David and Michael Russell LLP

The Woodlands Residential Home

Inspection report

61 Birkenhead Road
Meols
Wirral
CH47 5AG
Tel: 0151 632 4724

Date of inspection visit: 17, 18 and 22 December 2015
Date of publication: 23/02/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The Woodlands Residential Home provides personal care and accommodation for up to 14 people. Nursing care is not provided. The home is situated in Meols, Wirral. There is a small car park and garden available at the rear of the property. Bedrooms are single occupancy and are provided on two floors. A passenger lift enables access to bedrooms located on upper floors for people with mobility issues. On the ground floor, there is a communal lounge and a dining room for people to use.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities

Summary of findings

2014. These breaches related to the provision of safe and appropriate care, medication management, ensuring people's nutritional needs were met and the management of the service. You can see what action we told the provider to take at the back of the full version of the report.

We reviewed four care records. Some risks associated with people's care were assessed but we found that risks in relation to skin integrity, behavioural needs and some physical health conditions were not properly assessed and managed. This meant staff had no clear guidance on how to manage these conditions to prevent further decline. This placed people at risk of receiving inappropriate and unsafe care. Where people had mental health issues, their care plans lacked adequate information on how these issues impacted on their day to day lives and decision making.

People's nutritional needs and risks had been assessed but there were no appropriate nutritional care plans in place to advise staff how to promote people's nutritional intake. Where people had special dietary requirements or where at risk of malnutrition, care plans lacked any guidance on how staff should monitor and manage people's special dietary needs. This meant there was a risk people's nutritional needs would not be met.

Some people required assistance to eat their meals. We found that the majority of staff did so in a patient, sensitive manner by gently encouraging the person to eat whilst sat next to them. One staff member however although patient, did not support the person to eat in a way that promoted their dignity or safety.

We found that care plans contained person centred information about the person and their life prior to coming to the home. Care plans however were not holistic, did not reflect the totality of people's needs and care and some of the information was inaccurate. This made the delivery of good person centred care difficult as up to date information about the 'whole' person was not available to staff. We also saw that where person centred guidance had been given, it was not always followed by staff to ensure people received the care they needed.

We noted some elements of good leadership in the service. People told us they were happy with the care they received and said they were well looked after. We saw that people had prompt access to any medical or other health related support as and when required. Staff were confident in their job role, worked well together as a team and the manager was a positive role model for staff on how to provide kind and compassionate care. The way the provider and manager monitored the quality and safety of the service required improvement.

The audits in place to assess, monitor and mitigate any risks to people's health, safety and welfare were ineffective and inadequate. Care plan audits failed to identify any of issues with the planning and delivery of care that we found during the inspection. Premises related audits were poor as it was impossible to tell what parts of the home had been monitored for quality and safety purposes. Medication audits checked the quantity of medication in stock against medication administration records but where discrepancies were identified there was no evidence that they had been investigated and resolved. Audits of people's personal spending monies, held by the provider were ineffective as they did not verify that the balance of money each person had left was correct. This lack of effective audits demonstrated that the service was not consistently well led.

People we spoke with were happy at the home and spoke highly of the staff and manager. They told us staff were kind and respectful and ensured that they were well looked after.

We observed the serving of lunch in the dining room. Not many people attended the dining room to eat but we saw that people were given suitable menu choices and portion sizes were sufficient. Meals were served promptly and pleasantly by staff.

We noted that people looked well dressed and content. Staff supported people in a patient, unhurried manner and people looked relaxed and comfortable in the company of staff. Staff we spoke with had an understanding of people's needs, preferences and life prior to coming into the home. We saw that staff used this knowledge to communicate with, and relate to the people they cared for. We saw that people who lived with dementia responded positively to staff who interacted with them in this way. This showed that there were some elements of good person centred practice in operation at the home.

Summary of findings

We observed the home's morning medication round. We saw that staff had been trained in how to administer medication and that they did so safely. Record keeping in relation to 'carried over' medication and the ordering of repeat medication required improvement.

Staff were recruited safely and received regular training and support in the workplace. We found that the number of staff on duty was sufficient to meet people's needs. People told us they felt safe at the home and had no worries or concerns. Staff had received safeguarding training and demonstrated an understanding of safeguarding when asked. We saw that safeguarding incidents were appropriately investigated and reported.

There was a complaints procedure in place and the manager had responded appropriately to complaints made. Information for people at the home in relation to their service however was not readily available in the form of a service user guide.

Equipment was properly serviced and maintained. The premises, although shabby in parts, was safe. The provider told us they had a yearly refurbishment plan in place and we saw some evidence of this. The call bell system at the home required review to ensure that staff were able to quickly identify the location of the call.

People's views on the quality of the service had been sought in October 2015 with positive results.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People told us they felt safe living at the home. Staff were knowledgeable about types of abuse and who to report concerns to.

Some of people's risks in the delivery of care had been assessed but others had not been adequately assessed and managed.

Staff were recruited safely and staffing levels were sufficient to meet people's needs.

Medication was administered safely, staff were trained but improvements in record keeping and ordering were needed.

The home was satisfactorily maintained but a little shabby in parts. The call bell system required review to ensure staff were able to quickly to identify the location of a call for help.

Is the service effective?

Requires improvement

The service was not always effective

People nutritional needs were not properly assessed and managed. Staff lacked clear guidance on how to promote people's nutritional intake. People did not always receive appropriate support to eat their meals.

People had prompt access to their GPs and access to other healthcare professionals as and when required.

Staff had received appropriate training and support to do their job role. Staff spoken with had an understanding of people's needs.

Is the service caring?

Good

The service was caring.

People we spoke with held staff in high regard. Staff were observed to be kind when people required support.

Staff knew how to promote people's dignity and privacy and had an understanding of 'the person' they cared for.

End of life decision making was facilitated well with people's involvement actively encouraged.

People had access to independent advocacy services when they had trouble communicating their wishes to ensure their views were represented.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's care plans contained personal history information which staff used to relate to people in the day to day delivery of care but care plans for people who lived with dementia or other mental health issues were limited.

Guidance provided for the delivery of care was not always accurate, up to date or followed. This placed people at risk of receiving support that did not meet their needs.

A range of social activities was provided which promoted people's social well-being.

Complaints information was available and any complaints received had been properly investigated and responded to by the manager.

Is the service well-led?

Requires improvement 

The service was not always well led.

Some quality assurance systems were in place to monitor the quality of the service but they did not effectively ensure that risks to people's health, safety and welfare were picked up and addressed.

People's opinions of the quality of the service had been sought. The feedback gained was positive.

The Woodlands Residential 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 17, 18 and 22 December 2015. The first day of the inspection on the 17 December 2015 was unannounced. We only attended the morning of the 17th December 2015 as the people who lived at the home were going out on their Christmas meal to a local pub in the afternoon. The inspection was carried out by an adult social care (ASC) Inspector. Prior to our visit we looked at any information we had received about the home.

During the inspection we spoke with three people who lived at the home, two care staff, the registered manager and the provider. We also spoke with one visiting health professional.

We looked at the communal that people shared in the home and some of the bedrooms. We reviewed a range of documentation including four care records, medication records, four staff files, policies and procedures, health and safety audits and records relating to the quality checks undertaken by the manager.

Requires improvement

Is the service safe?

Our findings

All of the people we spoke with said that they felt safe at the home. One person told us the home was "Great", another said that they felt "Absolutely safe".

The provider had a policy and procedure in place for identifying and reporting potential safeguarding incidents. Staff had received safeguarding training and demonstrated a clear understanding of types of abuse and what to do if they suspected abuse had occurred. We reviewed a sample of safeguarding records. We saw that safeguarding concerns were appropriately reported and investigated in accordance with local safeguarding procedures.

We looked at the care plans belonging to four people who lived at the home. We saw that people's risks in relation to malnutrition, falls, moving and handling, level of dependency and pressure sores were assessed. Some of these risks were not appropriately managed and staff lacked guidance on how to mitigate these risks in the delivery of care. This placed people at risk of inappropriate and unsafe care.

For example, two people assessed as being at high risk of malnutrition had no risk management plans in place to advise staff how to manage this risk. One person's file contained a letter from the dietician indicating that the person had swallowing difficulties, yet the risks of this had not been considered. This meant staff may not know what to do to ensure that any swallowing difficulties were minimised.

Two people were immobile and at high risk of developing pressure sores. Both people had received professional support for their skin but there were no risk management plans in place to direct care staff on how to prevent further skin deterioration in the day to day delivery of care. For example, people with skin integrity issues often require regular re-positioning to manage the pressure placed on various parts of their body from immobility. We asked to see the re-positioning records for both people. One person had no re-positioning records and the other person's records were not consistent with good skin integrity care.

We saw that where guidance had been given, it was not always followed. For example, one person's mobility plan advised staff to support the person to stand for two minutes every two hours. Another person's continence care plan advised staff to change the person's continence aid after every meal. We observed both people during our inspection for the majority of the day and found neither of these activities were consistently undertaken.

Some of the people whose care files we looked at, had mental health issues that meant they sometimes displayed challenging behaviours. Although these behaviours were described, they had not been risk assessed and staff had limited guidance on how to prevent or manage such behaviours. This meant there was a risk people would not receive the support they needed when these behaviours occurred.

These incidences were a breach of Regulations 12 (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

On the second day of our inspection, we saw that the manager had responded to our concerns. People's skin integrity risks had been reviewed, re-positioning arrangements were in place and the manager told us that each person's risks and the care would be reviewed without delay to ensure staff had clear guidance on how to care for people safely. They had also met with the provider to decide how this would be done. This showed us that the manager and provider were committed to addressing any concerns.

The heating, gas, electrics, fire and moving and handling equipment all conformed with recognised safety standards and were regularly inspected by external contractors. The home was clean and there was sufficient protective personal equipment for staff to use in the delivery of personal care.

We noted that the call bell system required improvement to ensure people's calls for help were answered promptly. The call bell panel which pinpointed the location from which the call was made was situated in the kitchen. There were no other call bell panels in place for staff to refer to. This meant staff had to go to the kitchen first to check the call bell panel for the call's location before they could respond. This meant there was a risk people could

Requires improvement

Is the service safe?

experience a delay in receiving the support they needed. Call bell points were not available in communal areas to enable people to call for help as and when required. This meant there was a risk that people needs would go unmet.

The premises were safe but a little shabby in parts and one area of the home smelt unpleasant. We spoke to the provider about this. The manager told us the provider had an ongoing annual refurbishment plan. We were shown the refurbishment programme undertaken in 2014-2015. Records showed that work had been completed in accordance with programme. We did not see the refurbishment plan for 2015-2016 but the manager told us that there were plans in place for the installation of new specialised bathing facilities on the ground floor.

We looked at three staff files. All the files we looked at demonstrated that the necessary checks were undertaken to ensure that staff employed were of good character and suitable to work with vulnerable adults. The manager told us there were three care staff on duty from 8am until 10p.m. After 10p.m, one member of staff was on duty and another staff member did a 'sleeping' shift. This meant that they were 'on hand' to support the other member of staff as and when required. Managerial support was also available during the day and staff had access to 'on call' help at weekends. During our visit, we saw that the number of staff on duty was sufficient. People we spoke with confirmed this.

People's medication was stored securely in a locked medicine trolley in the manager's office. On the day first day of inspection however, we found a bottle of strong painkilling medication on a book shelf in the communal corridor. This meant it was accessible to people who lived at the home and their visitors. This placed it at risk of unauthorised use and removal.

The majority of people's medication was dispensed in monitored dosage packs. We checked a sample of three people's medication administration records (MAR). We found that the balance of medication left in people's monitored dosage packs matched what had been administered. It was not possible to account for boxed medications such as painkillers and medicines to be given 'as required' as staff had not recorded the quantity of medicines brought forward from the previous month. This meant it was not impossible to tell whether or not they had been given correctly.

We saw that some people had more than one of the same medication in the medication trolley. We asked the manager about this who told us that some people where on repeat prescriptions and sometimes this resulted in excess stock. They said they tried to keep on top of this by sending back any previous month's medication to the pharmacy. This was not an appropriate way to manage the ordering of people's medication. Excess stock makes it difficult to keep track of the quantity of medication at the home, its expiry date and whether the amount administered is correct. We spoke to the manager about this who told us they would discuss the ordering of people's repeat medication with the doctor.

Medication was administered by senior care staff. We observed the tea time medication round and saw that medication was administrated safely and in a pleasant, respectful way. Records showed staff responsible for the administration of medication had been trained to do so.

These issues demonstrated that the way in which medications were ordered and accounted for at the home required improvement. This was a breach of Regulations 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

All of the people we spoke with told us the care was good and that staff looked after them well. Their comments included "Staff are great"; "If we need help they are spot on" and the staff are "Fantastic".

Staff we spoke with had a general understanding of people's needs and care and spoke warmly about the people they cared for. We saw staff throughout the day checking people consented to the support they were given.

We saw evidence that advice from mental health services and social services had been sought and referrals made as and when appropriate for people who lived with mental health issues. This ensured people had access to the professional support they needed. People's care plan contained some information about people's emotional or behavioural needs but staff required further guidance on their day to day management and the emotional support people required.

Where people had dementia type conditions or short term memory loss, care plans lacked sufficient information about how these conditions impacted on the person's day to day life and their ability to consent to any care and treatment decisions made.

The Mental Capacity Acts 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do 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 or authorisations to deprive a person of their liberty were being met.

The manager told us that Deprivation of Liberty Safeguard applications had been made for two people who lived at the home and that the Local Authority had approved them. We looked at the DoLs information and saw that the deprivation of liberty safeguards put into place prevented people from leaving the home of their own accord. There was no evidence that the capacity of these people had been assessed by the manager of the home to ascertain whether people had capacity to keep themselves safe outside of the home, prior to these DoLs applications being made. Care files contained little information about the reasons why a DoLs was required. There was no evidence of any best interest decision making and no evidence that any least restrictive options were explored by staff at the home.

We spoke to the manager about this who acknowledged the home had not assessed people's capacity to make specific decisions where their capacity was in question with regards to this issue.

People had the choice of eating their meal in the dining room, the lounge or in their own bedrooms. On the day of our inspection, only five people had their meal in the dining area. We noted the dining room furniture looked new but the layout of the dining room made it difficult for people with mobility aids to mobilise safely around the tables.

We observed the serving of lunch. Festive music played softly in the background and the atmosphere was relaxed. People had two choices for lunch and the food provided was of sufficient quantity. People we spoke with told us they had enough to eat and drink, that the food was good and they always had a choice. One person told us the food was "Just like home". Throughout the day we saw people had access to suitable amounts of food, drinks and snacks.

We looked at the information in people's care files and found no appropriate nutritional care plans in place to advise staff how to promote people's nutritional intake. Where people had special dietary requirements or where at risk of malnutrition, care plans lacked any guidance on how staff should monitor and manage people's special dietary needs.

For example, we saw that one person had been referred to and received nutritional guidance from the community dietician. The person required a special diet for a physical condition that affected their ability to swallow. The care plan made no reference to this condition or their special diet. We spoke to two staff members about the diet this person required. Both staff members were aware the

Requires improvement

Is the service effective?

person was on a special diet but neither stated the correct one. We saw at lunchtime this person was served a pureed diet as opposed to the fork mashable diet advised by the dietician.

One person's care plan indicated that they had a medical condition that required a controlled diet. The person's care plan failed to provide any specific information about this medical condition, the risks to the person's health if the diet was not followed and the signs and symptoms to spot in the event of ill health. The care plan stated that the person required certain foods cut up but did not specify what these where or why.

People's food was served pleasantly and promptly by staff and we heard staff offering people alternatives if they did not like what was on offer. The majority of staff serving food and assisting people to eat or drink wore blue latex gloves. This did not look nice, was unnecessary and did not promote a positive dining experience.

During lunchtime, we observed three staff members assisting people to eat. Two of the staff were patient and sensitive when prompting the person to eat. We saw that they used appropriate language, spoke gently and promoted the person to be independent. The approach undertaken by the third staff member however although patient did not always respect people's right to dignified support. This staff member used childlike language to encourage one person to eat such as "Yay" when the person took a spoonful of food to eat and shouting encouragement across the room such as "Finish your pudding. Very good you're chewing".

We checked people's weights were monitored to ensure any weight loss was identified and addressed. We found that people's weight measurements had not been taken regularly and for some people no weight measurements had been taken at all. This showed that the risks in relation to malnutrition were not appropriately monitored. We spoke to the manager about this who told us they were unable to take some people's weight measurements as they were unable to weight bear.

We advised the manager that alternative methods of ensuring people's weights were taken were available. For example, a weighing chair or the use of arm circumference measurement to estimate body mass index (BMI). The manager acknowledged that neither of these methods was in use.

These examples are breaches of Regulation 14(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have suitable arrangements in place to ensure that people's dietary needs were met in an appropriate and safe way.

Records showed that people had prompt access to medical and other support services as an when required. We saw that people's health needs were followed up promptly and acted upon where required. We spoke to a visiting healthcare professional who told us that staff at the home were "Pretty good" at seeking advice for people's health needs. They told us that staff were "Quick off the mark" in responding to and accessing help for people who became unwell.

Staff told us they felt supported in their job role and they received regular supervision and appraisal. The manager's supervision and appraisal schedule confirmed this and staff training records showed that staff had access to on-going training opportunities.

Training was provided in health and safety; first aid; moving and handling, dementia, safeguarding, food hygiene, the administration of medication and infection control. We saw that some staff training required refreshment to ensure staff knowledge remained up to date.

Some people who lived at the home lived with dementia. We found that improvements to the décor and style of the home were needed to ensure the home was dementia friendly. For example, personalising people's bedrooms doors, the use of different colour schemes and appropriate signage to assist people with dementia to mobilise around the home independently.

Good

Is the service caring?

Our findings

We asked people if staff treated them well. People said that they did. People we spoke with thought highly of the staff at the home. People's comments included " Very good, couldn't ask for any better. I am well looked after"; "It's brilliant. Next best thing (to home)" and "Yes it's a nice place to live. Staff are great".

We observed staff throughout the day supporting people who lived at the home. The atmosphere was warm and welcoming. People were well dressed and cared for and the interactions between staff and the people they cared for were positive. It was clear from our observations that staff had good relationships with the people they cared for.

The majority of staff were observed to be respectful of people's dignity and supported them at their own pace. One staff member's approach in the support of people's dietary needs however required improvement to ensure people were treated with respect and not as children.

We asked staff how they maintained people's right to privacy and dignity. Both staff members were able to give us clear examples of how this was done. For example, by knocking on people's bedroom doors before entering, using their preferred name to address them and ensuring people were covered up appropriately during the delivery of personal care.

Staff we spoke with, were knowledgeable about people's preferences in the delivery of care and had an understanding of the person's life prior to coming into the home. We saw that one person enjoyed classical music and poetry. On the second day of our inspection, we observed a staff member tell the person a poem and put classical music on in the room in which the person was sitting. This demonstrated that staff were using information about the person to gain and understanding of, and relate to the people they cared for.

We saw that one person had a personal item that gave them comfort. We saw that staff ensured the person had this item with them throughout the day. They also used the item as a point of conversation to engage with the person. This showed us that staff cared about people's emotional well-being.

People were able to mobilise freely about the home and staff supported them with their needs in a patient and unhurried way. One person had built up a close relationship with the manager and spent the majority of their time in their company. The manager facilitated this relationship in a positive, constructive way so as not to cause the person distress. However this did impact on the manager's ability to spend time alone on managerial tasks.

We found the manager to be a positive, compassionate role model for staff. They had a hands-on approach and were kind and understanding in all of their interactions with people and staff.

We saw evidence that end of life discussions had taken place with people and their relatives including decisions about 'do not resuscitate' orders (DNAR). One person's care file showed a detailed audit trail of how the person's DNAR decision had been made and who had been consulted with during this process. This showed us that people's wishes about their end of life care were facilitated and respected.

We saw evidence that people had access to independent advocacy support and representation through the involvement of Independent Mental Capacity Advocates and Lasting Power of Attorney arrangements when specific important decisions, such as decisions about 'do not resuscitate' and deprivation of liberty safeguards needed to be made. This ensured people's wishes and feelings were taken into account when decisions were made on their behalf.

IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions such as decisions about where they will live or serious medical treatment decisions. A Lasting Power of Attorney means the person appointed has the legal power to make decisions on the person's behalf in relation to their health and welfare.

The manager told us that resident and relatives meetings used to take place on a regular basis but that they had been poorly attended during the latter part of 2014. In the end they had made a decision to discontinue them. No resident meeting had taken place since December 2014.

Information about the home and its policies and procedures in relation to care were provided in the entrance area of the home. This information was unwieldly for people to use and a short service user guide would have been much more user friendly to provide people with. We did not see a service user guide available to people at the home.

Requires improvement

Is the service responsive?

Our findings

We looked at three care files. All care files contained person centred information about the person's needs and preferences. It was evident that people who lived at the home and their families had been involved in discussing and planning their care.

Care files included information about people's personal life histories. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia.

We observed staff using this information 'in action' when supporting people in their daily lives. This was good practice. When asked the staff we spoke with, spoke warmly about the people they cared for and were able to tell us about people's lives prior to coming into the home and what their likes and dislikes were. It was obvious staff had got to know the 'person' they were caring for.

The care plans of people who lived with dementia however were limited. They did not explain the impact of the person's dementia on their day to day life and offered little guidance to staff on how to provide person centred care in relation to people's dementia or other mental health needs.

Where guidance was given, it was not always followed. For example, we saw that one person's care file indicated they lived with dementia. Their care plan advised staff to either write things down for the person or use picture cards to communicate with them so that they were able to express their wishes. Picture Cards are a set of pictures that are designed to convey a certain meaning or feeling for example, "I am hungry". They enable people with verbal communication difficulties to communicate their needs, wishes or feelings to staff. During the inspection, whilst staff engaged with this person, neither of these methods of communication were used.

We asked to see the picture cards in use. We were provided with a set of picture cards that centred on asking the person what activity they would like to do or the food they would like to eat. The picture cards were of limited value. They did not allow the person to express their wishes or feelings and staff would have found it hard to facilitate any meaningful communication with the person using these tools. This meant that appropriate tools to enable the person to communicate their needs had not been provided in accordance with their plan of care.

Some of the care plans we looked at were contradictory about people's needs and not up to date. The majority of people's care plans had been reviewed in advance and were dated January 2016.

It was evident that although care plans were noted as being reviewed, this review process was ineffective. Care reviews were not holistic in their approach and people's needs appeared to be reviewed in isolation from other needs the person may have had. Inaccurate or out of date information does not enable good person centred care to be provided in accordance with people's needs and wishes.

For example, one person's mobility care plan stated the person was able to stand and perform straight transfers with two staff and their mobility aid. The same person's safety care plan stated that they were unable to stand and required the use of a hoist. One person's care plan described them as having challenging behaviour which required monitoring. When we asked to see the person's behavioural monitoring charts, we found no monitoring had taken place since June 2015. This indicated that either the care plan was out of date or the required monitoring had not been undertaken. We asked the manager if the person's behaviour was being monitored using behavioural charts. They told us it was not.

These incidences were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have suitable arrangements in place to ensure care was planned appropriately to meet people's needs and preferences.

People we spoke with confirmed that regular activities were on offer at the home. On the first day of our inspection, the majority of people and staff at the home were going out for a Christmas lunch at a local pub. People and staff were in a jovial mood, well dressed and looking forward to the festivities. On the second day of our inspection, a pampering session took place in the afternoon and a visit from a local choir was planned for the following week.

Requires improvement

Is the service responsive?

The provider had a minibus which enabled them to take people out and about in the community. For example, weekly trips were made to a local church for a 'Bacon Butty Brunch'. The manager also told us that people who lived at the home and staff had recently enjoyed an arts related workshop that enabled them to explore their emotions through the use of a cushion. They said everyone had enjoyed this activity, even those people who rarely joined in. The manager told us they planned to invite the company who facilitated this activity back for another session. The activities on offer at the home demonstrated that people's social and emotional well- being was considered in the planning and delivery of care.

We looked at the provider's complaints procedure and saw that it gave clear timescales for the acknowledgement, investigation and response to any complaints made. Contact details for who people could contact in the event of a complaint were provided but the policy referred to some legislation that was out of date. For example, it referred to the National Minimum Care Standards which are no longer in force.

The manager told us they had received no written complaints but had, in accordance with the provider's policy, maintained a complaints book for any verbal complaints or concerns received. We looked at the complaints book and saw that the manager had fully investigated and responded to people's complaints and concerns. People we spoke with said they had no complaints about their care and were happy with the care they received.

Requires improvement

Is the service well-led?

Our findings

We observed the culture of the home to be open and inclusive. During our visit we found the manager responsive with a proactive approach to people's care. The provider was also fully involved in the management of the home and demonstrated a committed approach to ensuring improvements were made.

The staff team had a positive attitude. Staff we spoke with said they felt supported in the workplace and the home was well run. Staff were friendly, welcoming and were observed to have good relations with each other and a compassionate approach to people's care. This demonstrated elements of good leadership. Improvements were required however in how the provider and manager monitored the quality and safety of the service.

We found a number of inconsistences in people's care records about their needs and risks. Care plans did not give staff clear guidance on how to care for people safely. We also found that where care plan guidance was given, staff members did not consistently follow this advice. This indicated that the way in which care was delivered was not routinely checked.

We looked at the care plan audits undertaken at the home during October, November and December 2015. We found them to be ineffective. Each audit simply stated each person's care plan was "updated and reviewed". No issues or concerns with people's care plans were identified and none of issues we identified during our visit had been picked up. This meant that the audits failed to be effective in ensuring information about people's needs, risks and care was adequate, to date and being followed by staff.

The manager undertook a monthly maintenance audit. We saw that the audit identified the area of the home being checked but there was no information about what was actually being audited. For example, equipment, soft furnishings, décor etc. This meant the audit was of little value in identifying areas that required improvement. We reviewed the audits undertaken in August and September 2015 and saw that most of the audit was blank. The audit appeared to record what maintenance was completed for example "bulbs replaced" and "Fire door painted" as opposed to an actual maintenance check of the environment.

We reviewed the medication audits undertaken in August to October 2015. We found that where stock discrepancies were identified, there was no evidence they had been followed up. For example, the audit in October showed that the quantity of one person's 'as and when required' medication was incorrect with 14 tablets unaccounted for. 28 tablets of another person's medication were also unaccounted for. We asked the manager about this. They were unable to provide a satisfactory explanation of why the discrepancies had occurred or the action taken. Medication audits were not signed and dated so it was impossible to tell who had completed the audit and when.

Accident and incidents audits were undertaken on a monthly basis. We could see from the audits that a description of the accident or incident was given and the type, time and location of the falls were monitored regularly. The information about accident and incidents however was not analysed in any meaningful way to enable the manager to identify any trends including when, where and how accidents or incidents occurred so that preventative action could be taken.

The manager kept a small personal allowance for each person who lived at the home on their behalf. This enabled people to pay for chiropody services, hairdressing and visits out without having to go to the bank. We saw that an audit of people's monies was undertaken periodically.

We reviewed the financial audits completed in April and August 2015. We found them to be incomplete and meaningless. They noted what each person had spent money on, but failed to specify the amount or date on which the money was spent. This meant it was impossible to tell if the balance of monies was correct. The audit required two staff members to check and verify the balance of people's monies. There was no evidence this was done, as the signatory boxes where staff members should sign were empty. The manager had also not signed the audit in acceptance of that the balance of monies were correct. This meant it was impossible to tell who had undertaken the audit, when and if people's finances were correct.

These examples demonstrate a breach of Regulation 17(2(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because

Requires improvement

Is the service well-led?

although some audit systems were in place they were insufficient and were not used effectively to assess, monitor and mitigate the risks to people's health, safety and welfare.

We saw evidence that a satisfaction survey was undertaken with people and their relatives in October 2015. A staff survey was also undertaken. The response from people and their relatives was limited but we saw that all feedback given was positive and staff surveys confirmed that staff felt supported in their job role. This meant people, relatives and staff had had an opportunity to express their views about the quality of the service.

We spoke to both the manager and provider about our concerns during the inspection. We found both parties open and receptive to our feedback. After our visit, we received further confirmation from the manager that action was being taken to ensure improvements to the service were made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's plan of care did not assess all of their needs and risks and the provider had not done all that was reasonably practicable to mitigate such risks. Regulation 12(2)(a) and (b) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines at the home were not always managed in a proper or safe way. Regulation 12(2)(g) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People’s nutritional needs were not properly assessed and managed and people did not always receive appropriate support. Regulation 14(4)(a) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable arrangements in place to ensure that care was planned appropriately to meet people's needs and preferences. Regulation 12 (1) of the Health and Social Care Act 2014 Regulations.
	The provider did not have sufficient systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who lived at the home. Regulation 17(2)(a) and (b) of the Health and Social Care Act 2014 Regulations.