HC-One Oval Limited

Wombwell Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Wombwell Hall Care Home is a residential care home that was providing personal and nursing care to up to 120 people aged 65 and over at the time of the inspection. There were 116 people living at the service at the time of inspection. The service was divided into four separate units, each accommodating up to 30 people. People required nursing care and had care needs such as, living with dementia, diabetes, seizures or recovering from a stroke. Some people were nursed in bed, some people needed help with moving around and others were able to mobilise independently.

For more details, see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:
● Although the registered manager used a dependency tool to calculate the numbers of staff needed and felt assured their staffing levels were sufficient, most people we spoke with were clear there were not enough staff as they were often kept waiting to have their needs met. There were a number of agency staff used, particularly at night and people had concerns about this.
● People were not always supported to maintain their basic rights when they lacked capacity to make particular decisions, and were deprived of their liberty.
● Meaningful occupation through the day was not available to everyone, particularly those who were nursed in bed or chose to stay in their rooms.
● People did not always receive their medicines as prescribed as sometimes they did not receive the correct amounts of tablets.
● New staff were not always recruited in a safe way to make sure they were suitable to work with people living in the service.
● We found one area needing to improve: consideration to providing a more dementia friendly environment.

● Apart from the concerns about staffing, people and their relatives thought the staff were caring, friendly and worked hard.
● The food was described as good and people could order something different if they were not happy with what was on the menu. Qualified nurses took care of people's health needs and referred them to other healthcare professionals when needed.
● Staff were well trained and supported by a clear management structure.
● A registered manager was in post who knew people well.

Rating at last inspection: Requires Improvement (Report published 16 March 2018). Insufficient improvements had been made to raise standards since the last inspection. This service has been rated Requires Improvement at the last two inspections.

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of this report.

Follow up: We will continue to monitor this service and plan to inspect in line with our inspection schedule for those services rated Requires Improvement.

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 always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Wombwell Hall Care Home

Detailed findings

Background to this inspection

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

Inspection team: The inspection was carried out by two inspectors, a registered nurse who had specialist knowledge of dementia and two experts 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, older people and residential care.

Service and service type: Wombwell Hall Care Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced on the first day and we told the registered manager when we would return to complete the second day.

What we did: We reviewed information we had received about the service since the last inspection in January 2018. This included details about incidents the provider must notify us about, such as abuse, serious injury or when a person dies. We used this information to plan our inspection. Providers are required to send us information to give some key information about the service, what the service does well and improvements they plan to make. Due to a technical difficulty, this information was not received.

During the inspection we looked at the following:

- The environment, including the communal areas, bathrooms and people's bedrooms
- We spoke with 24 people living at the service and eight relatives who were visiting

• We spoke with the registered manager and 15 staff, including unit managers, nurses, care staff, activities coordinators and a cook
• We spoke with a healthcare professional and received feedback from two health and social care professionals
• Nine people's care records
• Medicines records
• Records of accidents, incidents and complaints
• Monitoring and audit records
• Six staff recruitment files
• Staff supervision records
• Staff training records
• Rotas
• Records of meetings with relatives and staff
• Fire, health and safety and maintenance records

After the inspection the registered manager sent us additional information we requested in a timely manner.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection, in January 2018, we rated the service as requires improvement in safe. We found breaches of Regulations 12 and 18, in relation to, failing to keep people safe from risk and staffing levels were not appropriate to meet peoples' needs. We asked the provider and registered manager to take action to meet the regulations. They sent an action plan on 4 April 2018 saying they would be compliant with Regulation 18 by the end of April 2018 and with Regulation 12 by the end of June 2018. Improvements had been made at this inspection to staffing levels and the management of risk, however we found further improvement was needed in both these areas.
Although there were some issues regarding people's medicines at the last inspection, these were dealt with and made safe during the inspection. However, the management of people's medicines was a further area of concern at this inspection.

Assessing risk, safety monitoring and management
● Although improvements had been made to risk assessments following the last inspection, these were not always individual for each person. In some cases, standard risks had been identified, which related to most people, for example, the risk of developing pressure areas. Some people's assessment scored them at high risk of developing pressure areas. However, an individual risk management plan had not been completed to alert staff to what measures they must take to prevent skin deterioration. One person who was nursed in bed did not have a specific risk assessment but they did have a care plan stating they should be repositioned every two to four hours. There was no evidence that this was happening as they did not have a position change chart in place for staff to record when they assisted the person to turn over. We asked staff about this who said the person repositions themselves, however the care plan did not record that this was the case. The care plan did not give direction to staff to apply prescribed creams to protect their skin.
● Some people were known to have been verbally and physically aggressive at times. This had been recorded in the initial assessment but guidance was not in place for staff to be able to provide positive and consistent support should the person become anxious. A number of new staff had joined the service and agency staff were used regularly who would not know how to provide appropriate support in these circumstances. The lack of guidance may put people and staff at risk if anxious situations were not supported appropriately.

The failure to ensure systems were in place to keep people safe is a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● The premises were well maintained by maintenance staff and repairs were carried out quickly. All essential servicing of equipment and services, such as hoists, fire alarms, gas and electrics were carried out regularly. Fire drills were undertaken regularly and at different times of the day, to make sure staff understood how to

respond to keep people safe in the event of a fire. People had personal emergency evacuation plans to plan their escape in the event of an emergency.

Using medicines safely

● People's medicines were not always managed in a safe way. An audit of a random sample of medicines in stock was carried out on two units. We looked at six people's medicines on one unit and four people's medicines on the other unit. Errors were found in both units. The medicines counted did not always tally with the tablets signed as given on the medicines administration records (MAR). In some cases, too many tablets were left in stock when checked against the staff signatures on the MAR. This meant that people may not have been given their medicines, even though staff had signed to say they had. In other cases, less tablets were left in stock than should have been. This meant that people may have been given more tablets than staff had signed for. One person was prescribed two types of painkiller to take as and when necessary. These medicines should not be given within six hours of each other. However, staff had given one of the painkillers at 5.45pm on one day and the other type at 9pm. On another day, staff had given one of the painkillers at 6.20am and the other type at 9am. People had not always received their medicines safely or as prescribed. The registered manager told us they would seek advice from the GP and put measures in place to ensure this does not happen again.

The failure to ensure the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People told us staff kept them informed about the medicines they were taking. One person said, "The nurse comes around and gives me my medication, I know what they are anyway, but she still explains what they are. I have no concerns whatsoever about my medication."
● Medicines were ordered, stored and disposed of safely. Medicines room and fridge temperature checks were carried out regularly to make sure medicines were stored at the correct temperature to maintain their efficacy. Registered nurses were responsible for administering medicines along with specially trained nursing assistants whose competence was checked regularly.

Staffing and recruitment

● At the last inspection, staffing levels were not suitable to meet people's needs. At this inspection, staffing levels had improved, but people, relatives and some staff told us there were not enough staff. The majority of people we spoke with told us there were not enough staff and many said they had to wait a long time when they needed assistance. People said the night times were most difficult. Some of the comments we received from people included, "There are not enough staff in the night but they do their best"; "It's the night I am concerned about. Sometimes it's only agency staff on duty at night and they don't know anything about us, and they are not regular ones, there is a different person all the time and it does not make you feel safe anymore; medication is fine, food is ok, but staffing is the major problem" and "The staff are good and seem to know what they are doing, but it seems they need more staff because you wait for about 30 minutes before help comes if you call."
● Staff said there were not always enough staff. Some staff said that although there were often two nurses on duty during the afternoon shift, sometimes there was one nurse which made it difficult to provide the care necessary, depending on people's needs. The provider's staffing grid showed two nurses should be on duty in each unit am and pm. Rota's looked at showed this was not always the case, sometimes only one nurse was on duty in the afternoon. Although some staff said there were enough staff on duty to attend to people's care needs, they felt they would like to spend more time with people to support their emotional needs and well-being. One staff member said, "I wish sometimes there was more staff so we had more time to sit and chat to residents, especially the ones in their rooms." Some people told us they often had to wait

to be assisted to go to the toilet or to have their pads changed, sometimes waiting as long as one hour.
● In addition to a registered manager, who was supported by a deputy manager, a unit manager was in post to manage each unit. The registered manager was in the process of recruiting to the position of unit manager as there was one vacancy. Active recruitment continued to be needed to fill nursing and care staff positions. There was still a high level of agency staff used to fill the gaps in the rota, so although the numbers of staff required to provide people's assessed care were on duty, they were not always consistent staff who knew people well, particularly at night.
● Rotas showed there were often not enough permanent staff to cover the shifts throughout the day and night with nights raising the main concern. Some nights, instead of three staff working on one unit, only one permanent staff member was on duty. The other two staff were made up of agency staff. The registered manager made sure the numbers of staff on duty reflected the numbers required according to their dependency tool. However, people told us they did not feel there were enough staff as they often had to wait long periods of time to receive assistance when they needed it, for example to go to the bathroom. This meant the deployment of staff did not ensure people's needs were met in a timely fashion with some people waiting for long periods of time before being supported.

The failure to ensure sufficient staff are deployed to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Additional staff supported the service, including, maintenance operatives, cooks, domestic staff and activity coordinators.
● Some parts of the recruitment process had not always been robustly followed so the registered manager could be assured only suitable staff were employed. Some gaps in applicants' employment history had not always been followed up to check the reasons why there were gaps. This meant the registered manager could not be assured that some applicants for employment were suitable to work with people living in the service. References were not always checked to make sure they were suitable referees or that they were authentic. A reference for one staff member suggested they were the staff member's last employer as they had given dates when they had been in their employment. However, their application form did not have this employer listed as their last employer and suggested this referee was a friend. This meant the application was confusing and the anomaly had not been picked up through the recruitment process. The recruitment documents for one nurse showed they had only one reference on file, although this was printed twice and placed in their staff file. No other references had been followed up. The registered manager agreed they would speak to their recruitment colleagues about this to make sure the relationship of the referees are clear and their authenticity is checked.

The failure to ensure robust recruitment processes are followed is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Recruitment was ongoing to fill the staff vacancies in order to provide a consistent staff team, which was a challenge at times due to the size of the service. The provider had a recruitment process in place which included assistance from a central recruitment team. Applicants for vacant positions had completed application forms and provided proof of id. Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who use care services. The provider made sure they checked the PIN number of registered nurses who applied for a position. This assured them that the nurses were qualified to practice and their registration was up to date.

Systems and processes to safeguard people from the risk of abuse
● Staff had a good understanding of how to keep people safe and their responsibilities in safeguarding

people from abuse. They told us how they would report issues of concern and knew they could go outside of the organisation if they felt they were not being listened to. A whistleblowing (where staff can raise a concern without fear of repercussions) helpline number was available to staff. We were told by staff that they were reminded of this regularly, in staff meetings and in supervision meetings. One member of staff told us they had used the helpline in the past and they were pleased with the response, "I was impressed by how quickly action was taken, it has given me confidence in this system."

Preventing and controlling infection

● All four units of the service were clean and staff had access to personal protective equipment to help prevent the spread of infection. There were no unpleasant odours present. Domestic staff were employed to provide cleaning services. They had a schedule of cleaning and recorded the tasks carried out on a daily basis.

● Information about how to prevent the spread of infection such as effective hand washing was available in the service.

Learning lessons when things go wrong

● Accidents and incidents were monitored each month by the registered manager who analysed the information provided by unit managers. The provider's senior management and health and safety teams kept an oversight of the process, making sure themes or concerns were not missed. Falls were analysed each month and a 'falls team' had been set up in the service, consisting of heads of department, to learn lessons from incidents with the intention of improving safety and outcomes for people. This approach had helped to identify and action areas for improvement.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our last inspection, in January 2018, we rated the service as requires improvement in effective. We found a breach of Regulation 18 in relation to staff training which had not been updated and staff had not received formal supervision. The provider and registered manager sent an action plan date 4 April 2018 saying they would be compliant with Regulation 18 by the end of June 2018. At this inspection, we found both these areas had improved. However, we found other areas of concern regarding people's rights within the basic principles of the Mental Capacity Act 2005 and care planning.

Ensuring consent to care and treatment in line with law and guidance

- 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- One person had a DoLS authorisation in place, dated 4 July 2018, for a period of 12 months. The local authority had made five conditions when authorising the DoLS, to protect the person's basic rights. None of the conditions were referred to within the person's care plan to make sure the conditions were met. Clear evidence was not available to show some conditions had been considered, those that had been considered were not given priority as they were still not met. For example, one condition stated a special wheelchair was to be provided as soon as possible to reduce the amount of time the person had to spend in bed. Although an occupational therapist (OT) had been asked to complete an assessment for a suitable wheelchair, the assessment was dated 28 November 2018. We spoke to the unit manager who said it had taken time to get an OT to visit, however, there was no record of when staff had made referrals or chased up the OT. No part of the care plan recorded this was a condition of the DoLS authorisation and must be prioritised to protect the person's rights. At the time of inspection, the person was still being nursed in bed. One of the other five conditions of the DoLS stated a record must be kept of the activities the person was supported to take part in to evidence they were meaningfully engaged with adequate stimulation for their well-being. Very limited records were kept of the activities the person was supported to engage in, there were only four records of activities over a four week period, even though keeping records of activity was a condition of the DoLS authorisation. Three records stated the activities coordinator had a chat with the

person and one record stated the person declined a chat. A member of staff told us activities coordinators had bought talking books for the person when we raised this as a suggestion, however, there were no records of this and the member of staff did not know if they had been used. The records that had been made showed less than adequate engagement.

● Where people lacked the capacity to consent or to make particular decisions, capacity assessments had been carried out and a best interests process had been followed for decisions that were common to most people. However, an individual approach was not always taken when considering best interests decisions regarding people's care and treatment. For example, when a DoLS authorisation had been made, best interests decisions had not always been made prior to planning the support people needed with their personal care. A mental capacity assessment had been undertaken with some people relating to, for example, consent to having their photograph taken for identification purposes. However, the consent forms had not been fully completed or signed.

The failure to ensure people's rights are upheld within the principles and procedures of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Some people were not provided with the necessary support to make sure they could eat their meal comfortably and to maintain their health and well-being. One person was nursed in bed and was eating their meal leaning over to their right side. Their dessert of sponge and custard was placed on the table beside them and they were eating it with their hands as the spoon was placed at the far side of the dish so not easy to reach. We passed them the spoon and they ate the whole dessert with the spoon while we chatted. Because of their position in the bed, food had spilled onto their skin and clothes. The person had not been supported into a more upright position to eat their meal with dignity or to maintain their health. We asked staff about this who said the person always leaned to one side and often ate with their hands. Staff were surprised that the person had continued to eat their dessert with a spoon. The person's care plan did not show that staff had tried options to support the person to eat their meal independently but successfully. Another person who had their meal in bed ate little at lunchtime and did not finish their food. Staff did not provide any assistance or sit with them to encourage the person to eat more. Their unfinished meal was taken away by staff. When we asked staff about this, they said the person often did not finish their food.

The failure to ensure people's care and support is individual and meets their needs and preferences is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People had a choice of food from a menu at mealtimes, including breakfast, where they could order a cooked breakfast if they wished. 'Night bites' were available in the evening if people were hungry, these included sandwiches and cakes and were sent to the kitchen in each unit before the main kitchen staff went off duty. The people we spoke with were happy with the food they were offered and said they had plenty, some people said they got too much. Relatives said the meals always looked good and their loved ones did not have any complaints.

● The cook was kept aware of people's likes, dislikes and dietary requirements by notifications sent from each unit. They had a good understanding of specialist diets, such as diabetic or vegetarian/vegan diets or providing soft options when people had swallowing difficulties. People were able to change their mind if they decided they wanted a different meal to the one they had ordered. We saw examples of this happening during our inspection. One person who had specific dietary needs and had to watch what they ate, told us they reminded the kitchen staff about what they could and could not eat and the kitchen staff did as they asked, preparing whatever they wanted.

Staff support: induction, training, skills and experience

● At the last inspection, staff were not effectively supported to update their training. At this inspection, we found that staff received the training they needed to carry out their roles. Most training courses were accessed and completed online. Staff told us they were happy with this and felt they were able to gather the skills and knowledge necessary. Some training was completed face to face as practical skills needed to be taught, for example, moving and handling training. Nurses checked the effectiveness of staff training to make sure they had understood and could put their training to good effect.

● Registered nurses were supported to maintain their professional qualification through access to training such as catheter care, end of life care and pain management. The provider provided personal development opportunities for senior care staff to complete a validated nine week course to become nursing assistants. This meant, once they had completed the course, nursing assistants were able to carry out some nursing tasks. Such as administering medicines, taking observations and acting as a role model to other staff.

● Staff told us they were happy with the support they received and had regular one to one supervision with their manager. Annual appraisals were completed to plan staff development.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The registered manager, unit managers or nurses carried out an initial assessment with people before they made the decision to admit the person. This enabled them to check that nurses and staff had the skills necessary to care for people's needs. An initial seven day care plan was put in place to enable staff to provide the person's care based on the information gathered during assessment. Nurses used their professional knowledge and training as well as following current guidance to develop a complete care plan during this period. This included peoples personal care needs and their cultural and religious needs and preferences.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People told us nursing staff made sure they saw a doctor or other healthcare professional, such as a dentist or chiropodist, if they needed to. Relatives said they were always kept informed if their loved one was unwell or had needed to see a doctor. One person told us how they were working hard on their recovery so they could move out to more independent accommodation. They told us about the progress they had made and shared with us how many agencies were working together with them and the staff to help to achieve their goal.

● One visiting healthcare professional told us they had no concerns about the service and that nurses and staff always followed their advice.

Adapting service, design, decoration to meet people's needs

● The service was large, consisting of 120 beds but divided into four units. Each unit was set out across one floor with ease of access for people of all abilities, including wheelchair users. The service was not specifically for people living with dementia, so this meant the service was not designed with the needs of people living with dementia in mind. However, many people were living with dementia. Details such as quiet areas, décor, easy to read signs to help people get around to the bathroom, dining room or to their bedroom had not been considered. This an area identified as needing improvement.

● The service was set in pleasant easy to access gardens, maintained throughout the year by a full time gardener. This provided an area for people to enjoy when the weather permitted.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- The people we spoke with made positive comments about the staff and their approach, despite the fact they thought there were not enough staff. One person told us, "The staff are marvellous. They do work hard, and much more, they make sure there is enough drink on my table and it's fresh and they make sure my clothes are nicely arranged" and another said, "They are patient, kind and loving."
- Relatives were equally happy with the caring nature of the staff. One relative said, "Staff are smashing. (My loved one) is always clean and tidy" and another told us about their loved one, (My loved one) cannot speak or hear so (relative) and staff communicate using a white board and writing."
- Visitors were welcome at any reasonable time and the visitors we spoke with said they were made to feel welcome, sometimes being offered a drink.

Supporting people to express their views and be involved in making decisions about their care

- Some people were not able to be involved in planning their care and some preferred their relatives to be involved. One person said, "Mostly it is my family that takes care of my care plan, and the staff follow it, they are good." Where people had contributed to their care plan, they had signed to confirm this.
- Where people did not have relatives to visit and help them to make decisions about their care, an independent advocate had been involved to support the person and make sure particular decisions were being made in their best interests.
- People told us how they made choices about their care and support on a day to day basis. They said that staff always respected their decisions. One person said, "Staff always support me the way I want, they talk to you and assure you all the time." Another person told us how they make their own decisions about what they want to do with their day; when they got up, what they wore, ate and what activities they wanted to join in with.

Respecting and promoting people's privacy, dignity and independence

- People and relatives told us how staff respected their privacy and dignity. One person said, "They knock before coming in, even if the door is open wide. Yes, they speak with me nicely and talk to me with eye level contact" and another commented, "Staff are very good, I am treated with great respect." One person told us they were encouraged to do as much as they could for themselves, "They don't want to take my independence away." A relative said, "The girls always treat them with dignity, I never worry about that."
- The staff we spoke with described how they protected people's privacy and dignity. One staff member said, "I always consider resident's dignity, I know how I would feel if someone was washing me, I would want to keep as covered up as possible, so I do the same for the residents I am washing, for example." Another staff member told us how they helped people to maintain their independence, "I know what people can do themselves and I would encourage them to do this for as long as they are able."

● Confidentiality was supported. People's personal records were locked away as necessary in secure cupboards or locked offices. Computers used by the provider and staff were password protected to keep information secure.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Although care plans were in place to describe the care and support people needed, they did not always include some important elements individual to the person. One person had a medical condition that meant they may need psychological as well as some physical care and support. Although this was not their main health need at the time, it was a condition that would need staff consistency and skilled care to support the person if they had difficulties. A care plan was not in place to provide advice and guidance to staff in how to best support the person if they became anxious, or to recognise physical symptoms that needed healthcare advice. Another person, who was nursed in bed, needed to be moved regularly to prevent pressure sores. The person became distressed at these times due to pain. Staff said the person did not like to be moved onto one particular side so this made them more anxious when they needed to be in that position. The person later told us they did not like being on that side as they were unable to watch TV as this was at the other side of the bed. We asked staff about this, who said they were aware of this but there were no electric plugs on that side to move the TV at the times the person was lying that way. Attention had not been given by staff to make sure they had explored all options.

● Although activities coordinators were in post and usually one working on each unit, many people were not always engaged in meaningful activity. Activities coordinators supported people with activities each morning within each unit. However, this was often limited to people who accessed the communal areas. Few activities were provided for people nursed in bed or who chose to stay in their rooms. A planned group activity was held every afternoon where people were supported to congregate in one unit. During the inspection, musical bingo was held. The people who attended enjoyed the afternoon and were given support to join in. Many people either were not able or chose not to attend the afternoon activity and as activities coordinators from each unit joined in to support this, limited time was available for those who did not join in. Some external entertainers visited. One relative told us about a singer who visits about once a month. They said, "He is excellent and he gets a nice crowd." The relative said they would like to see more of the entertainer as people enjoyed it.

● Activity schedules to record when people had been engaged in activity showed this did not happen every day or most days. Activities coordinators had recorded in the activity schedules of people who were nursed in bed. However, in most records, the amount of times people were visited in their rooms to encourage involvement in meaningful activity was limited, and the activities recorded were limited, for example, having a chat, or declined to chat, once or twice a week.

● In one unit, people were able to sit in a communal open plan lounge/dining area. Some people were sitting around a television, however, a radio was playing quite loud in the dining area. The radio belonged to one person who liked listening to their radio. However, thought needed to be given to other people, as well as the one individual, who may not be able to fully enjoy either the television or the radio and could be confusing and create anxiety for people living with dementia.

The failure to ensure people's care and support is individual, meets their needs and preferences and provides meaningful occupation is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People and relatives knew who to talk to if they had a complaint, most said they would speak to staff first.

● The provider and registered manager had responded to complaints in line with their complaints procedure. This included informal complaints, when people or relatives could complete a form if they raised an issue with staff, and this would be passed on to the registered manager. We asked staff if concerns people or relatives raised that staff dealt with immediately were logged and were told they were not. Staff said they could see the benefits of recording these concerns as it may identify themes that could be rectified to avoid it happening again. They said they would raise this as an idea for improvement.

End of life care and support

● Most people had an end of life care plan which highlighted if people had special wishes they wanted to share such as whether they wanted to be buried or cremated. Those who did not had said they did not wish to discuss the subject. Staff continued to keep this under review. Some people's end of life care plan recorded that their loved ones knew their wishes and would take care of arrangements, particularly people with specific religious and cultural needs.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

At our last inspection, in January 2018, we rated the service as requires improvement in well led. We found a breach of Regulation 17 in relation to, accurate record keeping; monitoring processes were not robust and management oversight was not clear. We asked the provider and registered manager to take action to meet the regulation. They sent an action plan dated 4 April 2018 where they said they would be compliant with Regulation 17 by the end of June 2018. At this inspection, although improvements had been made to the auditing systems to monitor the quality and safety of the care provided and the methods of communication, concerns were found that had not been identified or rectified.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Many people told us how they had to wait a long time to be assisted with their care and some people said how they had spoken up for others who had been kept waiting a long time. This was a theme of our discussions with people. Most people were positive about the staff, describing them as trying hard. Some people thought staffing levels had improved recently, as they were worse previously. The concerns around staffing levels had been raised in various ways and at various times by people and relatives since our last inspection when we raised concerns, but this continued to be a concern to people living across the service. Although the provider and registered manager had recruited more staff in the last 12 months, they had not fed back to people and relatives what other ways they would try to alleviate the concerns. For instance, trying out different ways of deploying staff, such as adding staff at crucial times.
- Some people had not received care that was person centred and took account of their individual needs. Some people who were deprived of their liberty through a DoLS authorisation had not had their basic rights prioritised and a best interest approach was not always taken when people were assessed as lacking capacity to make particular decisions.
- The provider used various ways of receiving feedback from people and their relatives. Relatives had been asked to complete an annual survey in May 2018. A mixture of positive and negative comments were received. Areas raised as being a concern to relatives such as staff shortages and quality of food, had been addressed by the registered manager in an action plan to make improvements. However, people and relatives continued to complain about shortages of staff. The results of the survey and the action being taken were displayed on notice boards within each unit but did not provide clear action to put people's minds at rest about staffing concerns.
- Resident and relatives' meetings were held in each unit. Although the provider's policy suggested these should be held every three months, this was not always the case as they were not held as frequently as this.

Records of the meetings held showed that people were able to raise concerns and areas for improvement. Staff shortages and the heavy use of agency staff were raised as a concern in all meeting records we looked at and people were complaining that call bells were not answered quickly enough, particularly at night. This included meetings held in May and October 2018. A record had not been made in the meeting minutes to show what staff had suggested they could do to ease people's and relatives' concerns.

The failure to listen to people's views and act on feedback given is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● The provider had a full range of quality assurance processes in place to monitor the quality and safety of the service. At the last inspection, the provider had recently taken over management of the service and monitoring procedures had not been fully implemented leading to a lack of robust oversight by the management team. At this inspection, this had improved; the provider's auditing procedures were embedded and working well in some areas, highlighting and actioning areas for improvement. As well as nurses, unit managers, the deputy manager and the registered manager having monitoring responsibilities, senior managers visited regularly to check the quality of the care provided. However, insufficient improvements had been made since the last inspection as the breaches found at that inspection had continued and further breaches of regulations had been found, as shown through this report.

● Audits had not identified the concerns we found around, risk management; medicines management; staff deployment; staff recruitment; ensuring people's rights within the principles of the Mental Capacity Act 2005; people's individual care requirements and their opportunity to engage in meaningful occupation to meet their preferences and avoid social isolation.

● The issue of people and staff feeling there were staff shortages were raised during senior manager monitoring visits, including visits in January and February 2019. This showed that concerns around staffing were continuing since our last inspection and senior managers were aware of people's views.

● We spoke with the registered manager about the views of people, relatives and staff, that there were times when there appeared to not be enough staff to meet people's needs. The registered manager agreed that recruitment was difficult at times and they were in a constant process of advertising for, and interviewing, staff. They confirmed that the staff vacancy situation had improved but they continued to use agency staff regularly. They showed us evidence that all shifts were covered to the levels needed to meet people's needs, based on the provider's dependency assessment tool. However, people continued to say they felt the staffing levels did not meet their needs and staff felt they were at times under pressure. Agency staff relieved some of this but people and staff felt agency use was no alternative for permanent staff as they often did not know people's needs or the day to day responsibilities of nurses and staff.

● The provider and registered manager failed to make sufficient improvements to raise the standard of quality and safety above the rating of Requires Improvement since the last inspection.

The failure to ensure a robust approach to improving the quality and safety of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager held 'flash meetings' each day at 11am. A member of staff from each area of the service attended, such as the nurse in charge on each of the four units, maintenance, the chef, housekeeping and activities. The registered manager told us they had introduced the meeting following the last inspection and were intended to aid communication, share information and concerns.

● Various staff meetings were held to aid communication within each unit and department across the service. Clinical review meetings were held between unit managers and nurses to discuss people's clinical

needs and to provide a forum for professional staff to support and provide guidance to each other. Staff told us they felt supported by their unit manager and were confident in approaching them with concerns or ideas for improvement. Unit managers told us they were well supported by the registered manager and deputy manager.

● Registered managers are required to notify CQC about events and incidents such as abuse, serious injuries and deaths. The registered manager had understood their role and responsibilities, had notified CQC about all important events that had occurred and had met all their regulatory requirements.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their ratings and it was on the provider's website.

Working in partnership with others

● The registered manager and deputy manager attended local provider forums, training opportunities and kept in contact with other providers in the local area, sharing good practice at times. The management team and nurses worked closely with visiting professionals such as GP's, specialist nurses and other healthcare professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to ensure people's care and support was individual, met their needs and preferences and provided meaningful occupation. Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure peoples rights were upheld within the principles and procedures of the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to ensure people received safe care and treatment. Regulation 12 (1)(2)

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

	The provider and registered manager failed to ensure a robust approach to listening to people's views and to improving the quality and safety of the service. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager failed to ensure robust recruitment processes were followed. Regulation 19(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure sufficient staff were deployed to meet people's needs. Regulation 18 (1)