HC-One Limited

Wymeswold Court

Inspection report

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Date of inspection visit: 9, 10 and 14 December 2015
Date of publication: 15/02/2016

Ratings

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

Overall summary

This inspection took place on the 9, 10 and 14 December 2015 and was unannounced.

At our last inspection carried out on 5, 6 and 9 February 2015 the provider was not meeting the requirements of the law in relation to the care and welfare of people who use services, the management of medicines and assessing and monitoring the quality of service provision. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make.

During this inspection we looked to see if these improvements had been made. We found that whilst some improvements had been made, some issues of concern remained.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during this inspection. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

Wymeswold Court provides accommodation for up to 40 people who require personal care. There were 20 people using the service at the time of our inspection including people living with dementia.

The person managing the service was an acting manager. They were in the process of applying to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us they felt safe living at Wymeswold Court and their relatives agreed with them.

Although the staff team knew their responsibilities for keeping people safe from harm, safeguarding incidents had not always been passed to the acting manager for their attention or action.

People had not always received their medicines as prescribed by their doctor.

People's needs were assessed prior to them moving into the service and plans of care were developed from this.

People had been involved in making day to day decisions about their care and support. However, where people lacked capacity to make decisions, there was little evidence to demonstrate that decisions had been made for them in their best interest or in consultation with others.

People felt there were currently enough members of staff on duty to meet their care and support needs. There were 20 people using the service at the time of our visit.

The majority of risks associated with people's care and support had been assessed and actions had been taken to minimise such risks.

Whilst there were times when we observed people being treated in a kind and caring manner, there were other times when they were not.

Checks had been carried out when new members of staff had been employed. This was to check that they were suitable to work at the service. The staff team had received training relevant to their role within the service and ongoing support had been provided.

Staff meetings and meetings for the people using the service and their relatives were being held. This provided people with the opportunity to be involved in how the service was run.

The staff team felt supported by the acting manager and felt able to speak with them if they had a concern of any kind.

People's nutritional and dietary requirements were assessed and a balanced diet was provided, with a choice of meal at each mealtime. Monitoring charts used to monitor people's food and fluid intake were not always completed consistently. Whilst the majority of people had a good experience at meal times, We found that one person did not.

There were systems in place to monitor the service being provided, though these had not always been effective in identifying shortfalls, particularly within people's care records.

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?
The service was not consistently safe.

People did not always receive their medicines as prescribed.

The staff team were aware of their responsibilities for keeping people safe but hadn't always followed the services safeguarding procedures.

Appropriate checks had been carried out when new members of staff had been employed.

Requires improvement

Is the service effective?
The service was not consistently effective.

People's plans of care did not always show that decisions had been made for them in their best interest or in consultation with others. Staff members understood the principles of the Mental Capacity Act 2005.

A balanced and varied diet was provided but records relating to nutrition and hydration were not always completed properly.

People were supported to access healthcare services.

Requires improvement

Is the service caring?
The service was not consistently caring.

People told us the staff team were kind, caring and considerate though this wasn't always evident.

People's privacy was respected but their care and support needs were not always met in a caring way.

People had been involved in making day to day decisions about their care and support.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People's needs had been assessed before they had moved into Wymeswold Court.

People had plans of care in place but these were not always up to date or accurate.

People were supported to maintain relationships with those important to them.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Requires improvement

Summary of findings

Auditing systems were in place to monitor the quality of the service being provided however these did not always pick up shortfalls within people's records.

People were given the opportunity to have a say on how the service was run.

The staff team felt supported by the acting manager.

Wymeswold Court

Detailed findings

Background to this inspection

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

This inspection took place on 9, 10 and 14 of December 2015 and was unannounced.

The inspection team consisted of four inspectors, including a pharmacist 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. Our expert by experience had expertise in understanding services for people with dementia.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information within in the PIR along with information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law. We also contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service.

At the time of our inspection there were 20 people using the service. We were able to speak with eight people living at Wymeswold Court, four relatives, eleven members of the staff team, the acting manager and the area operations director.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. This included five people's plans of care and associated documents including risk assessments. We also looked at four staff files including their recruitment and training records and the quality assurance audits that the management team completed.

Requires improvement

Is the service safe?

Our findings

At our last inspection we found that the registered person had not protected people against the risk of receiving unsafe care and treatment. This was because people's medicines had not always been available when they needed them and members of the staff team had not always handled people's medicines in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider sent us an action plan detailing the changes they would make.

At this inspection we looked to see if improvements had been made. We found that whilst some improvements had been made, areas of concern were still identified.

We looked in detail at the medicine administration records (MAR) and plans of care for five people. These showed that people were not always getting their medicines as prescribed. A monthly medication audit had taken place and daily audits of randomly checking five medicines administered were being carried out. However, we saw large stocks of medicines for disposal and some medicines administered would have run out before the end of the month. The daily audits of randomly checking five medicines had failed to spot that there was no stock of an antidepressant medicine for one of the people using the service and this was not administered for six days. Although this would not have had a serious impact on this person, it demonstrated that the process of ordering and checking to ensure that all the current medicines for each person were received was lacking and needed attention. The relief manager assured us that she would be proactive to ensure robust, daily auditing of complete MAR and check the competency of staff with regards to the ordering process to prevent further problems arising.

We found medicines were stored securely in a medicines cabinet and in the drug trolley which was consistently kept safe during the medicines rounds.

We found that agency staff were correctly following appropriate procedures. They consistently checked the balance of each medicine administered and correctly signed the MAR afterwards. We saw from the MAR however, that some members of the permanent staff team had not always followed the medicines policy or recorded the daily balance of medicines as per policy. Some topical medicines 'creams' in the MAR had not always been signed for by the permanent staff.

The staff team administered medicines consistently and in a kindly manner. We did however observe one member of the staff team apply a person's cream in the breakfast room where other people were having breakfast. They agreed that this should have been applied privately.

The provider should ensure that a process for administering medicines to the right people with same or similar names is included in the service's medicines policy and clearly highlighted on the MAR to avoid any administration errors. See National guidelines issued by NICE (Managing medicines in care homes published in March 2014).

We found only trained senior care staff administered medicines. However there was a lack of ongoing supervision and competency assessments. We identified that agency staff lacked induction training and orientation to ensure they remained competent in the administration of medicines. Both the senior care staff on duty and the agency staff said they had not read the medicines policy. We also noted that there was no current list of permanent or agency staff signatures to identify which staff had signed the MAR.

Our previous inspection found that people's care and treatment had not always been planned and delivered in a way that was intended to ensure people's safety and welfare. We had witnessed three unsafe moving and handling practices, unexplained bruising, a safeguarding incident that had not been investigated and call bells that were inappropriately placed. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we looked to see if improvements had been made. We found that whilst some improvements had been made, areas of concern were still identified.

The staff team were aware of their responsibilities for keeping people safe. They explained the procedure to follow if a safeguarding concern was identified. This included informing the acting manager. However, when we looked at one person's care records, we found that this process had not been followed in practice. An incident that had recently occurred had not been reported to the acting

Is the service safe?

manager for their attention and action to keep this person safe. The acting manager immediately referred the incident to the local safeguarding team for their attention and assured us that the reason for this not being reported would be investigated.

The majority of risks associated with people's care and support had been assessed. This enabled the acting manager to identify and assess any risks associated with people's care and support. Risk assessments had been completed on areas such as moving and handling, nutrition and skin care and these had been reviewed on a monthly basis. We did note in one person's records however, that they could become anxious and agitated in certain situations and was known to lash out at staff. There was no risk assessment in place for this situation. This could potentially put other people at risk.

One of the people using the service displayed behaviour that challenged others. The acting manager had been working with the local safeguarding team to safeguard both the person in question and the other people using the service. When we looked at this person's plan of care, we noted that a behavioural plan had been developed however; information on possible triggers or actions to take to diffuse the behaviours was not included within it. This information would provide the staff team with the tools they needed to support this person more effectively.

We observed the staff team assisting people to move around the service. Whilst the majority of the moving and handling practices were good and appropriate, we did note one occasion where the moving and handling technique was inappropriate. We informed the acting manager of this and they assured us that this would be addressed with the staff members in question.

We visited one person who was staying in their room. We noted that they had no access to their call bell. When we asked them how they would get the staff teams attention they told us, "I should shout and holler, but they are always popping in." We also noted that their bed table was out of reach and so the person was unable to access their television remote. This was rectified straight away.

People who were able to talk with us told us that they felt safe living at Wymeswold Court. One person told us, "Oh yes I feel perfectly all right, yes very safe, they are very good to me."

People who were able to speak with us told us that, on the whole, they felt there were enough staff members on duty to meet their care and support needs, though a lot of agency staff were used. One told us, "There has always been enough staff, I'm up in the night and if you need any help they would be there and would explain anything to you." Another person explained, "I don't' think there is, I think they could do with a few more, there's never anyone around when you want them."

A third told us, "No They don't seem to have enough staff, it's all right when the agency staff are here, but there short of [permanent] staff."

We looked at the staff rota and found that appropriate numbers of staff were on duty both day and night to meet the current care and support needs of the 20 people using the service. The staff members we spoke with agreed. One told us, "I feel there are enough staff on at present, but often these are agency staff." We did note that there was a large number of agency workers working at the service. The acting manager explained that there had been major difficulties in recruiting locally and were currently looking at ways to combat this. One way included the use of the provider's mini bus to escort new staff members to and from work.

We looked at the recruitment files belonging to four members of the staff team to see that appropriate checks had been carried out before they had started working at the service. Back ground checks including obtaining suitable references and a check with the Disclosure and Barring Scheme (DBS) had been carried out. A DBS check provides information as to whether someone is suitable to work at this service. We did note that specific information included in one person's file had not been followed up. The acting manager acknowledged this and this was rectified by the end of our inspection.

At our last inspection we identified areas of the service which were unclean and unhygienic. We accompanied the acting manager on her daily walk around the service on the second day of our visit and found that improvements had been made. However, we did note a strong smell of urine present in the communal lounge on the first floor and in a number of people's bedrooms. The acting manager acknowledged this and explained that they had arranged for a deep clean company to attend to this issue.

Requires improvement

Is the service safe?

Regular safety checks had been carried out on the equipment used for people's care and on the environment. These included checks on the emergency lighting the fire detection system and the hot water temperatures. Fire evacuation training had been provided to the staff team and regular practices had been carried out.

At the time of our inspection a major refurbishment was taking place at the service. This included the installation of a new sensory bathroom on the first floor and re-decoration throughout.

Requires improvement

Is the service effective?

Our findings

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. At the time of our visit 12 DoLS had been submitted and two had been authorised. The provider was complying with the conditions applied to the authorisations.

Staff members had received training on the MCA and those we spoke with understood its principles.

We looked at five people's records to check that decisions about their care and support had been made in their best interest and in consultation with others. Although we were told that decisions had been made in people's best interest, documentation was not always available to demonstrate this.

People who were able to talk with us told us that they thought the staff team knew their care and support needs and they looked after them well. Visiting relatives agreed. One person told us, "Yes I feel they meet my needs, I'd tell you if they didn't." A relative explained, "The staff look after individuals and that is more important than filling in paper work."

Permanent staff members told us they had received a period of induction when they first started working at the service and training relevant to their role had been provided. However when we spoke with two agency workers, they confirmed that they had received no induction into the service. They had not been shown what to do in the event of a fire, or informed of people's care and support needs. We shared this with the assistant operations director who arranged for an induction to be carried out.

The staff team had been provided with training in dementia awareness but not behaviour that challenged. During our inspection we observed members of the staff team not always handling situations between the people using the service in an effective way. On one occasion, a verbal altercation broke out between two people in the upstairs lounge. Another person was clearly upset by the raised voices and use of language. A staff member was seated between them completing notes. The staff member seemed to struggle to know what to do and told each person to, 'ignore the other' or 'be quite' at one point she told one person to "shut up" as she was goading the other. On another occasion the same staff member mimed them to be quiet. This was neither effective nor respectful.

We observed the staff team supporting the people using the service. Whilst permanent staff members were knowledgeable of people's care needs, agency workers were not so. This included one agency worker informing us that they were unaware of a person's specific needs with regard to their behaviour which challenged. We did however observe the staff team communicating with people so that they were supported in the way they preferred.

The staff team felt supported by the acting manager. Team meetings had been held and supervision sessions had been reintroduced. Supervision provides the staff team with the opportunity to meet with the acting manager to discuss their progress within the staff team. One staff member told us, "[Acting manager] is very good, she is supportive and is always there for us."

We asked people what they thought about the meals served at Wymeswold Court. One person told us, "The food is really nice, I can't fault them. One thing I really like that we have are macaroons, we have lovely meals from breakfast time to supper time."

At mealtimes people were supported to sit at the dining tables in one of the dining rooms. Tables were laid with placemats, napkins and condiments. On the first day of our visit one of the people using the service was seen enjoying

Requires improvement

Is the service effective?

a brunch of sausage, bacon and tomato. They told us that it was very tasty. During the lunchtime meal we observed good interactions between the staff team and the people using the service. Staff members offered lots of gentle support and people's requests for help were largely acknowledged. We observed one member of staff offering 1-2-1 assistance in a gentle and encouraging manner enabling the person to eat their meal. We did note that the dining experience for one person was not so enjoyable. They were rather anxious and wanted to return to their room. It took almost half an hour for their request to be actioned.

We saw that the cook had access to information about people's dietary needs. They were knowledgeable about the requirements for people who required soft or pureed food and for people who had food allergies. There was a four week menu in place which provided a variety of foods and choices.

For people who had been assessed to be at risk of dehydration or malnutrition, monitoring charts were used to document their food and fluid intake. When we looked at the fluid charts for two people we noted that whilst one included the recommended fluid intake amount for the staff team to follow, the other did not. This meant staff could not be sure that they had given the person the correct amount of fluids they needed to keep them well. One of the records also showed that on the 7 December the person had not been given any fluids after 5.00pm. When we looked at this person's food intake chart it showed that whilst they had been provided with sufficient to eat on the 7 December, on the 8 December they had been offered nothing to eat after 2.30pm. We discussed this with the acting manager who was sure that these incidents were more to do with poor recording than with people not receiving the foods and fluids they needed.

The people using the service had access to the relevant health professionals such as doctors, chiropodists and community nurses. This was evidenced in people's records. We also noted that when a person had been identified as having difficulties with swallowing, the local speech and language team had been contacted for their help and advice.

Requires improvement

Is the service caring?

Our findings

People who were able to speak with us told us the staff team who looked after them were kind and caring. One person told us, "The staff are very kind and very good." Another explained, "The staff are all right, they are very friendly, all you have to do is ask them and they'll do anything , nothing is too much trouble, they'll always help you out."

Relatives we spoke with felt that the staff cared for their relation in an appropriate manner. They told us, "The staff are kind and considerate."

Whilst we saw some caring interactions during our visit we also saw interactions which were not.

We observed one member of staff assisting a person with a cup of tea. The staff member sat with the person for 15 minutes encouraging them to drink at a pace that suited them. They spoke throughout and the person was supported to drink all of their tea. However we observed another member of staff giving drinks to people who were asleep. These people were not supported with their drink and they were left to go cold.

On one occasion we observed a member of staff taking the time to sit with people in one of the lounges. They were having a general chit chat and the staff member and the people using the service were seen laughing and joking together. However on another occasion we saw a member of staff pulling a ladies skirt down over her knees because it had ridden up. There was no interaction and once done, the staff member simply walked away. Another staff member was seen lifting a person's wheelchair footplates and then moving the person's feet to the floor. The staff member neither asked the person if it was alright for them to do this or talked with them in any way.

We observed some members of staff getting down to people's eye level and engaging in conversation which people clearly appreciated. However other times we saw the members of staff merely standing over people to check that they were alright and not engaging at all.

These incidents revealed to us that whilst some members of the staff team showed a caring attitude toward the people they were supporting, others did not.

Members of the staff team gave us examples of how they promoted people's privacy and dignity. One staff member told us, "I always close the door when people are in their own room. If I'm helping with personal care, I always make sure I cover their top half when I'm helping with their bottom half and vice versa." Another told us, "When asking if someone wants to use the bathroom, I speak quietly and try to be discreet."

Whenever possible, people had been involved in making day to day decisions about their care and support. The members of staff we spoke with during our visit gave us examples of how they obtained people's consent to their care on a daily basis. One staff member told us, "I always ask first to see that they are happy for me to help them."

People we spoke with confirmed to us that they were offered choices on a daily basis. One person told us, "Well yes most of the staff involve us in decision making but there's the odd ones [members of staff] who do not communicate properly." Another told us, "They always offer the choice of whether to get up or not and what to have at meal times."

The acting manager told us that advocacy services were available for people who were unable to make decisions or choices about their care and support. Details of advocacy services were displayed in the reception area and the acting manager told us they would support people to access these when required.

We looked at five people's plans of care to see if they included details about their personal history. We also looked to see if they included their personal preferences and their likes or dislikes. We saw that some were more comprehensive than others with regards to personal preferences. More person centred care could be offered if the staff team were aware of this type of information.

Requires improvement

Is the service responsive?

Our findings

At our last inspection we found that people's care and treatment had not been planned and delivered in a way that was intended to ensure people's safety and welfare. There was insufficient guidance for the staff team to follow when people displayed challenging or inappropriate behaviour, plans of care were not always followed and the people using the service did not always receive the care and support they required. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider sent us an action plan detailing the changes they would make.

At this inspection we looked to see if improvements had been made. We found that whilst some improvements had been made, areas of concern were still identified.

There had been no new admissions to the service since the acting manager had arrived, however they explained what they would do with regard to new people moving into the service. They explained that a comprehensive assessment would be completed to ensure that the staff team could meet each person's individual needs. From the initial assessment a plan of care would be developed.

We looked at five people's plans of care to determine whether they accurately reflected the care and support the people were receiving. We found that whilst some did, others did not.

For a person who had behaviour that challenged, their plan of care stated that they should receive hourly observations during the day and two hourly observations during the night. We found that they were having hourly observations both during the day and the night however; on the first day of our visit we saw that they had not received hourly observations between the hours of 7am and 11am. This meant people could have been put at risk. Their plan of care also required the staff team to explain to this person not to rub their eyes because they became red and sore. We observed this person doing this throughout our inspection with no intervention from the staff team. There were no details of how the staff team should support this person to reduce their anxieties or on how to protect others. Their daily records showed us that they were supported to use continence aids however, there was no mention of this within their plan of care. The acting manager stated there was an interim care plan in place but this was not included in the person's file.

One person's nutritional care plan stated that they required thickened fluids, needed support for all meals and drinks, used a spouted beaker, had their meals puréed and benefited from sitting in a wheelchair at mealtimes. This reflected the assessment carried out by the speech and language therapy team and was followed on the day of our inspection.

Another person's plan of care stated that the person required a pressure cushion and mattress to reduce the risk of pressure sores developing. When we checked, both of these pieces of equipment were in place.

The plans of care had been reviewed every month by the acting manager and prior to their arrival, the previously registered manager. This enabled the staff team to identify any changes in people's health and take the appropriate action. There was evidence of people's relatives being involved in the reviewing of the plans of care. A relative told us "The staff are skilled at making me and my family feel included in my mother's care."

A recent audit of people's records had been completed and the acting manager was in the process of updating and addressing the shortfalls.

At our last visit it was evident that people's personal care needs were not being met. This was not the case during this visit. People appeared well cared for, personal toiletries were in place and it was evident that these were being used when people were being supported.

An activities leader was employed. However on the first day of our visit, they were required to work on the floor as a member of the staff team had called in sick. Therefore no activities were offered. On the second day of our visit the activities leader supported three people to attend the local church for a carol festival which was very much enjoyed by those who attended. An activities room on the ground floor had been turned into a small Bistro and people were supported to enjoy this space. Recent activities provided included a Bollywood event which involved Indian dancers and Indian food and a visit by a petting zoo, where people enjoyed the opportunity to stroke snakes and rats and

Requires improvement

Is the service responsive?

other unusual animals. One person told us "Oh yes if there's anything I'd like to do everyone has a choice of what you like….if we have a craft we'd like to do the manager will organise for us to have a go at that craft."

People who were able to talk with us told us they knew how to raise any issues of concern and were confident these would be dealt with to their satisfaction. One person told us, "I would speak to [the acting manager] she would sort it." A relative explained, "I have raised a complaint about a member of staff who was picking on people and the situation was raised with the manager who investigated the incident, and dealt with it."

A formal complaints procedure was in place and a copy of this was prominently displayed. We did note that this still included the name of the previous manager; however we were told that the people using the service and their relatives knew who the new acting manager was. People we spoke with confirmed this. We saw that when a complaint had been received, this had been acknowledged and an investigation had been carried out. When a complaint had been substantiated action had been taken to drive improvement. When people had concerns, these had been taken seriously.

Requires improvement

Is the service well-led?

Our findings

At our last inspection we found that there was a system in place to assess and monitor the quality of service provision at the home. However this was inadequate and had failed to identify a number of concerns that we identified during our inspection. This meant there was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection the provider sent us an action plan detailing the changes they would make.

At this inspection we looked to see if improvements had been made. We found that whilst some improvements had been made, areas of concern were still identified.

We looked at the systems that were in place to check the quality and safety of the service being provided. The provider had acknowledged the shortfalls identified at our last visit and a visit by the senior service quality manager had been carried out. This had identified a number of areas which needed improvement and the acting manager was working to address these.

Monthly monitoring visits were also being carried out by the area operation's director and the acting manager was completing local audits on a daily, weekly and monthly basis. These audits monitored issues such as falls, pressure area care and incidents and accidents. People's plans of care and medication administration records were also regularly audited.

Although all of these monitoring systems were in place, shortfalls were still identified during this visit. Care plans and nutritional records were not all up to date or accurate. Shortfalls within people's medicines had not been recognised. This included the process of checking to ensure that all the current medicines for each person were available and received in a timely manner. It was also noted that a safeguarding incident recorded in a person's daily records had not been picked up by the monitoring processes. This meant that it hadn't been identified or acted on.

We found that people who use services and others were not protected by the systems that were in place to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 HSCA (RA) Regulations 2014 - Good governance.

The acting manager and area operations director both acknowledged these shortfalls. They explained that they were working with the local authority quality improvement team to improve the service being provided. They also explained that they wanted to work with us all to drive improvement at the service.

The acting manager explained that they were not taking any new admissions into the service currently but staffing levels would remain as if the service were at full occupancy. They told us that this would provide them with the opportunity to make necessary improvements at the service without impacting on the care and support of the 20 people using the service.

People had been given the opportunity to share their views and be involved in how the service was run. This was through daily dialogue with the staff team and the acting manager. The people using the service and their relatives had recently been sent surveys to complete and meetings had been held. Comments in the surveys returned included, "We have been at Wymeswold Court for a number of years and have seen many ups and downs however, after a recent resident's meeting and speaking to [acting manager] I am hopeful that things are taking a new direction and improvements are coming."

Staff members we spoke with told us they felt supported by the acting manager and they felt able to speak with them if they had any concerns or suggestions of any kind. One staff member explained, "Morale has been low in the past but it is improving. I had an issue and went straight to [The acting manager] and she dealt with it immediately." Another told us, "[The acting manager] is very approachable, if you have a problem you talk to her and she will sort it. If she can't she will take it higher, she has made a difference here." A third explained, "[Acting manager] is doing ok under the circumstances. I feel I can go to her to get things off my chest. Moral has lifted and things are getting better."

Monthly staff meetings had been held and supervision for staff had commenced. A new staff member told us, "I haven't had supervision yet but I know [acting manager] is putting the paperwork in place."

The staff team were aware of the provider's aims and objectives and a copy of these were displayed at the

Requires improvement

Is the service well-led?

service for people to view. One staff member told us, "It's about giving the best possible care that we can give." Another explained, "It is about keeping people safe and promoting people's dignity."

The acting manager was aware of their responsibilities to ensure that they informed us of certain events that happened at the service. These included any serious injuries, any allegations of abuse and any death of a person using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected by the systems that were in place to assess, monitor and improve the quality and safety of the service provided. Regulation 17 (2) (a).