involve people and relevant persons in the development and review of person-centred care plans and the failure to meet people's assessed needs was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there was a lot more for them to do following the recent appointment of a new activities coordinator. One person told us, "Here there are things to do now and people to talk to." Another person said, "We can go up to our rooms if we want, we can sit and read if we want, watch TV if we want or do an arts and crafts activity if we want." A relative said, "There is more for people to do now. Just this month this new lady is doing a lot more with people. Before there was nothing going on for anybody. There are no outings, except a chosen few go over to the vicarage." During our inspection we saw the activities coordinator encouraged people to take part in arts and crafts and complete puzzles in the morning. They told us, "Last Friday [a local supermarket's] community team came in and spent time with the residents, making Christmas decorations, they brought mince pies and a present for each resident, it was a great afternoon. Today a man is coming in to do karaoke." On both afternoons of our inspection karaoke sessions were held in the ground floor lounge. People were observed to be enjoying this and joining in with the singing. The registered manager told us that this usually took place once a week and people really enjoyed it. They had asked for it to happen more frequently. A number of local groups also supported and visited the home. During the festive season the local school had visited and had sung festive songs with people. A local group helped people maintain the gardens and a Pets as Therapy (PAT) dog visited weekly.

People and relatives were aware of the provider's complaints system, although none of the people who lived at the home had used it. Information about the complaints system was on display in the entrance hall of the home. A relative told us, "My [relative] wrote an email of complaint following my [relative]'s room really smelling foul when we visited. My [relative] was moved out of that room downstairs. They did listen." We saw that complaints were recorded and responded to appropriately. In addition to the formal complaints process the registered manager operated an 'open door' policy. Their office was in the corridor from the front door and relatives passed it on their way in and out of the building which made it easy for relatives to speak with them if they needed to. During the course of the inspection we observed a number of relatives calling in on the registered manager, in one case to drop of festive gifts for staff as an expression of their appreciation for the care given to their relative. The registered manager showed us that they recorded any comments made by relatives in a communication book. Staff told us that the registered manager talked with them about complaints

We saw evidence that the registered manager had carried out a satisfaction survey with people and relatives in July 2016. Nine forms had been returned, all of which had been positive about the care provided.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in February 2014 we found that the provider was not compliant with the regulations in place at that time in respect of involving people in the development of their care plans and people's care plans were not personalised. There were also issues concerning medicines management and the safe storage of records. When we revisited the service in June 2014 we found that the premises were not clean, people's records were not accurate and the quality assurance system in place at the time was ineffective. Although there had been improvements seen at the inspections we carried out in July 2014 and December 2014 the provider had not sustained these. When we inspected the service in February 2016 we found that the quality assurance system in place was not robust and that people's medicines were not always administered as they had been prescribed. During this inspection, as well as failings in medicines management, the quality assurance system and the accuracy of people's records, we found that the premises were neither clean nor well maintained. One of the directors of the provider organisation, who was at the service on a regular basis, told us that they had instructed the chef to clean the kitchen appliances as they had identified that these were dirty the week prior to our inspection. However, they had failed to ensure that the necessary cleaning had been carried out.

During this inspection we found that the quality assurance system was still ineffective. Although there were monthly audits of areas such as health and safety, medicines management, care plans, reporting of accidents and incidents, the kitchen and food hygiene these had failed to identify errors and omissions and calculations of compliance were inaccurate.

We found that the clinical lead, who was one of the people who administered medicines, completed the monthly medicines management audit. Although they had identified areas that required improvement, such as the need to have an up to date British National Formulary, they had taken no steps to address these areas. The calculations showing overall compliance with requirements were also incorrect. The audit completed in November 2016 was scored as 100% compliant when in fact a positive answer had only been given in six of the eight areas assessed. Similarly in one area 22 of 26 questions were affirmative but the score had been calculated as 98%.

During our inspection we found that information in care records was not always accurate or complete. The clinical lead was responsible for the completion of care plans but also carried out the monthly audits of these. These audits had failed to identify the errors and omissions that we had found when we looked at care records, although they had identified some omissions, such as completion of the 'This is Me' section of the records. We brought this to the registered manager's attention. They agreed that it was not good practice for a member of staff to audit an area for which they had responsibility.

Although the director from the provider organisation attended the service regularly there was no evidence that they, or anybody else from the provider organisation, took any steps to assure themselves of the quality of the service provided. There were no independent audits of the service to inform them of areas that required improvement.

These issues were a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they knew who the Registered Manager was and that they saw them regularly. One person told us, "She does come and speak to us sometimes, lovely lady she is. I don't have no problems here at all." Another person said, "The manager is a very nice lady, very approachable she is." However, a relative said, "The manager is approachable but I'm not sure how effective she is because things take a long time to sort out or get done. She is always around here somewhere."

The registered manager told us that people and relatives did not want to attend meetings with them to discuss the service or ways in which it could be improved. Instead they had introduced an 'open door' policy which enabled people or relatives to talk to them at any time. However, they were trying to reintroduce regular meetings and were inviting people and relatives to attend one of two meetings to be held in January 2017. One would be scheduled during the day and one in an evening to allow as many relatives as possible to attend either or both of the meetings.

People and relatives were able to make formal requests for changes to the service in the survey that had been sent out. The responses to the survey completed in July 2016 showed that people and their relatives wanted further improvements made to prevent laundry going missing. The service had investigated the options available and had introduced a system at their own expense to address the issue. This system tagged people's clothes with a numbered button which enabled laundry staff to identify which room the clothes needed to be returned to after washing. When people left the service the buttons were removed and reused for the next person to occupy the room. This showed that people and their relatives were able to contribute to the development of the service.

Minutes of staff meetings showed that staff had been encouraged to contribute to identifying improvements that could be made to the service. Topics covered at meetings had included policies and procedures, training, the role of key workers, monitoring visits and a full recap of the fire instructions. The registered manager told us that they encouraged all staff to contribute to discussions during the staff meetings and we saw that this had been included as an agenda item at a meeting held in September 2016.

Staff we spoke with were aware of the tasks that they were expected to perform in their roles but were unable to explain what their roles meant for the people who lived at the home. They had no awareness of any shared vision or values.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not personalised or reflected all the needs of individuals. People and the relatives had not been involved in the development or review of the care plans

The enforcement action we took:
Notice of proposal to restrict admissions.

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 People were not asked for consent before care or support was provided.

The enforcement action we took:
Notice of proposal to restrict admissions.

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 People were not given their medicines as they had been prescribed. Medicines administration charts were not completed correctly and the stock of medicines held did not reconcile with that shown on the records.

The enforcement action we took:
Notice of proposal to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not offered a choice of food

Treatment of disease, disorder or injury	

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not visibly clean or kept free from unpleasant odours. The premises were not properly maintained.

The enforcement action we took:

Notice of proposal to restrict admissions.

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 The quality assurance system was weak and members of staff with responsibility for some areas audited the areas for which they were responsible. Documents were inaccurate and incomplete.

The enforcement action we took:

Notice of proposal to restrict admissions.

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 were insufficient staff to provide for people's needs at all times. Staff were poorly trained.

The enforcement action we took:

Notice of proposal to restrict admissions.