Speciality Care (REIT Homes) Limited

Woodlands Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Woodlands Care Home took place on 5 and 7 December 2016 and was unannounced on both days. The previous inspection, which had taken place during September 2015 had found the home required improvements and there was a breach of regulation in relation to providing safe care and treatment.

This inspection found a continued breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and additional breaches, including Regulations 18 Staffing, 10 Dignity and respect and 17 Good governance were found.

There were 55 people living at Woodlands across four units during our inspection; 13 on Thornhill, 11 on Mirfield, 8 on Hopton and 23 on Calder. Each unit was self-contained with a communal lounge, dining area, bathroom and toilet facilities. Bedrooms were single rooms with en suite facilities. There was a central kitchen and laundry located on the ground floor and a hairdressing salon.

Admissions to Thornhill had been suspended by the local authority due to safeguarding concerns on this unit in relation to staffing, the role of one to one staff and the management of medicines. The registered manager was working with the local authority and clinical commissioning group to address these concerns.

The home had a registered manager in post at the time of our inspection. 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.

There was a safeguarding and whistleblowing policy in place and the registered manager and staff were able to outline the actions they would take if they had any concerns anyone was at risk of abuse or harm.

Risks to people were assessed. However, these sometimes lacked personal information and were not always up to date and therefore did not always reflect current risks.

People were not always provided with safe care and treatment. Some people were not assisted to move regularly and some people did not receive adequate assistance to meet their continence needs.

Regular checks were made to ensure the safety of the building and equipment.

Despite a dependency tool being used to help determine staff numbers, there were not always sufficient numbers of staff to meet people's needs. Safe recruitment of staff was evident.

Medicines were stored safely but were not always administered in a safe way. This included covert medicines being crushed without advice being sought regarding the safety of this and sufficient quantities of

prescribed medicines not being available.

Staff received induction and regular training. However, some staff had not received regular one to one supervision.

People were not always supported to have maximum choice and control of their lives and staff did not always support people in the least restrictive way possible. Some nursing and care staff were unaware of which people could legally be deprived of their liberty to receive care and treatment.

People's hydration needs were met and drinks were offered throughout the inspection. However, mealtimes on Calder were not well organised and we observed a person sat for a long period of time, awaiting their meal. Some people did not receive appropriate support to have their nutritional needs met.

People received additional support from health care professionals, in order to have their care and treatment needs met where this was appropriate.

Although some staff treated people with kindness and compassion, showing respect for their privacy and dignity, other staff did not. Some staff used derogatory terms and spoke over people to each other. Some staff failed to recognise when people's dignity was being compromised.

Care plans were updated regularly but people or their relatives were not always involved in this.

Activities took place and attempts had been made to make these person centred.

We saw people were offered choices throughout the day. However, during our inspection, everyone living in the home was served Halal meat and the registered manager confirmed people were not consulted or given a choice regarding this.

Some care records were inaccurate and incomplete and, in some cases, records were falsified. Audits were not robust and did not identify some areas for improvement. Regular staff meetings took place and staff felt informed. Staff felt the registered manager was effective.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some risk assessments had not been updated to reflect current needs and some were lacking in information.

Safe care and treatment was not always provided, particularly in relation to pressure area care.

Medicines were not always managed safely and effectively.

The numbers of staff deployed were not able to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they thought staff were effective.

The registered manager had applied for Deprivation of Liberty Safeguards authorisations, where appropriate, but staff were not always aware of the outcome of these.

Staff had received induction and training but not all staff had received regular one to one supervision.

Staff sometimes lacked knowledge and skills to de-escalate situations and provide appropriate support to people.

Is the service caring?

Inadequate

The service was not caring.

Although some people and relatives told us staff were caring, staff sometimes spoke with and about people in a disrespectful way and did not uphold people's right to make their own choices about the care they received.

We observed some staff provide care intervention without speaking with the person they were assisting.

Staff failed to recognise the significance of the impact of poor care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not involved in their care planning and reviewing of their care needs.

The activities coordinator was knowledgeable about people's interests and people participated in varied activities.

The complaints procedure was displayed and people told us they felt able to complain if the need arose.

Is the service well-led?

Inadequate

The service was not well led.

People told us they felt the service was well led but the observations of poor standards of care throughout the inspection showed there had been failures in the leadership of the home.

The provider had not sufficiently managed the development of the culture at the home so that person centred care was at the heart of all care delivery.

Contemporaneous records were not kept in relation to people's care and we found evidence of falsified records.

Some regular auditing took place but these were not sufficiently robust to identify areas for improvement that were highlighted during the inspection.

Woodlands 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 5 and 7 December 2016 and was unannounced. The first day of the inspection was carried out by four adult social care inspectors, an inspection manager 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 second day of the inspection was conducted by two adult social care inspectors.

Before the inspection we reviewed the information we held about the home, including reviewing statutory notifications and information received from the local authority and clinical commissioning group.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with eight people who lived at the home, four relatives of people who lived at the home, a visiting professional, a regional manager, the registered manager, a unit manager, a one to one member of staff, four nurses, eight care staff, an activities coordinator and a chef.

We looked at 14 people's care records, five staff files and training data, as well as records relating to the management of the service, such as maintenance and audit records. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Inadequate

Is the service safe?

Our findings

We asked seven people whether they felt safe living at Woodlands Care Home and they all confirmed they felt safe. One person told us, "I'm alright here. This is my home." Another person said, "Everything is hunky dory here." A relative we spoke with also told us they felt their family member was safe.

A relative of a person living on the Mirfield unit, however, said they did not feel completely assured and told us they felt there was not enough staff.

The registered manager and the staff we spoke with demonstrated an understanding of safeguarding and our records showed the registered manager had made appropriate referrals to the local authority safeguarding team and to the Care Quality Commission.

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. We saw the whistle blowing policy was displayed, which highlighted what staff could do and who they could contact if they felt the need to whistle blow. This helped to ensure any safeguarding concerns could be appropriately reported.

An inspector witnessed a member of staff assisting a person who was using a wheelchair. The member of staff caught the person's foot on the door frame. The person said it hurt. Two staff helped the person move from their wheelchair to their armchair. The manoeuvre was clumsy and the person said they did not like it. The inspector asked the member of staff to check the person's foot. The member of staff told the inspector the person had refused to let them look at it but they would check again later. We advised the registered manager to ensure this happened and that appropriate safeguarding referrals were made.

We found risks were assessed, using recognised tools in relation to choking, skin integrity and falling for example. However, we found risk assessments were generic and lacked personalised information. For example, a bedroom fire risk assessment form asked whether assistance was needed. The box, 'Yes,' was ticked but with no indication of what assistance the person may require.

We found 'long term care fall risk assessments' did not always contain up to date and sufficient information for staff so that people were moved safely. For example, one person was now being transferred by a hoist, when the assessment stated they were mobile and an assessment for another person lacked information about the type of sling to be used when staff transferred the person. This meant staff may not be aware of a person's needs or risk of falling and there was risk staff would use inappropriate equipment when assisting people to move.

We looked at whether safe care and treatment was provided for people living at Woodlands Care Home. There was inconsistency in the safe management and treatment of pressure sores. One person's wound had been managed well, but we found other people who were not provided assistance in accordance with their care plan, such as regular checks and positional changes, increasing the risk of skin breaking down. This had

been identified and highlighted within a root cause analysis which resulted in an action plan. However, lessons had not been learned in terms of providing safe care and treatment.

We observed on the Mirfield unit three people, who required the assistance of staff to move, sat in the same chairs in the same position throughout the first day of our inspection. Staff confirmed to us the people had not been assisted with continence needs for in excess of ten hours. A member of staff said, "We'll do tea and then get everyone sorted. When there's two of us needed it means there's no one else for others." This demonstrated people were not receiving safe care and treatment.

We looked at records relating to one person's positional changes and noted records indicated the person had been assisted to move at 12.59. However, the inspector had been in the room observing at this time and the positional change did not happen. The inspector examined records at 14.30 on the first day of the inspection, which indicated the person had been assisted to change their position at 14.49. Another person's record showed they had been assisted to move at 13.00 but the inspector had been observing and this also did not happen. This showed records did not reflect the actual care that was given. We highlighted this concern to the registered manager.

An application to deprive a person of their liberty indicated, '[Name] not free to leave unit unescorted and requires staff to escort [them] when attending smoke area due to previous incident of [name] accidentally setting fire to smoke room.' The application to deprive the person of their liberty had been approved. However, an inspector observed the person leave the unit unaccompanied. An inspector alerted a member of staff to this and the staff member said, "Oh, [they]'ll have gone for a cig," but did not follow the person. This meant the person posed a fire risk to themselves and others.

We spoke with a member of staff who was deployed through an agency to provide one to one care for a person. When we asked what the member of staff knew about the person for whom they were providing one to one care, they threw their arms in the air and said, "Erm, I just look at this file here to know anything." The member of staff also told us they had not been shown any emergency procedures for Woodlands Care Home.

Two inspectors asked two different members of staff on the Mirfield unit how many people were living on Mirfield. Neither member of staff was able to say how many people lived on the unit. This would make it difficult to provide effective and safe care, particularly in an emergency.

The above examples demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always provided in a safe way.

We looked at whether medicines were managed and administered safely. We found medicines were stored safely and securely and the stocks of medicines remaining reconciled with the records we inspected.

Concerns had been raised through safeguarding procedures that behaviour modifying medicines, that should be administered on a PRN (as required) basis, were administered inappropriately. We saw actions had been taken to address this and we saw distraction techniques were used. Positive behaviour charts were used to record people's behaviour that challenged. Records showed the level of aggression and use of a person's Lorazepam had decreased in recent months. This showed measures were in place to use behaviour modifying medicines only when appropriate to do so.

Some people took other PRN medicines for pain relief. We saw the nurse asked people whether they required their PRN medicines. Pain scales were used to assist staff to identify whether medicines were

required for people who could not verbalise their wishes. This helped staff to identify facial expressions to determine whether pain relief was required.

We observed medicines to be administered in a kind and patient manner and nurses followed good practice in relation to infection prevention and control. Medication Administration Records (MAR)s were signed once the person had taken their medicine.

We saw one person's (MAR) indicated, 'Out of stock,' and the person had gone four days without their nicotine patch. The nurse confirmed this.

For another person we found the person's medicines were crushed and given covertly, and the nurse confirmed this to us. We could find no evidence of consultation with a pharmacist or GP in relation to this decision. When we shared our concern with the registered manager, we were told there would be no evidence because the person should not be given covert medication because they will take their medication if staff give them time and are patient. We advised the registered manager this should be addressed with the nurse and the person's records needed to be updated.

The above demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not always managed properly and safely.

The registered manager showed us they used a tool to assist with determining the number of staff required. This was based on people's dependency scores. The registered manager said they felt there were sufficient numbers of staff. However, we found multiple instances where the numbers of staff deployed were unable to meet the needs of people living at Woodlands Care Home. For example, three people were not assisted with continence needs for at least ten hours.

One member of staff said, "The majority of the time we have enough staff to meet people's needs." But other staff comments included, "Not always able to get everyone up [by lunchtime]," and, "I'd prefer not to say," and, "Not enough staff," and, "Not [able to check on people in their rooms] as often as we'd like to, to be honest. We just try when we can."

A relative told us, "You never seem to see any staff about the place and there is only one nurse on Mirfield at night for all these people. Sometimes I come in here and see no one. I am here for a couple of hours and not sure if staff even know I have been here." Another relative told us they felt staff did not have time to talk to their family member. They were keen to point out they felt this was due to low staffing levels as opposed to staff being uncaring.

A nurse was shared between the Mirfield and Hopton units through the day. As the nurse was leaving the Mirfield unit to go to the Hopton unit, we asked what would happen if two carers were attending to a person's personal care. The nurse confirmed other people would be left unattended. Between 10.30 to 10.50 and 12.55 to 13.05 and 14.20 to 14.35 we observed there were no staff in the Mirfield lounge to assist people.

The Thornhill unit had two staff and a nurse, who was also covering another unit, at night time. On the second day of the inspection we arrived before the night shift ended. When we arrived, an ambulance and paramedics had been called to the home because a person had fallen and had a seizure. A member of staff told us they heard the, "Thud" of the fall from another unit so they, "Came running." The fall was unwitnessed. The member of staff told us they were supposed to be on Thornhill unit but had gone to the Mirfield unit to assist the member of staff on Mirfield to help people out of bed. This was because the Mirfield unit only had one member of staff at night time, as well as a nurse who also covered another unit. The

member of staff told us this was usual practice and they began assisting people out of bed on Thornhill at 05.00 so that between 06.00 and 07.00, a carer from Thornhill could go to Mirfield to help. We asked the member of staff whether people wanted to get up at 05.00 and were told, "No, that's sometimes why the aggression starts." A nurse said, "I think they start getting up at about 05.30. Some refuse and they stay in bed." Another member of staff confirmed they would leave Thornhill to assist getting people out of their beds on Mirfield. This meant during that period, the number of staff identified as required were not available on Thornhill unit. We raised this with the registered manager, who said they were not aware this was happening and, at the end of September they had completed a night shift on Thornhill and that was not the case at that time.

On the first day of our inspection, a person on Thornhill unit approached another person in the lounge whilst no staff were present in the lounge area. The person stood over the other person who was seated in their chair and made intimidating comments. The inspector went to alert a member of staff. Having found no staff available, the inspector went to the dining area which was along the corridor. There were no staff available to attend to the situation as they were assisting people with their meal. The inspector returned to the lounge and the person then held the other person's head in their hands, in a threatening manner. The inspector intervened to de-escalate the situation.

The examples above showed sufficient numbers of staff were not deployed to ensure people's care and treatment needs were met effectively. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether the premises were safe. We saw records of regular maintenance and safety checks such as water temperatures, fire system checks, nurse call systems and portable appliance testing. Lifting equipment was certified as safe. A recent fire drill had taken place, and the time to evacuate and any actions required were recorded. First aid boxes were checked and restocked monthly on each unit within the home. This helped to ensure the premises and equipment were safe.

Personal Emergency Evacuation Plans had been devised and each unit had a 'grab bag.' These bags contained foil blankets, a torch, high visibility vests and information relating to mobility needs, emergency contacts and details of assistance required. This helped to ensure people's safety in an emergency.

We saw accidents and incidents were logged and analysed. An analysis of falls in each unit was completed by the registered manager, which helped to identify trends. Key factors such as date, time, residents involved, location and actions taken were recorded.

We inspected five staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We saw examples and evidence to show actions were taken where staff conduct fell below that which was expected, such as formal disciplinary meetings.

Three domestic staff and a housekeeper were deployed across the home. On the days of the inspection, premises were free from odour, with the exception of the Calder unit. We noticed on both days of our inspection an offensive odour on this unit and we shared this with the registered manager. We observed carers wearing personal protective equipment (PPE) when it was appropriate to do so. Following our

inspection, the home was audited by the local authority in relation to infection prevention and control. Multiple areas were identified which required action, such as damage to walls, some floor coverings were not clean or in good state of repair, sharps devices such as needles and razors were not being managed safely, incontinence pads were disposed of in domestic waste and personal protective equipment, such as gloves, were not readily available in some communal areas of the home. This increased risks to people, staff and visitors in relation to infection prevention and control.

Requires Improvement

Is the service effective?

Our findings

We asked people whether they thought staff were effective. One person said, "Staff know what they are doing." Another said, "I have confidence in the staff." All the people we asked told us the food was good. One person added, "If I don't like what's on the menu, I can have something else." Another person said, "You can have tea, coffee and snacks whenever you want."

We looked at the training and support staff had received. We had received information from the local authority which stated a facilitator had tried to deliver supportive training sessions on behalf of the Council, however these had to be cancelled due to the non-attendance of staff. The registered manager told us a staff meeting had been held in order to address this with staff and the importance of attending had been impressed upon them.

The files we examined showed staff had completed training in areas such as safeguarding, fire safety, first aid, moving and handling and infection control. We also saw evidence some staff were working towards the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff received an induction which included shadowing more experienced members of staff and we saw evidence of this. A new member of staff we spoke with told us they had been shadowing shifts for, "A few days," and added, "I'm not counted in numbers." This new member of staff confirmed they had completed some moving and handling practical training and had completed some experiential training to obtain a better understanding of dementia or sensory loss.

We looked at the frequency of staff supervision. Records we reviewed showed inconsistency in the frequency of supervision. The registered manager told us they were aware not all staff had received regular supervision. They provided a matrix they had devised in order to plan supervision more effectively. This showed one to one staff supervisions were planned and had taken place during September, October and November. However, the matrix showed between January and July, only 13 members of staff had received one to one supervision, from a list of 47 staff.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We found decision specific mental capacity assessments had been completed for people where it was felt they may lack capacity to make decisions. However, where decisions were made in a person's best interests, we found there was a lack of evidence to show these decisions had been made in consultation with the person, their family or other relevant representatives. We shared our findings with the registered manager.

When we spoke with staff they were not aware of people who could be legally deprived of their liberty and whether any conditions were attached to the authorisation.

We found two 'Do not attempt cardio pulmonary resuscitation' (DNACPR) orders had been made without proper consultation with relevant people. We shared our concern with the registered manager.

We looked at whether people's nutritional and hydration needs were met. We saw staff offered drinks and snacks to people throughout the day. However, we found food and fluid charts were not fully completed so it was difficult to determine what people had had to eat and drink. Some people, who had been identified as requiring to be weighed weekly due to weight loss, had not been weighed weekly.

We observed some mealtime experiences. On the Thornhill unit we observed staff appropriately prompted people to eat if they had eaten only a little. We saw the member of staff on Hopton unit was very busy, particularly during the mealtime period. There was, however, a pleasant atmosphere on the unit and the staff member ensured everyone who required support was given support. People who requested alcohol were provided with this after lunch. The atmosphere was relaxed.

There was a lack of staff interaction on the Calder unit and the mealtime period was disorganised. We saw a person was pulling the table cloth which meant tea spilled out of their cup. The person then threw the table cloth over the cup of tea and the first cup of tea was removed. The person was given a second cup and pushed that one out of the way. They were then given juice and threw the table cloth over the juice. The person then threw two forks. This caused disruption to the meal time experience for the person and other people and there was a lack of staff knowledge and intervention in order to de-escalate the situation so people could eat their meals. We shared our concerns with the registered manager.

We considered the layout and design of the home. Corridors appeared clean and had name plaques and photographs on doors, which helped people to navigate to their rooms. Old photographs of the local area were on the corridor walls and photographs of different famous people and occupations from different eras were displayed. Some walls contained poems or arts and crafts work completed by people living at Woodlands Care Home. We did note, however, it was noticeable this was less evident on the Thornhill unit.

We found evidence of referrals to other healthcare professionals such as GPs, district nurses, tissue viability nurses and physiotherapists. This showed people living at the home received additional support when required to meet their care and treatment needs.

Inadequate

Is the service caring?

Our findings

People told us staff were caring. One person told us, "Staff are friendly." Another person said, "I like it here because it's easy to talk to people" and another said, "I get on well with staff and it's a homely, happy place."

We asked whether staff respected people's privacy. A person told us, "They respect my privacy if I want to be on my own, they understand that." A person living on Hopton told us, "I like the atmosphere of the place. We all get on well together."

One person told us they shout sometimes because of their mental illness. They told us staff had helped them to stop shouting so much now.

All the relatives we asked told us they felt staff were caring. One relative said, "Staff respect my relative's independence, are caring and treat them with dignity."

A further relative told us, although they felt staff were caring, their family member was often unshaven when they visited. We asked a member of staff on the Mirfield unit why none of the gentlemen had had a shave. The member of staff told us they had noticed that on the day of the inspection too. However, we pointed out that some gentlemen clearly had more than one day's growth. The member of staff said, "I know."

We observed some staff engaged with people by ensuring they were at the same eye level as the person and one member of staff sat on the floor to speak with one person. This demonstrated an understanding of how to engage appropriately with people.

One member of staff was assisting a person to eat and we heard the member of staff explain the food options to the person before every mouthful. This member of staff engaged very well with the person and provided the care and support required in a sensitive manner.

However, we also heard and saw some staff interacting in a way that did not promote a caring environment. For example, a member of staff was heard saying, "It always seems to be at tea time. They all kick off." An inspector also witnessed a person pull off a tablecloth and cutlery from a table and a member of staff said, "Give up." The person continued and the member of staff tutted. Another member of staff was heard saying, "That's [Name] in the corner. They sometimes kick off if they don't get their own way."

We saw some staff provide care and treatment in a respectful manner, kindly asking people if they required assistance. However, we also saw instances of staff moving people without speaking with them.

We observed two members of staff assisting a person to move, by using a hoist. The manoeuvre was clumsy. Staff were heard saying, "Just put that under there [meaning the straps of the sling, under the person's legs]. The staff members were talking to each other, over the person, without attempting to include the person in the conversation."

On the Mirfield unit, a person had their eyes closed and appeared to be sleeping in their chair. We heard a member of staff say the person's name loudly twice. Before the person could reply the staff member had begun to take off the person's apron. The person appeared confused and said, "Are you going to have one? Are you having one?" The staff member walked away whilst the person was talking to her and made no attempt to engage with the person or explain what they were doing.

On the first day of the inspection a person on the Mirfield unit repeatedly asked staff if they had seen their glasses. We heard a member of staff say, "I haven't seen them." However, there was no offer to assist the person further. This person was also not wearing their glasses on the second day of inspection. We asked a member of staff about this, and they said, "I know she has some but I'm not sure where they are. I'll look into it." This showed a lack of understanding from staff of the need for people to have access to their communication or sensory aids.

Staff looked visibly stressed. When a person was shouting, requesting support and staff were attending to other people a member of staff was seen holding their hands to their head.

We saw some staff lacked awareness of how to support a person to eat their meal. The person was sat at the table waiting for their meal for 25 minutes, despite everyone else being served their food. The person appeared to be emulating eating food from the tablecloth with their spoon. The person was then moved to a different seat because of some spillages caused by another person. The member of staff then attempted to assist the person to eat some pasta from a fork, unsuccessfully. We suggested the member of staff gave the person a spoon and they could eat their own meal. The member of staff gave the person a spoon but did not place it in the person's hand to enable them to eat their meal. We intervened and gave the person the spoon. The person then began to eat their meal independently. Staff could then be heard saying, "Oh, she's feeding herself." This showed staff lacked knowledge of how to support the person and, as a result, they were at risk of taking away the person's independence.

A member of staff startled a person when they approached them about dinner, because the person was sleeping. The member of staff did apologise. Food was brought into the lounge for the person but this then went cold as the person fell asleep again. Staff did not return to check whether the person had eaten, until a member of the inspection team approached staff. Staff then brought the person a fresh bowl which they then ate.

A member of staff told us they began assisting people out of bed on the Thornhill unit at 05.00 so that, between 06.00 and 07.00, a member of staff from the Thornhill unit could go to Mirfield to help. We asked the member of staff whether people wanted to get up at 05.00 and were told, "No, that's sometimes why the aggression starts." This approach showed a lack of respect for people and their right to make decisions about their care.

We saw some people appeared unkempt. Some gentlemen had not had a shave and we observed some people had greasy hair. We saw a person had long dirty fingernails and a person was sat wearing a jumper that was too small and had, 'Ridden up.' Another person had holes in their slippers and they were wearing stained trousers. There were times when staff failed to attempt to protect people's dignity, for example, a person whose jumper had slipped down from their shoulder. An inspector pointed this out to a member of staff who then assisted the person to readjust their clothing.

The above examples show people were not always treated with dignity and respect and people's independence was not always supported. This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other occasions when we observed staff acted quickly and appropriately to protect people's dignity. For example, a person began to undress in a communal area and a member of staff quickly assisted the person and protected their dignity.

A staff member told us they tried to protect people's privacy and dignity by, "Covering private areas with a towel, asking permission, check they are happy with what we're doing."

We saw examples of people's cultural needs being met. For example, we saw a person's care plan indicated they would wish to wear certain items in keeping with their culture. The staff we asked could tell us about this. They were aware of this need and assured us the person always wore these items.

The registered manager told us end of life care was not routinely discussed with people. We highlighted the importance of this to the registered manager because, only by discussing these needs can end of life care be appropriately provided.

Requires Improvement

Is the service responsive?

Our findings

Three people we spoke with told us they were aware they had a care plan. One person told us, "Staff talk to me to see how I am getting on." A relative told us, "Staff know [Name]'s likes and dislikes."

We sampled 14 care records. As well as key information, such as care and treatment needs, we found information relating to people's background, life history, family, likes and dislikes. Care records included a dependency assessment which considered needs relating to consent and capacity, drug therapies, mobility and continence, nutrition, personal hygiene, skin integrity and psychological needs for example. These were updated monthly. Tools were used in order to develop an overall level of need, according to each dependency score, and this information was then used to help determine staffing numbers.

We saw some care plans contained useful information such as, 'When I am happy I will talk about my daughter. When I am anxious if you sing with me it aids me staying calm and happy. When I am unhappy I may attempt to strike you. A change of face is often effective.' Containing information such as this helps staff to provide effective, responsive care to people.

The information contained in some care plans was vague. For example, one person's plan indicated, 'Staff to support,' in relation to personal hygiene. The plan did not specify the level of support that would be required or how staff should appropriately support the person.

The registered manager told us care plans were reviewed monthly or more frequently if required. We asked the registered manager whether they involved people in reviews of their care. The registered manager told us, "Not as much as we should do."

The registered provider employed three activities coordinators. A minibus and driver were also available. Some people attended the local pub regularly. We saw provision had been provided for a person based on their background and previous past-times and the person was supported to play a sport of their choice in the local community. This showed activities provision was responsive to the person's needs.

People were assessed using a recognised tool for assessing activities of daily living and leisure activity. Activities were planned and arranged using the tool. People living at Woodlands Care Home told us about activities they were involved in such as going to the local pub. One person told us, "I like music, they play my CDs and I can sing." We saw some external activities had been sourced such as a bird of prey presentation and music entertainer. A person on the Mirfield unit told us they enjoyed the dancing.

A family member we spoke with told us they could visit the home whenever they wished. This showed people were able to maintain contact with those important to them and helped to reduce social isolation.

We observed people being given choices throughout the days of the inspection, such as food and drink. However, we did observe on the Calder unit that everyone was given orange juice with their tea time meal with no other choice being offered.

One person, who did not wish to eat their meal with other people or eat the same meals as other people, ordered their own food at the kitchen in order to make their own sandwich every day. They were very pleased to be able to do this. This enabled the person to retain choice and a level of control and independence.

We spoke with the head chef who told us all the meat served was Halal. We asked the registered manager whether people had been consulted about this and the registered manager confirmed this was not the case. This meant people were not being given a choice about the type of food they were eating. Following the inspection, the regional manager confirmed to us the policy of the catering provider was to provide Halal meat upon request and, if Halal meat was being served, this must be stated on the menu. The regional manager assured us they had addressed this and shared the learning across the provider group to ensure people were given choice about the type of food they ate.

The complaints procedure was displayed in the home. A person we asked said, "I'd go to the office and tell them straight and they would listen to me if I had a complaint." Another person said, "Yes, I know how to complain. I would go and see the manager." The registered manager showed us there was a system in place for managing and responding to complaints.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered to manage the home since October 2016. Prior to this the registered manager had worked as deputy manager at the home.

We asked people whether they felt the home was well led. A person told us they felt the home was well managed because, "It's clean and tidy, staff respect your privacy, staff are good and I get on well with them." Another person told us the home was well managed because, "It's home from home." People we spoke with knew the registered manager and one person said, "She is always popping in."

A family member we spoke with told us, "I would recommend this place because of the support and care my relative receives." However, another relative told us they felt the home was not well managed because of the amount of agency staff used. This relative also said, "I phoned to speak to the manager in the summer and was told the manager was on holiday and there didn't seem to be anyone else to talk to, which concerned me."

A staff member told us they felt able to talk to the registered manager. They said, "I'm not frightened to have discussions." Another member of staff told us the registered manager was very involved and said, "She tracks care plans, communicates information and cascades down." A further staff member said, "I think it's improving. Things are on the up. [Registered manager] was a nurse before on Calder. I think she is fantastic. She is good, approachable. You can talk to her but if there are any issues she will deal with it. She is very knowledgeable about service users. I am looking forward to being a part of improving the home."

A nurse told us, "If any staff have a concern, I encourage them to tell me. It's about being open, honest and transparent." However, we did not find an honest and transparent culture within the home. We found evidence some records were falsified. We found a record of assisting a person to move had been written in advance and we found records of care being provided, such as repositioning people, that were not provided. Records showed people had been hoisted, when the inspector had been observing for that period of time and a hoist was not brought into the room. When we raised this with the registered manager, we were told the member of staff had, "Panicked because they thought CQC would expect to see something written down."

We found multiple examples of inaccurate or incomplete records in relation to people's care and treatment, such as gaps in information in food and fluid charts and records of people's weight.

Effective systems to assess, monitor and improve the quality and safety of service were not in place. The registered manager told us all nurses did a 'round' on each unit and this was recorded to look at skin integrity, paperwork and whether people were happy. The registered manager told us they looked at this information and any concerns would be addressed and shared with head office. We examined the shift reports which stated, 'This report must be completed by the nurse in charge of each shift, in each unit.' These reports contained information relating to the number of residents, any hospital admissions, discharges, deaths, medication supplies, GP visits and people whose condition had changed or

deteriorated. We found these reports were filed away in a disorganised manner. Once we had arranged the documents in order, we found in excess of 14 days of reports on each unit, for the month of November 2016, were missing. This showed the system in place was not effective in assessing and identifying any information that required action or improvement.

Other audits and safety checks were completed, for example in relation to hoists, slings, mattresses and bed rails. The record showed for two people there was no check of the condition of their mattress for five and eleven months respectively in the year 2016, because 'the person had been in bed' This meant, despite checks and audits taking place, they were not effective in identifying areas for improvement. We also found medication audits took place regularly but they had not identified a person had run out of medication.

There was an overall lack of ensuring that quality standards were met and the leadership of the home did not embed a positive culture that was open and person-centred. This resulted in unsafe care and treatment being provided and people being disempowered. Although a dependency tool was used to help determine staffing numbers, the registered manager had not identified that the number of staff deployed were not able to meet people's needs safely and people's dignity was being compromised.

The above examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems were not in place to assess, monitor and improve the quality of service and contemporaneous records were not kept, including records of the care and treatment provided.

We saw the registered manager completed a, 'Daily Walkabout' within the home. They completed observations and sampled care records. We looked at some records and these recorded information such as whether the home was clean, whether people appeared well care for, whether staff were engaging positively with people and the atmosphere of the home were considered.

Staff meetings took place such as head of department meetings, nurse meetings and care staff meetings. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

The registered manager said they felt very supported by the regional manager and registered provider. The registered manager attended regular home manager meetings and these offered peer support. Further support was available to the registered manager through the registered provider's quality team.

The registered manager and a regional manager told us they wanted to empower the nurses to lead. The registered manager felt nurses had, "Lost their autonomy along the way." This was being discussed at team meetings.

The registered provider was introducing a programme for improving dementia care, called the Dementia Care Framework. The aim of this was to provide staff with the skills and resources to provide effective dementia care. We sampled an information pack for the framework and information such as rights and charters, the dementia experience, communications, activities and engagement, distress reactions, environment and inspiring leadership was included. The registered manager told us, although this was early stages, the vision was to equip all staff with information to provide effective dementia care.

The previous inspection ratings were displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

The registered manager had identified with the senior management of the service that one of the units at Woodlands Care Home could potentially meet people's needs more effectively and improved care could be provided if the unit was split into two. Plans were in place to further these conversations and we were informed a consultation would be a part of this process.

The registered manager told us relatives and visiting professionals could leave feedback on an electronic device in reception. There was a sign displayed above the device which stated, 'Don't forget to leave your feedback.' However, upon arrival for our inspection, the device was unplugged and not working. We highlighted this to the registered manager who told us they would address this. However, we found the same on the second day of our inspection. The registered manager told us this was because a member of night staff had unplugged the device overnight, to use the socket but they would raise this with the member of staff concerned.

A regional manager we spoke with told us they felt the registered manager was an effective manager and they felt the approach was driving improvement in person centred care. We were told, "[Registered manager] is really committed to the needs of residents and embedding person centred care around the dementia care framework implementation."