Bupa Care Homes (ANS) Limited

Woodend Nursing and Residential Centre

Inspection report

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Ratings

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

Overall summary

We carried out a comprehensive inspection of this service over three days; 29, 30 of January and 2 February 2015. The first day of the inspection was unannounced.

We followed up on the action taken to address identified breaches of the regulations found at a responsive inspection on 14 May 2014. The inspection on 14 May 2014 was undertaken in response to concerns that one or more of the regulations was not being met.

Woodend Nursing and residential centre provides nursing and residential care for up to 79 older people. At the time of our inspection there were 64 people living in the home.

People are supported over four floors. The basement floor provides accommodation for people in need of residential support. The ground floor provides accommodation to people requiring nursing care, The first floor provides support to people living with dementia and the top floor supports people with higher dependency needs. Each floor has a communal lounge/ dining room and each floor has access to a satellite kitchen for making snacks and hot drinks. The home's kitchen and laundry are situated in the basement and the home is accessible by a lift and stairs to all floors.

Summary of findings

The home is required to have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The registered manager had left two weeks prior to the inspection. The service was being managed part time by a registered manager from another BUPA home. The acting manager had been in post for approximately three weeks prior to the inspection. The management team were in the process of recruiting a new full time registered manager.

After the inspection of 14 May 2014 the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches of the regulations. We undertook this unannounced comprehensive inspection; to complete a new approach inspection, to ask the five key questions of, is the service; safe, effective, caring, responsive and well-led. This inspection will give the home an overall quality rating and check they had followed their plan to confirm they now meet legal requirements.

We found the provider had followed part of their plan to rectify some breaches but we also found some had not been addressed and other concerns were identified leading to continued and further breaches of some of the regulations.

At the inspection in May 2014 we were concerned safeguarding procedures were not being followed and accidents and incidents were not always reported in line with safeguarding procedures. At this inspection we found the service had increased the number of safeguarding incidents reported but still found incidents and accidents were not consistently recorded or investigated. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we were told by the acting manager of four people who received their medication covertly. We reviewed the records used to inform this decision. We found records were inadequate to support giving the medication covertly and to support it was in the person's best interest. Records referred to assessments and decisions that could not be found including deprivation of liberty safeguards and reviews of capacity. We discussed this with the acting manager and quality manager and were told the paperwork could be difficult to follow and new paperwork was going to be used shortly. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we were shown one Deprivation of Liberty Safeguards (DoLS) application that had been made. The provider was aware more were required. We saw lap belts in use on wheel chairs and recliner chairs used to restrict people getting up. This practice is usually undertaken to protect people from harm. However, when we looked in the care plans for these people we did not see effective and appropriate assessment and risk management procedures used in accordance with the Mental Capacity Act 2005. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspection in May 2014 we found inconsistencies in how staff supported people with their diet and hydration. Records did not include key information about changes in dietary requirements and needs. People were not being weighed more frequently following requests from other professionals or after identified weight loss and care plans had not been updated. At this inspection we found some improvements had been made, however we saw people not getting their food prepared in line with professional assessments. We saw people's weight was being recorded but it was not assessed effectively to reduce risks. We looked at the monthly management information, used to monitor the service, over three months and found that records showed increases in weight loss with no additional action identified to address the situation. This left people at continued risk of not receiving appropriate support. We also found this in the inspection in May 2014. People were not fully protected against the risks of inappropriate or unsafe care. Needs were not always appropriately assessed and care was not always planned

Summary of findings

and delivered on appropriate assessments. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we found internal monthly meetings to address the health and safety of the environment and general monitoring of the home had not taken place for over six months. We saw from the recent infection control audits and available reports that many actions had been identified, including damp to the basement area, redecoration of communal areas and bedrooms and a lack of facilities for clinical waste. We were told by the acting manager that some of these actions may take some time to implement due to budget constraints.

We also found that consideration had not been given to the client group when decorating and improving facilities within the home. All of the corridors looked the same and there was nothing to stimulate or occupy people as they moved around the home. We saw that many of the bathrooms were used for storage of equipment including hoists and wheelchairs. We saw a lack of clinical waste pedal operated bins in most of the bathrooms and toilets. We also saw a lack of easily accessible PPE (Person Protective Clothing) used to reduce the risk of cross contamination and infection control. The lack of appropriate audit and resulting operation of the service, has left services users at risk of receiving support in an environment that is potentially unsafe and unsuitable. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 HSCA (RA) Regulations 2014 Good governance.

We observed the mealtime experience using the Short Observational Framework for Inspection (SOFI). We saw people were not provided with care as they requested. When we spoke with staff we were told contradictory information to what was recorded in some plans of care. When we looked at plans of care we found contradictions across assessments and the associated care plans. This was also found in the inspection in May 2014. Inconsistencies across care plans can lead to staff forming their own perceptions of people that are not based on the person's individual health care needs. If care is not delivered or planned in line with appropriate and effective assessment there is a risk of people not receiving care that meets their individual needs this is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in May 2014 we found staff had not always ensured people's dignity was preserved. The action plan provided to us identified actions the provider would take to improve this. At this inspection we found the actions had not all been completed. We received two complaints prior to the inspection about welfare and dignity including people not being comfortable or covered whilst in bed. People living in the home told us of similar concerns during this inspection. At this inspection we found people were not involved in planning their day to day care nor had their views on how their care was delivered been sought. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the inspection in May 2014 we found care plans had not been updated to reflect the changing needs of the person. At this inspection we saw in the care plans we looked at that they were not updated when information changed at review. We saw some care plans had not been reviewed for up to two months. We looked at daily records and saw changes to support needs were not reflected within the associated care plans. We looked at information across care files and found information that was recorded in daily records was not routinely used to update care plans. When plans are not updated and show inconsistencies, there is a risk of people not getting the care and support required to meet their needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection in May 2014 we found a system of audits was in place that included; infection control, medication and mattresses. However shortfalls were identified in the care being provided which meant the systems in place were not properly implemented or acted

Summary of findings

upon. At this inspection we found continued shortfalls in care provided. Monitoring of care plans was ineffective as we saw continued contradictions in the information held within them. At our inspection in May 2014 we also saw records of accidents and incidents contained conflicting information, this remained the case in this inspection. The provider did not have effective systems in place to monitor and assess the suitability of provision within the home. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we reviewed the last three month provider reviews and metrics reports which included high level monitoring of the service provided. We also looked at some of the information sources that fed into the reports including accident and incident reports, deprivation of liberty safeguards, complaints and weight records. We cross referenced this information with what notifications should have been received by CQC following on from incidents including serious injury and safeguarding concerns. We did not find any correlation between these records and notifications received by the CQC. For example over the three months eight accidents resulting in injury were recorded on the metrics report. CQC had only received two injury notifications over this three month period. This meant that notifications were not being made by the provider as required by the commission This is a breach of regulation 18 of Health and Social Care Act 2008 (Registration) Regulations 2010. Notification of other incidents.

At this inspection we reviewed the clinical review meeting minutes held on one of the units on 30 December 2014. The action plan following the inspection in May 2014 stated this meeting would be robust, minutes would be signed off by the area manager and monthly and weekly weights would be discussed and monitored. Information would be fed into monthly management information including the quality metrics report and the provider reviews and actions for improvement would be agreed. We found that records showed increases in weight loss with no additional action identified for a number of months. This was not clear within the clinical review meeting minutes. Inconsistencies in recording of important healthcare information left people at continued risk of not receiving appropriate support. The provider had not identified, assessed and managed risks relating to the health and welfare of people using the service. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection in May 2014 we were told a questionnaire was sent to relatives on an annual basis but the most recently completed surveys could not be found on the day of the inspection. As part of the action plan submitted to us following the inspection we were told the questionnaire would be kept at the home and an action plan would be developed and shared with the relatives and residents. We found this had not happened. We reviewed the questionnaire at this inspection and found marked reductions in customer satisfaction that had not been considered or assessed. The provider had not had regard for the comments and views of people living in the home or their relatives. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

Some aspects of the service were not safe.

Staff we spoke with did not understand the safeguards around restrictive practice and the steps that needed to be taken before the practice could commence.

Staff had not received ongoing training to ensure they were competent to fulfil their role.

The service had developed contingency plans and personal emergency evacuation plans to support people in the event of an emergency.

Is the service effective?

Inadequate

The service was not effective.

We found many staff did not understand some of the basic principles of the Mental Capacity Act 2005 including the link between capacity assessments, consent and best interest decisions and between restrictive practice and the Deprivation of Liberty Safeguards (DoLS).

Different staff we spoke with interpreted guidance and procedure differently, including when someone's care plan would be reviewed.

We found one person was not receiving food in a consistency as directed by professionals.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Most people we spoke with told us staff, were kind, patient and caring.

We observed some people being cared for without consideration for their individual needs.

Is the service responsive?

Inadequate

The service was not responsive.

We did not see an ongoing involvement with people's care plans from people living in the home.

People we spoke with enjoyed the activities but would like more of them.

Care plans were not consistently reviewed and when assessments identified changes the care plans were not updated.

Is the service well-led?

Inadequate

The service was not well led

Summary of findings

The registered manager did not accurately record and monitor activity associated with keeping people safe.

Processes and systems that had been set up to monitor service provision were ineffective.

Consideration was not given, or any improvements made following a reduction in resident and relative satisfaction recorded in the annual questionnaire.

Woodend Nursing and Residential Centre

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 over three days 29, 30 January and 2 February 2015. The first day of the inspection was unannounced. The inspection team included an adult social care inspector, a second inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people services.

Before the inspection we did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before our inspection, we reviewed the information we held about the home, requested information from Trafford Council and sourced information from other professionals who worked with the home. During the inspection we spoke with 17 staff including the acting manager, the area manager, quality manager and clinical services lead. We also spoke with carers, nurses, laundry staff and the chef. We spoke with 14 people who lived in the home and eight people who were visiting someone in the home. We spoke with five visiting professionals including a social worker and a GP. We observed how staff and people living in the home interacted and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate their experience of care to us. We observed support provided; in the communal areas including the dining rooms during lunch, during the medication round and when people were in their own room. We looked in the kitchen, laundry and staff rooms and in all other areas of the home.

We reviewed 11 people's care files and looked at supplementary care records including personal care records, nutrition and hydration records and body maps. We reviewed the medication records and associated audits. We also looked at records used to manage the home including all available accident/incident records, monitoring and audit records and management information for the last three months. We looked at how this was used to inform change and best practice. We reviewed meeting minutes and five personnel files and looked at the information used by the manager to support the staff team including training, supervisions, communications and procedures.

Requires Improvement

Is the service safe?

Our findings

We spoke with people we could about feeling safe. One person told us, "I always feel safe, there is always someone about you can call on." Another said, "They felt moderately safe but would ideally like more staff on at night."

We observed people did not have to wait for long periods of time to have their call bell answered and staff were available to support people at lunch time in a dignified way. We were told by the senior staff that staffing would be increased if people's needs increased and carers told us this had happened. However the Dunham unit in the basement was staffed by only one carer and everyone we spoke with on this floor said more staff were needed. This unit supported the most able people within the home and we were assured people living there were all mobile. When we visited this floor and spoke with people we saw that all but one was mobile and the person, who was not, was supported to become more mobile following an operation. At times people would have to wait longer for support if the carer had to take one of the residents to the hairdressers or somewhere else in the building. The call bell sounded throughout the building allowing other carers to know if someone on that unit required support and someone would respond to the bell if required.

At our last inspection in May 2014 we found that staff were not following safeguarding procedures and reporting all poor practice. At this inspection we saw there had been an increase in safeguarding incidents reported. However not all incidents had been identified and consequently reported. The acting manager had developed a folder to hold all accident and incident records together. Yet over the inspection we identified a number of falls and incidents including restrictive practice which had not been recorded, assessed or reported in accordance with safeguarding procedures.

We saw safeguarding posters were displayed on some notice boards within the home and a new falls protocol and communication had been distributed to staff.

The action plan provided to us following the inspection in May 2014 had identified how the provider was to ensure the home was following regulations associated with keeping people safe. All reportable incidents were not reported by the home in line with their own policy. We saw records in daily notes and within assessments that contradicted other records. This included collations of monthly activity associated with keeping people safe that was submitted by the home to the regional office. All accidents and incidents were not thoroughly investigated by the home manager or clinical services manager. We saw a large number of accident forms had not been signed off or completed in line with the guidance attached to them. Monthly reviews of accidents had not taken place since the last inspection. The acting manager had begun to implement this but they were working from inaccurate records as not all accidents and incidents had been reported. If records associated with keeping people safe are not accurate then potentially the home cannot introduce changes to keep people protected and safe from harm.

We found information relating to accidents and incidents was not being recorded and investigated appropriately to reduce the risk of reoccurrence. The provider had not taken reasonable steps to ensure they could identify the possibility of abuse before it occurred. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in May 2014 we found that care plans we looked at, contained risk assessments in relation to people's moving and handing requirements. Some of the care plans we looked at had not been updated to reflect the changing needs of the person. During this inspection we looked at assessments for moving and handling and observed how people were being moved. We could see assessments had been reviewed and we saw that people were appropriately moved in line with assessed moving and handling needs.

The action plan provided to us following the inspection in May 2014 had identified how the provider was to ensure the home was following regulations associated with keeping people safe. All staff had not undertaken moving and handling training or refresher training as required. We were provided with a training matrix on the day of our inspection. We enquired as to the expected frequency of training and were told one training course was every three years and another was annual. We looked at the records for the annual training and saw that on the day of our inspection 38 of the 83 staff had not completed refresher training. We acknowledged that a training schedule had been developed and the acting manager told us all staff

Requires Improvement

Is the service safe?

should be trained before the end of March 2015. Management had begun to walk around the home observing care provided and how staff interacted with each other and the people they were supporting. This information was recorded on a walk around report. We saw copies of these which included an assessment of staff competency in moving and handling.

We found the home had taken steps to assess potential risks to the environment and the building. A contingency plan was in place identifying alternative temporary accommodation if the home became uninhabitable for any reason. We saw personal emergency evacuation plans (PEEP) were in each person's care file and we saw emergency equipment including ski pads (used to transport immobile people) at the entrance to each unit. We noted all equipment including lifts and hoists had been professionally checked within the last 12 months and gas and electrical safety installations were tested as required.

We looked at five personnel files and reviewed training and supervision records for the whole staff team. We found recruitment practices included checking someone's suitability for employment including seeking references and a DBS (Disclosure and Barring Service) check. Potential staff were interviewed and once in post received an induction to their role.

We observed two medication rounds over the inspection and reviewed a selection of Medicine Administration Records (MARs). We saw records were kept of people's allergies and a picture of each resident was displayed to the front of their MAR. There was a record of each person's medication to take as required including details of what the medication was for and when it should be offered. Staff we spoke with were able to tell us how someone may show signs of pain or discomfort when they could not verbalise their pain. We saw records that confirmed this.

We watched how staff administered and recorded medication given. Staff informed people of what the medication was for and gave them opportunity to accept or refuse medication. Records showed when medicine had been refused and a more detailed explanation was given on the reverse of the record. We were told of four people who received their medicine covertly. When people refuse medicines that are important to maintain good health, medicines can be disguised in something else to reduce the risk of refusal. We reviewed the records used to inform this decision. We found records were inadequate. We saw assessments for capacity were not completed effectively; medicines referred to in best interest decisions did not match the medicines being given covertly. Dates were not in line with the start of the practice and records referred to assessments and decisions which could not be found. This included deprivation of liberty safeguards and reviews of capacity. We discussed this with the acting manager and quality manager and were told the paperwork could be difficult to follow and new paperwork was being used shortly. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw medicines trolleys were locked and stored in a clinical room when not in use. Records were kept of fridge temperatures and controlled drugs were stored and recorded as required in line with best practice guidelines. We saw records of medicines to be destroyed and saw pick up notes from the local pharmacy. Medicines were given as prescribed and we saw medicines being collected and given to individuals outside of the usual medication rounds as required.

Inadequate

Is the service effective?

Our findings

Staff we spoke with said the home was going through a period of change. Most staff had received supervision within the last six months and we saw evidence to support this. We saw most staff had received an appraisal within the last 12 months but many were now due.

The staff had daily meetings to discuss the day to day requirements of the home. Items discussed included people's needs, including medication and appointments to be made or due, visiting professionals and staffing on all floors. We were told the daily meetings would be used to inform weekly clinical risk meetings. We attended a daily meeting and we looked at the minutes of the meeting. The minutes were not clear and could not be used as an audit trail for the day's clinical activity. The minutes identified a resident of the day on each floor. A resident of the day was a fail safe way to ensure people's care was reviewed. Staff would pay specific attention to ensure the person had the meal of their choice and time would be spent with them developing more of their life story. We commented that we did not see any evidence of the resident of the day during our inspection, we were told it was allocated on room numbers on each floor and therefore on this day there would not be one as room 29 was not occupied. Unclear and inconsistent understanding of systems could lead to communication breakdowns and potentially impact in an adverse way on delivery of care and support.

Staff we spoke with had all received a comprehensive induction when they began work at the home. The provider had an inclusive training programme that was accessed internally from area trainers. It was clear from the training matrix that some staff had undertaken some training between May and September 2014 but from September 2014 to January 2015, limited training had been attended. We saw the acting manager had arranged a full programme of training for the coming months.

The Care Quality Commission (CQC) monitors the operation in care homes of the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). The aim is to make sure that people in care homes, hospitals and supported living who lack the capacity to make decisions for themselves are looked after in a way that does not inappropriately restrict their choices. We saw there were policies and procedures in place and training was available for staff in relation to the Mental Capacity Act (MCA) and DoLS Codes of Practice. However we found that many staff did not understand some of the basic principles of the MCA including the link between restrictive practice and the DoLS or between capacity assessments, consent and best interest decisions.

We looked in detail at how the home managed and supported those people who may lack capacity to make their own decisions. We reviewed how the home worked within the Mental Capacity Act 2005 and the deprivation of liberty safeguards. We looked at how the home recorded and implemented decisions made in someone's best interest when the person had been assessed as lacking the capacity to make an informed decision for themselves.

In seven of the care plans we reviewed, we looked at the detail included about people's capacity to make decisions and give consent. We found all plans included assessments of people's capacity. One assessment was made at the pre admission stage and another following admission to the home. The outcome of these assessments impacted on other plans of care including mobility and continence. We found assessments were consistently contradictory or completed incorrectly. Conclusions drawn from the records differed to what staff told us. One assessment concluded someone had no capacity yet they did not identify what communication techniques they had used to determine the assessment. It appeared no attempt had been made to enable the person to understand what was being asked of them. Another assessment stated someone had occasional confusion yet all of their care plans reflected someone with no capacity to make decisions and give consent.

When reviewing all care files we did not see any consent forms for the home to manage people's medication and yet no one within the home managed their own. We saw consent was mostly given by people's next of kin to photography and to share information, without an assessment to determine if someone could give their own consent. We did not see any consent for restrictive practice supported by a best interest decision other than for administration of covert medication as identified above. We asked the acting manager and the quality manager to review the information they held on restrictive practice.

We saw one DoLs application that had been made. The provider was aware more were required. We saw lap belts in use on wheel chairs and recliner chairs used to restrict someone getting up. When we looked in the care plans for

these people we did not see effective and appropriate assessment and risk management procedures used in accordance with the MCA. People being restrained by lap belts on wheelchairs or in reclining chairs did not have appropriate assessments to ascertain if the practice was in the individual's best interest. There was no information or support available from advocacy services and where power of attorney authorities had been identified they were not always informed or involved in decisions. The lack of effective assessment of people's capacity and ineffective use and appropriate implementation of protections, is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the inspection in May 2014 we found discrepancies in how staff supported people with their diet and hydration. Records did not include key information about changes in dietary requirements and needs. When people required extra monitoring of their diet, records were incomplete and did not meet their aim of recording how much food or fluid a person had consumed. People were not being weighed more frequently following requests from other professionals or after identified weight loss and care plans had not been updated.

At this inspection we found improvements had been made. We found staff were considerate when supporting people with their food. We looked at nutrition information in detail in nine files. We found in seven files that information had been updated and reviewed. Support had been increased as required or when requested in two of the four files where support needs had changed. One file was for a person who had been prescribed Complan (a nutrition supplement drink) in October 2014 following a decrease in weight and an increased risk of malnutrition. Their care plan had not been updated to reflect this. The person had been weighed weekly in line with procedures but the loss of a further one kg in December 2014 on their weight record had not been transferred to a reassessment of their health. Another person's weight fluctuated losing two kg and then gaining nearly one kg in less than a month. Information had not impacted on the person's MUST (Malnutrition Universal Screening Tool) score as this was decreasing and stated they had not lost any weight since November 2014.

Supplementary food and fluid charts were being checked by senior staff during the day and recording on these forms had improved. The action plan stated night staff would transfer information from the supplementary charts to the daily living record. It was clear that in the one file we looked at the correct information had not been copied into the file and a generic all food and fluids given was recorded.

During this inspection we found steps had been taken to better support people with their hydration and nutrition. However we observed one person who was not encouraged effectively to eat their meal. This person was a slight build and potentially at risk. We reviewed this person's records and found the meal had not been prepared in line with their assessed needs. The food had been pureed but was thick and their records from the SALT (Speech And Language Therapist) team stated their food needed to be of a pouring consistency. We also noted this person's daily record stated 'all food and fluid given'. This was confusing as the person had eaten very little at lunch. We took a closer look at other individual records for monitoring food and fluid intake and found they had been completed accurately. Inconsistencies in information recorded in peoples records could lead to inappropriate care and support being given. When care is not planned and delivered in line with peoples' assessed individual need this is a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with 13 people who lived at the home about the support they received. People told us if they requested a doctor the home would call one for them and most people who could express an opinion felt the home would look after them. Two people told us they needed to see a chiropodist and their request had not yet been met. We shared this information with the acting manager who told us a chiropodist would be called for the people requesting to see one. On the day of the inspection we saw a local optician was visiting to review the vision of a number of people who lived in the home. We also heard conversations between staff and people and their families around available support that would or had been called including district nurses and physiotherapists. When providers are unable to meet the needs of people living in the home they should ensure services are provided externally. This shows providers are meeting the needs of people in their care.

The building was large and in places we could see it looked tired and in need of refurbishment. We asked the acting

Is the service effective?

manager what programme of works was in place to maintain the environment. We were told meetings to address the health and safety of the environment and general monitoring of the home had not taken place for some time. We noted the "weekly manager walk around" had started again following the acting manager coming into post. This had helped identify areas in need of immediate remedial works.

The local authority had undertaken an infection control audit in January 2015 and staff had completed an audit of odour management for each floor, also in January 2015. We saw from the audits and available reports that many actions had been identified, including damp to the basement area, redecoration of communal areas and bedrooms and a lack of facilities for clinical waste. The acting manager had progressed some of these concerns but remedial action had not been identified for completion in a timely manner.

The building was a large detached building set in its own grounds. Support was provided over four floors including the basement level. Floors consisted of a middle corridor upon which the nursing station and communal areas were located. Bedrooms were off this corridor and off adjoining corridors to both the left and right. People supported by the service were allocated to a floor/unit dependent on their needs. Specifically a floor for people who may be lacking in capacity was located to the first floor. People with higher dependency needs were supported on the top floor. We found these floors and the corridors on them were not easily distinguishable and this meant that people particularly those living with a diagnoses of dementia could not orientate themselves easily in this environment.

We spoke with staff and some people living in the home about the design and decoration of the home. We were told by some people that they do not like to go out of their room as they get confused and have difficulty finding their way back. We noted signage was poor around the home and many rooms did not have numbers, or people's names, or room names on them. One staff member told us people get confused when the carpets are darker as they think they are going to fall. We asked the manager if any consideration had been given to the different client needs when decorating the home and were told it had not.

We also saw many of the bathrooms were used for storage of equipment including hoists and wheelchairs. The provider identified this as a concern but without appropriate risk assessment additional space had not been found as a priority.

The lack of appropriate audit and resulting operation of the premises, has left services users at risk of receiving support in an environment that is potentially unsafe and unsuitable. The provider must ensure services users have access to premises of suitable design and layout and has proper measures in place for the operation of the premises to carry on the regulated activity. This is a breach of regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requires Improvement

Is the service caring?

Our findings

We spoke to people living in the home and visiting relatives about what they thought of the care they or their family member received. We found people on different floors had different experiences. On Dunham unit in the basement, one person we spoke felt isolated and at times lonely. One person told us, "You see people wondering around, I just wish they had more time to talk to me, I get very lonely." People on this unit praised the staff interactions they had but felt there was not enough staff. On other floors we were told staff were kind, patient and caring. One person told us, "The staff are all very kind."

We observed staff laughing and joking with people and taking time when supporting them. We noted people's likes and dislikes and preferences were recorded and we saw people drinking beer with their lunch as they had done for many years. We saw staff knocking on people's doors before entering and were told by people and visitors they were happy with the care. One relative told us, "I am happy for (family member) to stay here, the service she is receiving is excellent."

We observed how staff and people living in the home interacted. We saw positive interactions most of the time. However the content of some interactions was not always based on people's identified support needs.

We observed the lunch time routine and completed a SOFI (Short observational Framework for Inspection), a tool for observing staff interactions when people cannot always make themselves be understood. We observed one person taking vegetables out of their mouth and saying they could not chew them. This person asked for their teeth consistently through lunch and became quite upset. The carer said to the person on a number of occasions "You don't have any teeth." The carer then used distraction techniques and discussed the weather and what might be for pudding. We checked the person care file and discovered the person did have teeth. The care plan noted the person refused to wear them. When care plans include conclusive statements of this kind, they pose a risk of not promoting people's independence, their rights to choice and to make decisions. It was clear at this time the person wanted to wear their teeth but they were not given the option.

We observed some instances where staff were not caring with their interventions with people. We saw that one person asked to go to the toilet on numerous occasions but staff did not support the person to do so. Twenty minutes after asking to go to the toilet this person was hoisted from their wheelchair to a seat with no discussion around using the toilet or if they needed any support with personal care. We asked staff about this person's needs and their assessment of capacity and were told they did not have capacity. We looked at this person's care plan and found contradictions across assessments and the associated care plans. Inconsistencies across care plans can lead to staff forming their own perceptions of people that are not based on the person's individual health care needs.

If care is not delivered or planned in line with appropriate and effective assessment there is a risk of people not receiving care that meets their individual needs this is a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspection in May 2014 we found some staff had not ensured people were comfortable or their dignity was maintained before leaving them to move on to their next task. The action plan provided to us following the inspection in May had identified how the provider was to ensure the home was following legal requirements to consistently promote dignified practice.

A 'Focus on dignity' audit had been completed in January 2015. Some aspects of the audit contradicted observations made over the inspection period. For example we did not see a suggestion or comments box and was told it had been removed and we did not see the resident of the day system in use on any of the units. An observational supervision, including how staff approached dignity, had been completed for approximately 30% of staff when the action plan following the inspection in May 2014 started it would be completed on all and dignity training including dementia training was still to be completed with over half of the staff team

The Care Quality Commission had received two complaints in relation to dignity and welfare prior to this inspection, we were told of undignified practice during this inspection and we observed undignified practice on occasions during this inspection. This included people who remained in bed with bedding that needed changing or refitting to meet the

Requires Improvement

Is the service caring?

needs of the person in bed, and people not receiving support with personal care following requests. We were told by one person, "I'm never asked if I want my pad changed, it is done when staff want to/or have time to change it."

We saw from people's care files that people living in the home were involved in their pre assessment. We also saw the activity co-ordinator spent time with people when they first arrived to complete people's likes and dislikes and life stories. Once people began residing at the home we did not see any further involvement with them within the care plans we reviewed. We did see signatures of the next of kin signing some assessments and reviews. The involvement of people's next of kin was not supported by decisions to determine the person living in the home could not be involved themselves.

We saw from the 11 care files we looked at that people living in the home had little input into their on-going care and support. We saw some family members signed an agreement to have photographs taken and to share information with other agencies. We saw care plans were reviewed on a monthly basis and on one occasion when this changed an assessment, we saw a family member had signed in agreement. However there was no specific information to support why the person themselves could not agree to the assessment.

When services do not treat people with dignity and respect and do not involve them with their care planning, nor make attempts to ensure their views are considered is a breach of regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Visitors we spoke with told us visiting times were flexible and they were welcomed by staff. We were told they felt informed of changes in their family member's needs and were able to talk to staff if they wanted. We saw visitors eating dinner and lunch with their family and they were routinely offered drinks when people living in the home were offered them.

Inadequate

Is the service responsive?

Our findings

We asked people how they were involved with their day to day care. One person said, "No you do as you are told." Another said, "No discussion." We asked staff about this and was told, it was not common practice to involve residents in their care plans or to get residents to sign them. This demonstrated that people were not involved with agreeing their own ongoing care and support. People on Dunham unit in the basement all had capacity yet none of them told us they had been involved with their ongoing care planning or reviews. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw pre assessment information included likes and dislikes. We saw a 'map of life' and a 'this is me' document that included people's life history and a family tree. This showed us people's interests and preferences were taken into account when developing their care. We saw staff took account of this when engaging with people who lived in the home. This included giving people what they liked to drink, giving flexibility at meal times with as many as twenty different meal options being prepared over the course of the inspection. We saw one person was frustrated at not having been able to get to the hairdressers for a couple of weeks, the staff phoned the hairdresser and they stayed on to do the person's hair.

At the inspection in May 2014 we found that, although plans had been signed as reviewed on a regular basis, where there had been changes to a person's support needs, some care plans had not been amended to record the changes. The action plan provided to us following the inspection in May 2014 had identified how the provider was to ensure the home was following legal requirements to ensure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. We were told systems would be implemented to better monitor that care plans reflected current and accurate support needs of the people living in the home.

In the care plans we looked at we saw they were not updated when information changed at review. We saw some care plans had not been reviewed for up to two months. We looked at daily records and saw changes in one person's food supplement prescription. The nutrition assessment was reviewed and stated no change to plan. We looked at the medicines log and the new prescription had not been added. We looked at another care file and saw different care plans within it contradicted each other. One said the person had capacity, eats unsupported and participates in social activity and another said "constantly anxious and unable to engage with usual activity". When plans are not updated and show inconsistencies there is a risk of people not getting the care and support required to meet their needs.

The lack of action since the inspection in May 2014 and the continued contradictions and inconsistencies across care plans is a continued breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with the activity co-ordinator who told us they spent time with each new resident getting to know them and completing their life history. We saw activity events advertised on the notice boards and observed people flower arranging on the day of the inspection. People told us they liked the activities but there were not enough of them. The co-ordinator only had time to attend to two of the floors on each day.

We were told relative meetings had been held each week for some time, but we were unable to review any minutes as notes had not been kept. A meeting had been subsequently held the week of our inspection and minutes were available. We could see the issue of complaints had been raised and relatives were asking for clarification on timescales for dealing with complaints. We were told some people had been waiting over a month for a response to a complaint they had made. We saw a complaints procedure was displayed in the main reception area identifying the timescales complaints should be addressed within.

The people we spoke with told us if they had any concerns they would speak to their relatives or one of the nurses.

Inadequate

Is the service well-led?

Our findings

On the first day of the inspection we were shown around by the clinical services manager. They were knowledgeable about all the people living in the home, knew their names and what unit they were on. When walking around the building the atmosphere was calm and people were involved in chatting amongst themselves or with staff. One person who was visiting someone in the home said, "I think this is as good as it gets, whenever we have seen each other the manager has been more than helpful." All of the people living on the Dunham unit in the basement said they did not know who the manager was.

The home's registered manager had recently left. A temporary acting manager had been in post part time for approximately three weeks prior to the inspection. It was clear from talking to staff, relatives and people living in the home that this manager was more visible. Many of the actions from the action plan had only been implemented following the appointment of the acting manager. Unfortunately this did not give us the opportunity to observe how the changes impacted on the provision of care as systems and processes were still embedding.

Staff we spoke with were clear who their immediate line manager was and all said they felt supported. We were told the acting manager had an open door policy and was approachable. Every staff member was happy in their job and said management would always help out on the floor if they were short staffed and something happened which meant one or more people needed more support.

Since the last inspection an observational supervision tool had been introduced and used for approximately 30% of staff. This tool identified how the staff member interacted with the people living in the home. Where improvements had been required we saw how the clinical service manager discussed these with the staff member. As the supervisions had not been completed with everyone some of the key messages for improvements had not been communicated to the whole staff team. As the tool had not been utilised until November 2014 it was unclear on the impact the tool had on improvements to staff interactions with people who lived in the home. We were told by the acting manager that team meetings would begin to be undertaken more regularly and in line with organisational standards as soon as possible. These meetings could then be used to share messages more quickly across the whole staff team.

The action plan provided to us following our inspection in May 2014 had identified how the provider was to ensure the home was following legal requirements to effectively support people with their nutrition and hydration. We were told care plan audits would increase to 20% of the home's occupancy for a period of three months. We looked at a sample of the audits that had been undertaken. We saw an audit of one file had identified issues in July 2014. We saw this file was re-audited in November 2014. There was no reference made to the original audit and further issues were identified. We looked at three of the actions on the audit and they had not been completed at the time of the inspection.

The acting manager had managed a different home and was in the process of implementing organisational standards at Woodend. However we found systems were not being followed by all staff making it impossible for the manager to accurately record and monitor activity at the home.

Following on from our inspection in May 2014 we were provided with an action plan identifying the action the provider would take to meet the regulations. We found most of the actions had either yet to be implemented or had only been implemented within the last few weeks. We found that 20% of care plans had not been reviewed monthly. Where care plans had been reviewed information identified as inaccurate had not been rectified leaving a continued risk of people receiving inappropriate care. Processes and systems that had been set up recently were ineffective as the root cause of inaccurate records had not been addressed. The provider did not have effective systems in place to monitor and assess the suitability of provision within the home. This was a continued breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each month a quality metrics report was submitted to area office. This report included collated information about activity within the home including accidents and illness. The area team reflected on the data within the metrics report and supported the home manager if required. In

Inadequate

Is the service well-led?

addition the area manager and quality manager completed a monthly provider review. This review was an audit of the quality of provision at the home and included reflection on the monthly metrics.

We reviewed the last three month provider reviews and metrics reports. We reviewed some of the information sources that fed into the reports including accident and incident reports, Deprivation of Liberty Safeguards (DoLS), complaints and weight records. We also looked at what notifications should have been received by CQC following on from incidents including serious injury and safeguarding concerns. We did not find any correlation between these records and notifications received by the CQC. For example over the three months eight accidents resulting in injury were recorded on the metrics report. CQC had only received two injury notifications over this three month period. This meant that notifications were not being made by the provider as required by the commission This is a breach of regulation 18 Health and Social Care Act 2008 (Registration) Regulations

We reviewed the clinical review meeting minutes held on one of the units on 30 December 2014. The action plan following the inspection in May 2014 stated this meeting would be robust, minutes would be signed off by the area manager and monthly and weekly weights would be discussed and monitored. Information would be fed into monthly management information including the quality metrics report and the provider reviews and actions for improvement would be agreed. We looked at the monthly management information and found that records showed increases in weight loss with no additional action identified for a number of months. This was not clear within the clinical review meeting minutes. Inconsistencies in recording of important healthcare information left people at continued risk of not receiving appropriate support. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The suggestion box had recently been removed and the last resident/relative survey had not been collated or actioned. We discussed this with the regional manager and were told the provider had anticipated concerns would be picked up through other forums and audits. The survey completed in January 2014 showed a marked drop in satisfaction and no action had been taken to address the concerns raised. The action plan submitted to us following the inspection in May 2014 stated the questionnaire would be kept at the home and an action plan would be developed and shared with the relatives and residents as things progressed. We found this had not happened. The provider had not taken regard for the comments and views of people living in the home or their relatives. This was a continued breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home had recently been audited by both the infection control team and the local authority contracts team. We found the home had not acted on the advice given to make improvements to infection prevention and control or how accident and incidents were recorded, investigated and monitored. The provider was not currently using results of audits and investigations to drive improvements.

Actions identified by the provider to meet the identified breaches of the regulations during our inspection in May 2014 had not all been completed. Action plans requiring improvements following external audits had not been completed. The provider had not taken regard to the reports prepared by the commission identifying the registered person's compliance with the provision of the regulated activities provided at Woodend nursing and residential centre. This is a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate audit and resulting action to identify a suitable design and layout and adequate operation of the premises.**

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 **The Provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not involved with on-going assessment and review of their care and welfare needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **CQC were not sent notifications of other incidents in line with registration requirements.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People using the service were not safeguarded against the risk of abuse, because the registered person did not take reasonable steps to identify abuse before it occurred and failed to respond appropriately to safeguarding incidents.