Bupa Care Homes (ANS) Limited

Woodend Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Woodend Care Home on 28 and 29 June 2016. The first day of the inspection was unannounced. This meant the home did not know we were coming.

Woodend Care Home (known as 'Woodend' by the people who live and work there) can provide nursing and residential care for up to 79 older people. When we started the inspection 41 people were living in the home and there were admissions during the two days we were there. People were supported over three floors and a basement floor was being renovated at the time of our inspection. The ground floor provided accommodation primarily for people requiring residential care. The first floor provided support to people living with dementia and the top floor provided nursing care. Each floor had a communal lounge and dining room, and a small kitchen area. The kitchen and laundry room were situated in the basement. There was a lift and stairs to all floors.

Our last inspection took place on 17 and 18 November 2015. At that time we rated the service as requires improvement overall and inadequate in well-led. As the previous inspection in January 2015 had rated the service as inadequate overall, we placed the service into 'Special Measures' because it was inadequate for two consecutive inspections in one of the domains.

At this inspection we found there had been improvements which were sufficient for the service to be rated as requires improvement overall with no inadequate domains. This meant the service could come out of special measures.

The service had a registered manager who had been in post since January 2016. 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.

Recruitment files we inspected were not complete. Not all files for recently recruited employees contained records of the interviews they had, completed health questionnaires or evidence of a full employment record.

We noted improvements in medicines management from the last inspection in November 2015 and some examples of good practice in dementia care in relation to medicines. However, we saw an out of date medicine being administered, a care worker administering medicines which involved touching people and not washing their hands afterwards and found an unlocked medicine trolley in a communal area.

People told us there were not enough staff. Care workers said there were enough staff if all those rostered came to work. The registered manager had used a dependency tool to calculate staffing levels but was not sure if the information it was based upon was accurate. We observed that people's basic needs were met on

fully staffed floors and care workers struggled on those that were not.

Compliance with and staff knowledge of the Mental Capacity Act 2005 had improved since the last inspection November 2015, however, we identified three people who were being deprived of their liberty without authorisation from the local authority.

People's confidentiality was not respected as care staff discussed people's care and well-being in the presence of others living at Woodend. Care files were also not stored securely.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Care assessments and plans had improved since the last inspection and were seen to be detailed and person-centred. However, we identified two people who at times displayed behaviours that may challenge others that did not have care plans to help guide staff when supporting them.

The registered manager had followed the home's policies and procedures when responding to complaints, however, people's relatives told us they did not feel complaints they had voiced were acted upon.

Feedback from care workers about the culture at the home was not all positive. Some care workers remained unsettled by the numerous changes in management that had occurred in recent years and others were not complimentary about the current registered manager's leadership style.

Care workers had supervision with senior staff. The registered manager was reviewing the supervision and appraisal system to ensure care workers received an annual appraisal and supervision every two months. Staff received the training they needed to meet people's needs.

Most people were happy with the food served at Woodend. We saw the home had changed how foods were offered to people living with dementia to try and encourage them to eat more.

We saw that people had access to a range of healthcare professionals in order to support their holistic health. Feedback from visiting healthcare professionals about the home was positive.

The involvement of people and their relatives in care planning had improved since our last inspection. Care workers knew people well as individuals and we saw warm and friendly interactions between people and care workers.

Some senior care staff at the home were receiving advanced training in end of life care and people had their future wishes recorded in their care plans.

Activities at the home were much improved since our last inspection in November 2015. A second activities coordinator had been employed and feedback from people and their relatives was positive.

Feedback from the local authority and Clinical Commissioning Group about improvements made to the home since our last inspection was positive. They had lifted the embargo on new admissions to the home in May 2016.

A good system of safety and quality auditing was now in place at Woodend. We saw the provider's recovery team had supported the registered manager to improve the service with regular meetings and detailed

reviews of the home.

The registered manager had started holding regular meetings with people and their relatives to generate feedback about the home.

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.

Recruitment records for recently employed staff were not complete. There were issues with staff availability and the registered manager could not be sure the dependency tool he used to calculate staffing levels was accurate.

Out of date medicines had been administered. We noted issues with handwashing during a medicine round and found a medicine trolley which was unlocked.

Safety systems and procedures were much improved. People had emergency evacuation plans and risk assessments were in place. Staff knew how to safeguard the people. The home was clean and tidy.

Is the service effective?

Requires Improvement

The service was not always effective.

We found improvements in the home's compliance with and staff knowledge of the Mental Capacity Act 2005. However, we identified three people whose liberty was being deprived without authorisation.

The registered manager had implemented a system of supervision and annual appraisal for care workers. Staff received the training they needed to support the people at Woodend.

Most people were positive about the food quality and choice on offer at the home. People had access to a range of healthcare professionals in order to maintain their holistic health.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed care workers discussing people's health and well-being in front of other people and their relatives. People's care files were not kept securely.

Most people and their relatives told us they were involved in planning their care. Each person had a set day every month where their care files were reviewed and they and their relatives were invited to take part.

Feedback from people on whether staff were caring was mixed. We observed warm and friendly interactions between staff at the home and the people.

The registered manager was committed to improving the end of life care provided at the home. Senior care staff were undertaking end of life care training and we saw 'future decisions' care plans in people's files.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care assessments and plans had improved since our last inspection. However, we found two people who at times displayed behaviours that challenged others lacked care plans for this.

The provision of activities was much improved since the last inspection. People told us they were happy with the activities on offer and we saw a second activities coordinator had been employed.

Records showed the registered manager had investigated and responded to complaints appropriately. However, three people's relatives told us they were not happy with the way complaints they had made had been handled.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff morale at the home was still poor. Some staff lacked trust that the registered manager would stay at the home and others criticised his style of management.

We received positive feedback from the local authority and Clinical Commissioning Group about the home. They felt sufficient improvement had been made to lift their admissions embargo, and had done so in May 2016.

Safety and quality monitoring at the home had much improved and we saw the provider had been involved in this. Meetings had been held for people and their relatives to share information and

generate feedback on the home.

Woodend 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.

The inspection took place on 28 and 29 June 2016 and the first day was unannounced.

The inspection team consisted of three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had worked in domiciliary care and had assisted relatives to find home and residential care services.

Before the inspection we reviewed the information we held about the service. This included seeking feedback from the local authority safeguarding team, the Clinical Commissioning Group (CCG) and Healthwatch Trafford. The local authority and CCG had been working with the home on a service improvement plan that had initially been imposed upon Woodend Care Home in October 2015. An embargo on further admissions to the home had also been agreed. After our last inspection in November 2015, the areas for improvement we identified were added to this plan. Feedback from the local authority and CCG prior to this inspection was positive and the embargo on admissions had been lifted in May 2016. Healthwatch Trafford had no information of concern to share with us.

Prior to the inspection, the registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, such as what the service does well and the improvements they plan to make.

On the day of the inspection we spoke with 15 people who used the service, 10 people's relatives, the registered manager, the area manager from Bupa's recovery team, the clinical services manager, 12 members of care staff (including care assistants and nurses who worked nights and days), two domestic staff, a laundry worker and a member of kitchen staff. We also spoke with two visiting healthcare professionals.

We spent time observing care in the communal lounge/dining rooms and used the Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around the building. This included going in people's bedrooms (with their permission), bathrooms, the kitchen, the laundry room, medicine store rooms and in communal areas. We inspected records, which included six people's care records, nine medicine administration charts, four staff recruitment files, the staff training matrix, staff supervision and appraisals records and other documentation relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Woodend and their relatives agreed. One person told us, I feel safe", and a second said, "I can speak to staff if I'm worried and they listen." Relatives told us, "I feel happy that [my relative] is safe", and, "I wouldn't want [my relative] to move anywhere else – [they are] safe here."

We checked recruitment documentation for four recently employed members of staff at Woodend. There were gaps in each file we looked at. For example, three employees lacked a full employment history, either recorded on their application form or clarified at interview, as is required by the Regulations. One employee had no record of the interview they had received and two employees had no health questionnaires on file. Of most concern was one employee who had no record of a Disclosure and Barring Service (or DBS) check. The DBS helps employers to make safer recruitment decisions by sharing information about people who have restrictions on their ability to work with vulnerable groups. We raised our concerns about the lack of DBS check for this individual with the registered manager and he assured us it had been done and was able to produce evidence to this effect shortly after the inspection.

The issues with recruitment records constituted a breach of Regulation 12 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection November 2015 we found a breach of the Regulations relating to medicines as not all medicines prescribed 'as required' had protocols in place to inform staff when they could be administered. In addition, topical medicines had not been dated when they were opened and medicine administration charts (MARs) were not all up to date and some were difficult to read. At this inspection we found that all 'as required' medicines had protocols in place, except for two people's who had recently had all their medicines reviewed. We looked at eight people's MARs and found no gaps in recording or any other issues with how medicines had been recorded.

We observed two medicine rounds. Care workers explained to people which tablets they were being given and locked the medicine trolley during the round when they were not using it. We saw good practice with the administration of medicines to people living with dementia, in that timing of medicines had been adjusted to suit the people receiving them. For example, one person liked to sleep later so the time their medicines were administered was later. A care worker told us, "We let people get up when they want. If you wake people with dementia they can become disorientated and anxious." We saw any medicines administered covertly to people had been subject to the correct decision-making process.

We checked medicine storage rooms as part of the inspection. Medicines were stored securely in cupboards or trolleys in locked rooms. Medicines fridge temperatures were recorded daily and systems of receiving and destroying medicines were in place. We examined records and stock for controlled drugs, such as morphine, and found everything was recorded properly.

We did identify some issues with medicines at this inspection. During one medicine round we observed a care worker administer medicines to four people. Two of the people received an injection, one needed oral

inhalers and another a liquid dietary supplement; we noted that the care worker did not wash their hands after administering medicines to each person. When checking the refrigerated medicines we found that one person had been receiving out of date medicines on a regular basis. Previously the person had been receiving 40ml of a dietary supplement four times a day from 200ml bottles which had to be discarded 48 hours after opening. At this dose and frequency the medicine would be used up within 48 hours. At the time of our inspection the person was prescribed 30ml of the supplement once a day. The bottle we saw in use on 28 June 2016 was dated when opened on 25 June 2016, and therefore out of date. The care worker estimated the prescription had been changed to 30ml once a day one or two months earlier and confirmed the 200ml bottle of dietary supplement was used until it ran out. This meant the person had received medicine over four days out of date on a regular basis for several weeks prior to our inspection. During the inspection we also found a medicines trolley at the care workers' station outside the floor's lounge area which was unlocked. We alerted the care workers immediately and it was locked.

Issues with handwashing, the administration of out of date medicines and an unlocked medicine trolley where people could access it constituted a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought there were enough staff on duty to meet their needs. People told us, "When I really need something they (the care staff) aren't there", "Some staff spend lots of time talking together and even if I ask for something they carry on", and, "There aren't enough care staff or catering staff." One relative said of staffing levels, "There are lots of staff", a second said there seemed to be enough staff, whereas a third described the impact of staff ringing in sick leaving shifts short staffed. A fourth relative said there were times when there were no staff in one of the lounge areas for 10 to 15 minutes at a time. In the same lounge area of the home on the floor for people living with dementia we noted periods during the first day of the inspection when no staff were present for up to 20 minutes, leaving at least six people unsupported.

We asked the staff at Woodend if they thought there were sufficient staff to support the people and opinions were mixed. One care worker told us, "We have enough staff", a second care worker said, "On paper yeah. But it's about dependency. There are a lot of people here who need assistance to eat and drink", and a third care worker commented, "I don't have the freedom to provide the best care due to staffing." Other care workers told us, "I feel we have enough staff but staff will moan all the time. There is way too much talking in corridors and that's the issue", and, "Yes if everyone turns up. You feel so vulnerable when you're working with low staff. We want to do the best for our residents." Three care workers felt that staffing levels allocated did not take into account the support needed by people living with dementia. Care workers also expressed concern that there would not be enough staff if admissions to the home continued.

One of our inspectors spent the first day of the inspection on a floor of the home where one of the four care workers expected that morning had called in sick. We noted that by 10.45am there were only two people in the lounge area as the care workers struggled to support the people to wash, dress and have their breakfast in their rooms. During the inspection a member of staff commented that nearly all of the people on this floor required the assistance of two members of staff, which meant a team of three care workers was in reality only half as effective as a team of four.

After the last inspection November 2015 we recommended the home use a dependency tool to calculate whether sufficient staff were on duty each shift to meet people's needs. At this inspection the registered manager showed us a tool that had recently been employed. It calculated the number of staff needed based upon the level of dependency of each person and the number of people on each floor of the home. It showed that current staff numbers were sufficient. We asked if individuals' level of dependency had been

reviewed since their admission to the home and the registered manager admitted he was not sure. He said he was aware this might be an issue and had already tasked the clinical services manager with updating the dependency levels of all of the people at Woodend so he could be sure the dependency tool was accurate. He stated that staffing levels would be increased if the dependency tool indicated this was required.

We looked at day staff rotas on one floor of the home for the period 27 May 2016 to 09 June 2016. A full complement of staff would consist of three care workers. We noted that on 13 occasions during this period there we less than three members of staff recorded on the rota, suggesting staff were either not available or staff sickness was a problem.

We spoke with the registered manager and area recovery team manager about the levels of staffing at the home. The registered manager conceded staffing was an issue at the home, stating, "Short staffing is an issue we have every day here." The registered manager explained the process of trying to cover shifts when staff called in sick involved ringing round existing staff at the home before calling three other Bupa care homes in the area for support. He also said recruitment was ongoing at the home and confirmed that staff numbers per shift would increase as admissions continued since the lifting of the embargo. Both managers confirmed staff sickness had been a problem, but quoted figures that showed it had started to improve. The registered manager told us he did all back to work interviews with staff to ensure any issues were addressed or support provided, if required.

We observed the care people received during the two days of inspection. This included care in the communal lounge areas using the Short Observational Framework for Inspections (SOFI), which is a way to help us understand the experience of people using the service who could not express their views to us. Our observations showed there were sufficient care workers on duty to meet the basic needs of the people when the floor was fully staffed. The team on one floor which was short one care worker on one of the days of inspection appeared to be under pressure. We concluded that staff availability and sickness was an issue the registered manager had acknowledged and was trying to address. In addition, the dependency tool currently used by the home at the time of inspection may not have been based upon accurate information but was already under review.

Issues with the consistency of staffing levels on a day to day basis due to staff absence constituted a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at accident and incident forms at the home. We saw accidents and incidents had been recorded by care workers in sufficient detail, however, the follow up investigation recorded by managers was often lacking. For example, a person had fallen and fractured a limb. The report of what happened was detailed, however, the summary of the manager's investigation stated that the incident had been 'safeguarded' (reported to the local authority), had been added to the electronic records system and reported to CQC. It did not detail what investigations had been undertaken or measures put in place to prevent a reoccurrence. Another person had been found on the floor in their room. The manager's investigation summary stated the person had no injuries, that the correct form had been filled in and the person's relatives had been informed. Again, there was no information as to how the incident had been investigated or what measures had been put in place to prevent it happening again. We raised our concerns regarding accident and incident recording with the registered manager. He could describe in detail how each incident had been investigated and the measures put in place as a result; he also agreed that the level of detail on the forms was lacking and said they would be improved in future.

We asked care workers about the different forms of abuse and how they protected people from it. All of the care workers could describe the various forms of abuse and said they would report any concerns to a

manager immediately. Senior care workers knew the processes for reporting safeguarding concerns to the local authority and to the Care Quality Commission (CQC). One care worker told us, "We want people to feel safe and comfortable" This meant care workers knew how to safeguard the people from abuse.

We looked at records for gas and electrical safety and for maintenance checks on equipment. At the last inspection in November 2015 we found checks on water temperatures, kitchen equipment, heating, lighting and hoist slings were incomplete; in addition, checks on the fire safety system were not made in line with the home's policy and fire drills had not been held regularly. At this inspection we found all of these aspects had been addressed and checks had been made in line with the home's policies and procedures. The home had risk assessments in place for all relevant aspects of the building. People had personal emergency evacuation plans on file and an up to date list of those living at the home was present in the emergency file located in the reception area. This meant the system of safety checks had improved since the last inspection making the home safer for the people.

We found the home was clean and tidy. This included communal areas, in people's rooms, in bathrooms and toilets and the equipment people used. The domestic workers we spoke with could explain the daily and weekly cleaning schedule and described how rooms were deep-cleaned when people left the home. This meant that the home was clean which helped keep the people safe from infections.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection November 2015 we found a breach in the Regulation relating to consent to care, as there were a lack of comprehensive capacity assessments and best interest decisions for people known to lack capacity or who had variable capacity to make decisions. Staff knowledge of MCA and DoLS was also poor. At this inspection we noted a big improvement in the recording of capacity assessments and best interest decisions. We saw they were in place for various aspects of care people living with dementia received, for example, the use of sensor mats which alerted staff when a person got out of bed, and for decisions around whether or not a person would be resuscitated in the event of a cardiac arrest. We asked staff to explain MCA and DoLS to us during this inspection and found care workers' level of knowledge was appropriate for their role. For example, all could describe the basics of the legislation and how they provided people with choices, whereas senior care workers (including nurses) could explain the process of capacity assessment and best interest decision-making. This meant that MCA procedures and staff knowledge had improved since the last inspection so staff could better support people known to lack capacity.

We looked in the care files of people who lacked capacity to make decisions to see if applications for DoLS were in place. Under the Regulations, if people lack the capacity to consent to living in a care home or hospital, or are deprived of their liberty via constant supervision or would be prevented from leaving for their own safety, a DoLS authorisation is required. Of the six care files we looked at, five people lacked capacity to consent to living at Woodend and would require a DoLS authorisation. We noted three of these people had no DoLS documentation in their files. The records of all DoLS applications kept by the registered manager showed two of these people were listed as requiring a DoLS but an application had yet to be made. The other person was not listed at all. This meant people who lacked capacity to consent to live at Woodend were being deprived of their liberty without authorisation. We raised this with the registered manager who said DoLS applications would be made for these people as soon as possible following the correct process.

The unauthorised deprivation of people's liberty constituted a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked care workers if they had received training to support the people at Woodend and they said they had. Care workers described an induction which included mandatory units such as safeguarding, fire safety, moving and handling and food hygiene. We saw the care worker induction incorporated all aspects of the

Care Certificate. Care workers also said they received annual updates of certain mandatory subjects. One care worker told us, "I feel Bupa has a very good training programme."

We saw the home's staff training matrix. It showed the training which had been assigned to staff and what they had completed. According to the matrix attendance on courses such as moving and handling, pressure area care, Mental Capacity Act 2005 and medication awareness was over 90%. We noted that there were other courses, such as safeguarding and food hygiene where attendance was just below 90% and raised this with the registered manager. He said a new training lead was starting the week following our inspection and it would be their role to arrange staff training and identify those who had not completed any training assigned to them. The registered manager told us if staff missed training critical to their role in future it would be rearranged once, and if they missed it a second time, they would not be allowed to work at the home until they had completed it. He also said the new training lead was going to prioritise additional training in supporting people living with dementia. This meant the home ensured staff received the training they needed to meet people's needs.

At the last inspection in November 2015 an interim manager had instigated regular supervision and annual appraisals for staff, as it had been highlighted by the local authority and Clinical Commissioning Group that supervision of staff was intermittent. At this inspection we asked staff if they received regular supervision and an annual appraisal from a senior staff member. All care workers said they had received supervision since our last inspection, although some could not recall when it was. Most staff also said they had received an annual appraisal, although one member of staff said they had never had an annual appraisal. We saw the supervision tracker kept by the registered manager which showed 17 members of staff had supervision in the three months prior to our inspection. The registered manager said he was in the process of ensuring all staff had supervision at least every two months and an appraisal annually. He was also reviewing the way supervision was organised and delegated to senior staff. This meant the system of supervision and appraisal had continued to improve since the last inspection, but there was still more work to do to embed the system.

We asked people what they thought of the food at Woodend and the feedback was mostly positive. Comments included, "Very good food and lots of choice", "The food is satisfactory", "The food is OK", "They don't stick to the menu that is on the board", "Meals are boring, the same every week", and, "The meals are nice. Staff read out what I would like and I choose." Relatives were all happy with the food served at the home. One relative said that they could have a meal with their family member if they wished and a second said they were always offered a hot drink and biscuits.

We spoke with a kitchen worker who explained how people chose their meals. Care workers helped people to make choices each day and would highlight if they had special dietary requirements, such as soft or fortified foods. The menu was based on a four-weekly cycle and people had two choices for each meal, although the kitchen worker said other options were always available, such as egg and chips or sandwiches. This meant that people had a choice of foods for each meal.

We checked the kitchen as part of the inspection. We saw that stocks of food were sufficient, the environment was clean and tidy, and schedules for cleaning and the recording of fridge temperatures were in place. The home was last inspected for food hygiene by the local authority in January 2016 and had received five stars out of a possible five. We observed a meal time during the inspection. Tables were set with placemats and condiments and people were eating a meal of scampi, roast potatoes and salad. The care workers serving food wore aprons and gloves. The meal itself was relaxed and people appeared content and happy with the food provided.

One person whose care plan we inspected was at risk of weight loss so care workers were recording how much they ate and drank. We checked this person's food and fluid charts during the inspection and found that they had been completed with sufficient detail and in a timely way after meals. This meant care workers were recording information important for this person's health and well-being properly.

The home had recently started to focus more on the nutritional needs of people living with dementia. People living with dementia can sometime lose interest in eating and walk away from meals or start to prefer sweeter choices. We saw Woodend kitchen staff were making more finger foods for people living with dementia which they could take with them if they walked away from their meal. We observed people at risk of weight loss were offered sandwiches and high calorie snacks such as cheese and biscuits and cream scones in between meals, in order to promote weight gain. A relative of a person living with dementia commented about the use of finger foods, saying it was better for their family member. This meant the home had changed the foods available to better meet the needs of people living with dementia.

People told us they could see a GP if they needed to and their relatives agreed. One person said, "If I need a doctor I just have to ask", and a relative commented, "If I think [my relative] needs a doctor, nine times out of 10 they (care staff) have already called." We saw from the care files we inspected that people had access to a range of healthcare professionals. These included GPs, podiatrists, the dementia crisis team, a psychiatrist, speech and language therapists, dieticians, dentists and opticians. During our inspection we spoke to two visiting healthcare professionals, both of whom gave positive feedback about the home. One commented that the home had made appropriate referrals to the dementia crisis team and followed any advice that was given. The other said, "Communication is really good and staff are always ready to help." This meant that the home supported people to maintain their holistic health.

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought the care staff were caring and the feedback was mixed. People told us, "Staff are all right", "Staff are occasionally kind to me", "Staff are excellent", "Some staff are kind, some are not", and, "Staff are lovely, they look after me." Relatives were all positive about the staff at Woodend; they told us, "Staff are great, they look after [my relative]", "All staff are lovely, not just the care staff – kitchen staff and laundry", "Staff are very friendly and caring," and, "Staff listen and help."

During this inspection we attended two 'handover' meetings, where staff finishing their shifts meet with those starting theirs to provide updates on how people were, any changes in people's support needs or any other information they may need for their shift. On one floor this took place at the care workers' station and we noted that a person who lived at Woodend was sitting with the care workers as the senior night care worker handed over. On another floor, there was a walking handover, where care staff went to people's rooms, and in some instances opened their doors, while providing a verbal handover of events within earshot of other people living at Woodend. We noted that the cupboards used to store people's care plans were not locked at any time during the inspection, one of which was located in the communal lounge area on that particular floor. In addition, there were occasions when people's care documentation was left on desks at care workers' stations where people, relatives or other visitors could access it.

We asked people if care workers respected their privacy and dignity. One person told us, "Staff knock but just walk in. They don't wait for me to answer." Our observations during the inspection supported this, although we did see care workers asking people if they preferred their doors open or closed when they left people's rooms. People's care plans also noted whether they preferred their doors open or closed at night.

Handing over information about people using the service in front of others did not respect their dignity or confidentiality. Failure to keep care documentation securely was a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2015 we found a breach of the Regulations as people and their relatives (when appropriate) had not been involved in designing and reviewing their care plans. At this inspection we asked people and their relatives if this had changed and we looked for evidence of their involvement in care plans. People able to respond to our questions told us they had helped design their care plans and we saw they had signed them. Most relatives said they were involved in care plan reviews; one relative said, "I am asked to attend the meetings", and a second told us, "It took a while for them to involve me in the care plan." Two relatives told us they had not been invited to take part in planning their relatives care.

We noted the home had a 'resident of the day' system, whereby one person on each floor had a specific day of the month when their care plans were reviewed. A care worker told us that this day was fixed so that plans would always be reviewed and evaluated on a monthly basis. We saw in minutes from the January 2016 residents and relatives' meeting that the registered manager had encouraged people and their relatives to become more involved in care planning. The registered manager confirmed each relative had received a letter advising them of their family member's monthly 'resident of the day' date so that they could attend,

with the assurances this date could be changed to suit them. Minutes of this meeting had been displayed on the wall in the ground floor corridor of the home. Care workers described how they supported people to be involved in their care plan review meetings; one told us, "We encourage people who live here to take part in their plans, and they do." This showed us that the participation of people and their relatives in care planning had improved since our last inspection November 2015.

Care workers could describe how they supported people to maintain their dignity and independence by encouraging them to do as much as they could for themselves. People's care plans for each aspect of their care included details of what the person could do in a separate section to what support they needed. This helped staff to support people to stay independent. Care workers we spoke with could demonstrate an in depth knowledge of the people they supported, including their personal histories and important family members; one relative agreed with this, telling us, "Staff know [my relative] and [their] needs well." During the inspection we observed numerous interactions between people and staff which were warm and friendly. For example, an off duty care worker had popped into the home. When a person living with dementia saw them their face lit up and they initiated a hug which the care worker reciprocated. The off duty care worker then asked the person if they would like a cup of tea and brought it for them. They told us, "I make [name] feel safe because [they] know me." We also observed a good rapport between the people and domestic and catering staff. This meant that care workers and other support staff knew the people well as individuals.

At the last inspection in November 2015 we received negative feedback about the laundry service at the home. Some people and their relatives complained that items had gone missing and woollen clothing had been shrunk. At this inspection we asked people if they had any problems with the laundry service and they said they did not. We also saw the issues with the laundry service had been included on the home's action plan for improvement and regular checks were now being made. This meant that the laundry service had improved since the last inspection.

We asked the registered manager if any of the people had been referred to advocacy services since our last inspection. He said no one had, but this was due to all residents having family members who acted as advocates for them. We saw that details of advocacy services were clearly displayed in the home and the registered manager was knowledgeable about the various types of advocates people may need and how referrals could be made.

We saw people's care files contained plans which recorded their future wishes. One person who had been very poorly also had a detailed and person-centred end of life care plan in place. Relatives we spoke with said they had been involved with end of life care planning for their family members. At the time of the inspection, two of the nurses at Woodend were undertaking Six Steps end of life care training. The Six Steps is a programme of learning for care homes to help develop awareness and knowledge of end of life care. The registered manager said a new member of staff starting at the home had a postgraduate qualification in end of life care, so existing staff were looking forward to learning from their expertise. He had also booked nursing staff onto a training course so that they could better support people with medicines at the end of life. The registered manager told us, "I want to improve the end of life care." This showed that Woodend was committed to providing people with evidence-based end of life care which met their preferences.

Requires Improvement

Is the service responsive?

Our findings

We looked at six people's care files as part of the inspection. We found people's care files had a structure which was consistent with other care homes run by the same provider. Each aspect of care had been assessed and there was information about what the person could do themselves and what support they needed from care workers. Areas of care assessed and planned for each person included eating and drinking, continence care, mental health and well-being and mobility.

At the last inspection November 2015 we found a breach of the Regulations because care plans were not consistent or comprehensive and in some cases had not been updated when the support people needed had changed. There were also issues with how care for people with behaviours that may challenge others was planned and the frequency of care plan reviews. At this inspection we found that care plans had improved; for the most part they were comprehensive, person-centred and reviewed monthly. Information about the care required by people living with dementia was included in their mental health and well-being care plans and people at risk of pressure ulcers had pressure relief care plans.

At the last inspection we found a person who at times had displayed behaviours that may have challenged others had not been assessed properly. This is usually done by completing antecedent behaviour consequence or ABC charts. ABC charts help care workers plan people's care by understanding when certain behaviours may occur and how staff should best support the person. At this inspection we looked at the care files of three people who at times displayed behaviours that may challenge others. One person had a detailed and person-centred care plan for their behaviours in place which directed staff in how to distract or divert the person if they became upset or anxious. The other two people did not have specific care plans for the behaviours they experienced at times, although how the people behaved was described in other care plans in their files, for example, washing and dressing. One of these people did have ABC charts, however, they were not completed in such a way as to help identify triggers for the person's behaviour or how best to support the person. Care workers we spoke with could describe each person's behaviours and how they helped to support them as individuals, and we observed one person displaying behaviours that may challenge others being supported by a care worker in a sensitive and understanding way. This meant that people with behaviours that may challenge others were receiving the support they needed, however their care plans did not always contain sufficient detail to guide care workers who did not already know them.

We asked care workers how they would find out how to support a new person moving to the home. They all said that they would receive a handover from the senior care worker as they came on duty and would then read the person's care plans.

We read people's daily notes to see if they received care according to their care plans. The notes we read were detailed and person-centred, and described how people had been supported according to their personal preferences. We did come across an incident whereby a person living with dementia had been supported to eat a culturally inappropriate food; this had been brought to the registered manager's attention by the person's relative in the form of a complaint. We looked at the person's care file and found information about their dietary preferences was very clearly stated. The registered manager said he was

investigating how the incident had happened; he also said kitchen staff now prepared this person's meals separately to prevent any further occurrences. This meant that people were not always supported according to their care plans.

At the last inspection in November 2015 we found a breach in the Regulations because people did not have access to meaningful activities. At this inspection feedback was much more positive and the home had employed a second activities coordinator. People, their relatives and staff commented on how much more there was going on, and we saw in people's care files they had been supported to spend time in the garden, to arrange flowers, play games and attend gardening and book clubs. We saw there was information about the activities planned clearly displayed around the home and observed people taking part in activities on different floors in the home. People and their relatives told us they received a weekly planner of activities and a yearly list of trips outside the home. One person told us, "[Name] the activity lady is fantastic", and a care worker said, "The activities that are happening now are the best I've ever seen." Care workers also described how people who were nursed in bed or chose to spend the majority of their time in their rooms were included in activities. One care worker said, "We're very conscious that we need to go and see people in their rooms." We noted the activity planner included 'room visits and one to ones' as an activity, when the activities coordinators would visit people in their rooms for a chat or other activity. Records, feedback and our observations showed that people's access to activities had much improved since our last inspection.

There was a system of acknowledging, investigating and responding to complaints in place at Woodend. Recent complaints and concerns were logged on a tracker so we could see what stage the investigation had reached and which member of the management staff was dealing with it. One formal complaint had been received in May 2016 which concerned a member of staff supplied by an agency. We saw the registered manager had investigated and responded to the complaint appropriately and had fed back to the agency about the member of staff.

We asked people and their relatives if they had ever complained about the home or if they knew how to complain. People told us, "I would speak to staff and they would listen", "I don't see the point in complaining, nothing will be done", and, "I'll tell the staff if I'm not happy and they will help me". Relatives said, "I know who to complain to but they don't come back to you", "I don't feel complaints are handled correctly", and, "I've complained, nothing was done." This meant that some people and their relatives felt complaints they had voiced had not been taken seriously or acted upon.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2015 we found a breach of the Regulations as the action plan submitted by the home after the previous inspection in January 2015 did not include measures to address all the issues we had identified. In addition, the home had no registered manager in post and had not had one since January 2015; an interim manager was in post, the fourth manager the home had in 2015, but they subsequently left in December 2015.

A new manager had started at Woodend in January 2016 and had since become the registered manager for the home on a permanent basis. 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.

At the last inspection we found staff morale was poor; this was due to uncertainty around management and leadership at the home. We were surprised to find low morale was still an issue at this inspection so we asked care workers about the current leadership and management at the home. Feedback was mixed. Care workers told us, "I feel the management are helping me more", "[The registered manager is] much more a manager rather than a leader", "I can talk to him (the registered manager) and be quite honest", "If you go to him (the registered manager) with a problem I feel he's not interested. You're not allowed to voice your opinions", "[The registered manager] is OK, some don't like him because of his approach", and, "[The registered manager] is fine. It's taken a while to get on with him, but he is approachable and has an open door policy." Regardless of their opinions, all care workers acknowledged that the home had improved since the registered manager had joined the service in January 2016.

We concluded from our discussions with staff that some care workers felt a level of uncertainty and insecurity, particularly those that had worked at the home for longer, which was based upon their experience of numerous managers that had come and gone. One care worker told us, "I keep hearing he's (the registered manager) saying 'no one likes change' but I don't think he'll stay." Other care workers seemed resistant to the changes in practice the registered manager was trying to implement or did not like his style of leadership; some members of staff said they did not feel listened to by management and that the registered manager was not approachable. A care worker explained, "People (care staff) become resistant to change because we've seen so many managers", and then added, "It (the home) needs someone like him. I can see that."

All of the care workers we spoke with were committed to the home and the people they supported and told us they enjoyed their jobs. Care staff commented, "I love it here and I love my job", "I'm very passionate about this place", and, "I hate to be so negative because I really like working here."

We discussed our findings regarding staff morale with the registered manager and area manager for the recovery team during the inspection. The registered manager said he was aware staff morale was still an issue and said of people's opinions of him, "They're (the staff) getting used to my style of management. If I

see something I tell people." The registered manager agreed he had work to do to build trust with the staff at Woodend but said he had accepted a permanent contract and was fully committed to the job, stating, "I'm proud to be the manager here." The registered manager and area manager for the recovery team said they were considering ways to improve the culture at Woodend. We saw they had starting holding regular team meetings for staff and had organised a 'staff surgery' in March 2016 where care workers were encouraged to feedback back about their experience of working at the home. The registered manager was also in the process of organising a staff survey to generate more feedback. He said he was aware low morale was a problem but in his first six months at the home he had focused on the action plan and improving care for the people. He told us, "I'm six months into a job I reckon will take me three years." This meant that the culture and morale at the home were still not healthy, but the registered manager was aware of the issues and was trying to make it better.

As stated earlier in this report, in October 2015 (prior to our last inspection) the local authority and Clinical Commissioning Group (CCG) had together raised concerns about the home and agreed an embargo on all admissions until improvements were made. This resulted in a service improvement plan, to which the issues we found at the last inspection were added to make a joint action plan. Between January 2016 when the current manager started and May 2016, officers from the local authority and CCG had regular meetings with the registered manager to provide support and gauge the progress of improvements. The registered manager was also supported by a new 'recovery team' from the provider, which was set up in 2016 to help failing services improve. We spoke with local authority and CCG colleagues the day before this inspection and they told us the embargo on admissions to Woodend had been lifted in May 2016. One CCG officer said, "We lifted the embargo because we feel they made improvements in terms of the actions they were provided with", and then added, "In general it's heading in the right direction."

The joint local authority/CCG and CQC action plan generated after the last inspection was detailed and covered all the aspects we had raised. As discussed in other sections of this report, we noted significant improvements had been made, although there was still more to do in some areas.

At the last inspection we found a breach of the Regulations as the systems of audit in place to monitor the safety and quality of the home were not adequate. At this inspection we saw that a new system of audit was in place and the monitoring and safety and quality was a lot better. All care files had been reviewed by the clinical service manager between March 2016 and the time of our inspection. This had involved scoring each file according to the quality of its content. We saw the clinical services manager had reassessed care files that had scored poorly at the first review and had found them to be much improved. The care file reviews by the clinical services manager were in addition to the monthly review of each care file as part of each person's 'resident of the day' meeting. This meant care files were checked for quality on a regular basis and to ensure they were up to date.

Other regular audits at the home now included weekly reviews of people's weight and of any pressure ulcers people may have, plus regular reviews of any falls, medicines errors, safeguarding referrals to the local authority, deaths, unplanned hospital admissions, complaints, and accidents and incidents. All of these aspects were reported to the provider via an electronic system with an analysis of trends plus any other relevant information added by the registered manager. We saw medicines were now audited fully on a monthly basis; in addition, medicine administration charts were checked by senior care workers on a different floor each day and any omissions or irregularities were recorded and dealt with the same day. We also saw detailed quarterly infection control audits had been documented by the housekeeping manager. This meant the system of quality and safety audit in place at Woodend was now fit for purpose.

The role of the provider's recovery team was to support the home to improve. We saw this had involved

weekly visits to the home and a detailed monthly review. Records of these reviews showed all aspects of the home had been analysed, including the kitchen, laundry service, activities provided, quality of care plans, medicines and daily records kept by care workers. Each review had generated an action plan and we saw outstanding issues were checked prior to the next monthly review and recorded as either ongoing or completed. The registered manager said weekly and monthly meetings with the recovery team also involved discussion of the home's action plan for improvement, so that progress could be assessed and any outstanding areas addressed. This meant the provider had demonstrated a commitment to improving the home.

Feedback at the last inspection as to how the home quality assured the service with people and their relatives was mixed. At this inspection we saw the registered manager had initiated regular residents and relatives meetings and minutes of the last meeting were displayed prominently at the home. At these meeting the registered manager had updated attendees about the admissions embargo and ongoing work to improve the home. Minutes showed that aspects such as activities and resident/relative involvement in care planning had also been discussed. Attendees had agreed that meetings would be held bi-monthly, but we saw it minuted that the registered manager had emphasised he had an open door policy should people or their relatives have any issues or concerns between meetings. This meant that the home sought feedback from the people and their relatives on the quality of the service provided.

In accordance with the Regulations, registered managers are responsible for notifying CQC about certain incidents, accidents or events. We checked the records of notifications made by the registered manager to CQC against the records of incidents and accidents held at the home and found that all notifications had been made correctly. Under the Regulations services also have a duty to display the previous CQC inspection rating in a prominent place where people and their relatives can see it. At this inspection we saw the previous CQC inspection rating was clearly displayed in a prominent area of the home. This meant the registered manager was complying with the requirements of the Regulations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Applications for Deprivation of Liberty Safeguards authorisations had not been made for people who lacked capacity to consent to live at the home. Regulation 11 (1)

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 Recruitment files could not evidence safe recruitment at the home as they were not complete. Regulation 12 (1) and (2) (c) We found issues with medicines management and safe storage of medicines. 12 (1) and (2) (g)

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 People's documentation was not stored securely. Regulation 17 (1) and (2) (c)

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 issues with staff availability at the home.

Regulation 18 (1)