Care UK Community Partnerships Ltd

Woodland Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

The inspection of Woodland Hall Avenue took place on the 24, 26, 27 and 31st January 2017. We did not announce we were inspecting the service on the 24 and 27 January 2017. We told the provider we were returning to the service on the 26 and 31 January 2017.

At our last inspection on 16 and 21 July 2015 the service was rated good overall.

Woodland Hall provides nursing care for up to 72 people who have a range of care and nursing needs associated with old age, including dementia. On the first day of the inspection there were 58 people using the service. The number of people varied slightly during the other days of the inspection.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the service was being managed by an operations manager who had support from other management staff in the running of the service. We were told that the provider was taking steps to recruit a manager who once appointed would register with us.

Systems and processes were in place to safeguard people. Staff knew how to recognise abuse and how to respond to concerns. People's individual needs and risks were identified and managed as part of their plan of care and support to minimise the likelihood of harm. Accidents and incidents were addressed appropriately.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensure that an individual being deprived of their liberty is monitored and the reasons why they are being restricted is regularly reviewed to make sure it is still in the person's best interests. The home had made necessary applications for DoLS and we saw evidence that authorisations had been granted.

People were treated with respect. We saw examples of staff engaging with people in a positive kindly manner. People were supported and encouraged to make choices in their day to day lives. Staff told us they enjoyed working in the home providing people with the support and care they needed.

People's social needs were not fully met. Not all areas of people's care plans were person centred and people lacked the opportunity to take part in activities to promote their well-being and minimise social isolation. People told us there was not much to do. The service needed to improve in this area and was in breach of regulation.

Staff received some training to enable them to be skilled and competent to carry out their roles and

responsibilities. However staff had not received training in meeting some aspects of people specific needs and care workers had not received regular one-to-one supervision to support them to carry out their roles and responsibilities. The service needed to improve in this area and was in breach of regulation.

People were supported to maintain good health. They had access to a wide range of appropriate healthcare services that monitored their health and provided people with appropriate support, treatment and specialist advice when needed. We found systems were in place to manage and administer medicines safely.

Staff were appropriately recruited. They underwent a range of pre-employment checks to ensure they were suitable for the role. Checks had also been undertaken to ensure that all the nurses who worked at the home had a current registration with the Nursing and Midwifery Council (NMC).

There were systems in place to regularly assess, monitor and improve the quality of the services provided for people. These included unannounced spot checks of the service carried out by management staff.

We have made a recommendation that the staffing needs of the service be reviewed as we found during meal times people waited significant periods of time before receiving assistance with their meals. Also we have recommended that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their end of life care.

The service was in breach of two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation care plans lack of person centeredness and a lack of opportunities for people to engage in activities. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff knew how to recognise and respond to abuse and understood their responsibility to keep people safe and protect them from harm.

We have recommended that the provider reviews the staffing needs to ensure there were sufficient staff available to support people at busy times.

Risks to people were identified and measures were in place to protect people from harm whilst promoting their independence.

Medicines were managed and administered to people safely.

Recruitment and selection arrangements made sure only suitable staff with appropriate skills and experience were employed to provide care and support for people.

Is the service effective?

Requires Improvement

There were aspects of the service that were not effective. It was not evident that all staff received the training and supervision they needed to enable them to carry out their responsibilities in meeting people's individual needs.

People were provided with a choice of meals and refreshments that met their preferences and dietary needs.

People were supported to maintain good health. They had access to a range of healthcare services to make sure they received effective healthcare and treatment.

Staff were aware of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and their implications for people living in the home.

Is the service caring?

Good

The service was caring. Staff were approachable and provided people with the care and support they needed. Staff respected people and encouraged and supported them to make choices

and be involved as much as possible in decisions about their care.

Staff understood people's individual needs and respected their right to privacy. Staff had a good understanding of the importance of confidentiality.

People's well-being and their relationships with those important to them were promoted and supported.

We have recommended that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their end of life care.

Is the service responsive?

Requires Improvement

There were areas of the service that were not responsive. Some aspects of people's care plans were not personalised to show the service had knowledge and understanding of each person's individual and specific needs.

People were not supported to take part in a range of recreational activities.

People's relatives knew how to make a complaint. Staff understood the procedures for receiving and responding to concerns and complaints.

Is the service well-led?

Requires Improvement

There were areas of the service that were not well led. Improvements had and were being made but interim management arrangements whilst there was no registered manager in post had not always provided the leadership and stability required.

Improvements had been made but there were areas of the service that needed further development.

There were a range of processes in place to monitor and improve the quality of the service.

Woodland Hall

Detailed findings

Background to this inspection

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

The inspection was carried out by two adult social care inspectors, a CQC pharmacist inspector, a specialist advisor [SPA] who was a qualified nurse 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.

Before the inspection we looked at information we held about the service. This information included notifications sent to the Care Quality Commission [CQC] and all other contact that we had with the home since the previous inspection.

During the inspection we spent time observing how people were supported by staff and we spoke with eight people using the service. Most people who used the service due to their needs could not describe their experience of the service so we 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 also spoke with the regional manager, operations manager, deputy manager, clinical lead, four nurses and six care workers, administration officer, activities co-ordinator, chef, housekeeping staff, maintenance person, hairdresser and chair of the Friends of Woodland Hall. We also spoke with eight people's relatives during the inspection and following our visit we spoke with seven people's relatives on the telephone. Prior the inspection we had frequent contact with the host local authority about the service.

We also reviewed a variety of records which related to people's individual care and the running of the home. These records included; care files of nine people living in the home, four staff records, audits, and policies and procedures that related to the management of the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe living in the home. Comments from people using the service included; "Yes, and if I had to, I would speak to [deputy manager], he's very good," "I've never seen anything nasty; they [staff] could easily get exasperated but they don't and always help nicely," "[Person] is quite safe in this place."

Relatives of people told us they felt people were safe and did not worry about people's day to day safety. They told us they would inform management staff if they had concerns about people's well-being. Comments from relatives included "I feel [person] is absolutely safe," and "[Person] is well loved and looked after by staff, I think [person] is safe." Care workers told us "I would report any incident to a nurse in charge or [deputy manager]," and "I am confident that the manager will raise any safeguarding concern to the local authority because I have seen her doing it".

There were policies and procedures in place, which informed staff of the action they needed to take to keep people safe including when they suspected abuse or were aware of poor practice from other staff. Information was displayed that informed staff about the action they should take if they suspected a person was being abused. Staff had received training about safeguarding people. Staff were able to describe different kinds of abuse. They told us they would immediately report any concerns or suspicions of abuse to the nurse in charge and/or management staff the registered manager and where appropriate, the local authority or Care Quality Commission [CQC]. Staff were confident that any safeguarding concerns would be addressed appropriately by them. Records showed where there had been allegations of abuse the operations manager had reported these to the CQC and the local safeguarding authority as required. Staff were aware of whistleblowing procedures but some care workers needed prompting when describing what whistleblowing meant.

People's care files included appropriate individual risk assessments that included people's risk of malnutrition, falls and risks associated with moving and handling. Guidance was in place for staff to follow to minimise the risk of people being harmed and to keep people safe. Staff had a good understanding of risks and the management of them. One care worker spoke about how staff minimised the risk of a person being injured at night and told us "[Person] tends to roll out of bed so we have the bed at its lowest setting at night with a crash mattress in place". Another care worker informed us about a person who was at risk of losing weight and told us "We make sure that [Person] eats regularly and give them food supplements. We also monitor their food intake and weight." People's risk assessments were reviewed and updated regularly to reflect any changes.

People had bedrail risk assessments. However, we saw two people's beds with bedrails without protective bumpers, which could lead to injury due to risk of entrapment. One of the bedrails risk assessment was incomplete and the other was unavailable. A nurse told us that one person did not require bedrails so they would immobilise them and they would review and update the other risk assessment. This was carried out during the inspection. Not all staff had been aware that the bedrails had a locking mechanism to ensure that the rails were locked in place when not in use.

There was information in people's care plans about people's behaviour that challenged the service. Guidance for staff to follow to manage this behaviour was documented. Although care workers told us they had not received specific training in managing challenging behaviour they were able to tell us about people and their behaviours and what they would do manage them such as supporting people to be less agitated. For example when a care worker spoke about a person whose behaviour was at times challenging, they told us "We have to speak with them, explain and discuss what we are doing. Sometimes we have to give them space and go back to them afterwards. They like tea, so we make them a cup of tea which helps."

There was a system in place for responding to and managing accidents or incidents. Accidents and incidents forms were completed and details of the action taken by staff were documented. Management staff had had worked with the local authorities to investigate and address issues relating to incident concerns.

The four staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure only suitable staff were employed to care for people. These included checks to find out if the prospective employees had a criminal record or had been barred from working with people who needed care and support. Staff we spoke with told us they were interviewed for their jobs, supplied two references and did not start work until they had a criminal record check.

There were systems in place to manage and monitor the staffing of the service so people received the care they needed and were safe. The operations manager told us that staffing numbers and skill mix were determined from a range of assessments of people's needs including; dependency, nutritional and pressure area assessments. They told us staffing needs were reviewed weekly and during the morning senior staff meetings with the nurses. We heard during a morning staff meeting a management member of staff ask nurses if they had enough staff on duty. During the inspection people's needs were met in a calm and unhurried way and extra care staff were provided to accompany people to health appointments outside of the service.

We spoke to staff on each unit who told us that generally there were enough staff on duty to provide people with the assistance and support they needed with their personal care and if more staff were needed this was provided for them. They told us "Sometimes we are short of staff. They do try and get staff. It is not a general problem." Staff told us "I have been here for nearly two years and I have seen an improvement in the recruitment of staff. Whenever somebody calls sick, the manager tries to get a replacement, we have extra staff for 1:1 observation and when somebody requires to go to an appointment," "There are enough staff here. Whenever I need assistance to support people with their personal care there is always somebody around" and "There is enough staff, if we need someone, we can just ask." A person using the service told us "You can always find them (staff) when you want them." However, care workers on one unit told us there were times when they were busy and extra staffing was needed. They commented "In the unit, we need more staff as residents here have complex needs and need support with their food and for us to have the time to speak with people," and "We need more staff especially in the morning."

Staff were observed not to be rushed but were busy. Call bells were attended to promptly. A person told us that staff usually answered their call bell quickly. However, some people's relatives told us they felt there were occasions when there was not always sufficient staff. A relative told us they had on an occasion spent some time looking for a member of staff to speak with. Another person's relative told us; "No, there are not enough of them [staff]." A care worker told us that the nurses spent a significant amount of time administering medicines so were not always available to provide them with assistance with supporting people using the service. During the inspection we observed that a lot of their time was taken by nurses administering medicines, allocating staff, writing notes, attending meetings, talking to relatives and liaising with other professionals, updating care plans and hand overs. A nurse told us that the service could benefit

from more nurses. They told us "I am very reliant on the goodwill and skills of the carers. I trust that they would do a good job and they do. I would not be honest if I tell you that I regularly check their work".

During lunchtime there were occasions when people did not get the support they needed promptly with their meals as staff were busy assisting others with their meal. Also there were times during the inspection when there was not a member of staff in the communal lounges to observe and support people, which could mean people's safety was at risk. For example during a morning handover meeting the communal lounge in one unit was left unattended for a few minutes when night care workers went off duty. In another unit we observed two instances in which people in the lounge area were left unattended whilst care workers either had to prepare drinks for people or attend to a person in their room. Although on these occasions the lounges were left unattended for short time, care workers did not ensure there was a member of staff in the room before they left to ensure people remained safe.

We also noted that fifteen minutes handover time first thing in the morning was not sufficient for a night nurse to complete a comprehensive handover of each person's needs, complete a walk around with the day nurse and check some medicines.

The operations manager told us they would review mealtimes and consider two meal sittings so there would be enough staff to provide people with the assistance they needed.

The service has been employing a significant number of agency staff in recent months. The operations manager told us due to recent staff recruitment the number of agency staff hours had reduced from 500 hours per week to 100 hours and that the aim was to continue to reduce the use of agency staff by employing permanent staff. People's relatives told us they had found the high use of agency staff did not have a positive impact on the service provided to people. A person's relative told us that due to the significant and complex needs of the person using the service familiarity and consistency of staff was very important to their well-being and the high usage of agency staff had not promoted and supported this. Also some relatives told us that staff changes within the units had not been conducive to people's welfare as when staff moved to an unfamiliar unit they did not know people well and fully understand their individual needs. A person's relative told us "Staff move a lot. We get used to staff and they are moved to another unit."

The operations manager told us they aimed to ensure that regular agency staff were employed so they were familiar with the service and that they had needed to move care staff and nurses to other units to ensure the staff skill mix was appropriate to meet people's needs. They told us they would review staffing needs and that further staff recruitment was planned including employment of 'bank' staff [staff that could be called a short notice to fill shift vacancies]. A person's relative told us they had found improvements had been made and commented; "There were different staff every day now there is better consistency of staff."

We recommend that the staffing level and skill mix of the service in each unit is reviewed to demonstrate that people's needs are always met by the service and to keep people safe.

There were various health and safety checks and risk assessments carried out to make sure the premises and systems within the home were maintained and serviced as required to meet health and safety legislation and make sure people were protected. These included regular checks of the hot water temperature, fire safety, gas and electric systems. A fire emergency plan including evacuation procedure was displayed. People's care plans included information about the assistance they needed to leave the building in the event of an emergency.

People received a range of support from relatives and others with the management of their finances. The service manages cash for most people. We checked three people's monies and saw appropriate records were maintained of people's income and expenditure, which were monitored to minimise the risk of financial abuse.

The provider had made suitable arrangements about the provision of medicines for people using the service. We checked medicines storage, medicines administration record [MAR] charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in locked medicines cupboards within each treatment room. Medicines requiring refrigeration were stored at appropriate temperatures. We found no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed.

Medicines were administered by nurses that had been trained in medicines administration and had their competency to manage and administer medicines assessed. We observed nurses administering medicines to people in a positive and sensitive manner. We saw a nurse wait until a person had swallowed their medicines before administering medicines to another person. We noticed a nurse did not wear a protective vest to ensure they were not disturbed during the administration of medicines. The operations manager told us during the inspection that protective vests had been ordered.

We observed that people were able to obtain their 'when required' [PRN] medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. For example, we saw 10 PRN forms for pain-relief/laxative medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider, Clinical Commissioning Group [CCG] pharmacist and community pharmacy supplier, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis. A recent improvement made by the provider included updating all the records of people who were on receiving covert medicines [medicines administered in a disguised format, such as in food] and PRN medicines to ensure the protocols were signed by the patient's representatives, GP and pharmacist. This had been highlighted previously from previous audits and a safeguarding issue and was in line with national guidance.

The home was clean during the inspection. People and their relatives told us they found the home to be clean. Housekeeping staff carried out domestic cleaning and laundering tasks. Soap and paper towels were available and staff had access to protective clothing including disposable gloves and aprons. Foam hand cleanser were available to people. However we found on two occasions in communal bathrooms that the hand cleanser had run out. We mentioned this to a housekeeper who promptly refilled the hand washing dispensers. A member of staff told us that people's bathrooms were only cleaned once a day which they felt was not sufficient.

Requires Improvement

Is the service effective?

Our findings

People using the service told us they were happy with the care and support they received from staff, who they said were kind to them. People told us "They [staff] are very professional," and "They seem to know what they are doing." Relatives also spoke in a positive manner about the care provided by care and nursing staff. They told us "They are the best staff," "The care is great, some of the staff are great and some are still learning," "Regular nurses are very good" and "The experienced carers are very knowledgeable."

"Staff were positive about working at the home. They told us "Yes I like working here. I like the staff. I love the people and like to help them. I feel like it's my family here", "Before I was agency staff providing one to one and now I am permanent so I know the home and people very well" and "There is good teamwork here, really good."

Care workers told us when they started working in the home they had received an induction, which included; learning about the organisation, policies and procedures, people's needs, shadowing more experienced staff and completing a range of training. They informed us the induction had helped them to know what was expected of them when carrying out their role in providing people with the care and support they needed. A care worker told us "I fill in a booklet and the nurse signs that I am doing things correctly. It has made me feel more confident." Another care worker told us "I got an induction. I shadowed other care workers. I read the care plans, spoke with people, relatives and colleagues. This is how I got to know about people's needs." Agency staff had also received an induction when they started work in the home. The service was not currently using the Care Certificate induction which is the benchmark set in April 2015 for the induction of new care workers. This was discussed with the operations manager.

Staff told us they were supported to gain and develop their knowledge and skills to enable them to support people effectively. Care workers told us "I have completed all the mandatory training. I am also up to date with my other training," "I have completed all the training I require to do my job well. The home gives you time to complete your training," "It is good. I get the support I need. I started as a care worker and they gave me the training to become a nurse", and "I have had training in dementia but not challenging behaviour.

Care workers were supported to complete vocational qualifications in health and social care which were relevant to their roles. Records showed that some nurses had attended recent meetings were clinical topics such as medicines, documentation and clinical risks such as weight loss, wounds, incidents and accidents were discussed.

Training records showed staff had completed training in a range of areas relevant to their roles and responsibilities. This training included; moving and handling, first aid, safeguarding adults, health and safety fire safety, infection control, basic life support, and food safety. Staff had also received training in some other relevant areas including; dementia awareness, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards [DoLS], pressure area care, falls, medicines and wound care. A care worker told us about the different types of dementia. The operations manager told us they intend to develop a dementia champion role for a member of staff to promote best practice in dementia care. The clinical lead manager told us

nurses had completed training to develop their competency. This included venepuncture [taking blood samples from people], urinary catheter and care planning training.

However, the home provided a service to people who have a range of needs including; those who challenged the service, had mental health needs, or had health needs such as epilepsy, a stroke, Parkinson's Disease, or were receiving end of life care. Staff training records did not show that staff had received training in these areas which could mean staff may not have the knowledge and skills they needed to provide people with the care they needed and to keep them and staff safe. This was discussed this with management staff. They told us they were planning to liaise with a local hospice to develop end of life training.

Records showed that a range of senior staff had recently had one-to one supervision with management staff to discuss their progress, aspects of the service and the needs of people using the service. However, prior to that they had not received regular one-to one supervision and care workers told us they had not experienced any recent supervision and staff meetings. "We have had supervisions but not recently. No recent team meetings either" and "We have had some team meetings before but I have not had any supervision." Records showed most care workers had not had the opportunity to have regular one to one meetings with a senior member of staff since early 2016. The operations manager told us that senior staff including nurses, following training in giving supervision would start regular supervision of care workers and other staff shortly. Not all staff had received an appraisal in 2016. The operations manager told us and records showed action was being taken to make improvements in this area as some staff had recently received appraisal of their performance and others had been planned.

There had also been in 2016 occasional small staff meetings to discuss specific topics such as activities and health and safety however, regular planned general staff meetings which provided staff with the opportunity to receive information about the service, become informed about any changes and to raise issues and discuss best practice with management staff had not taken place.

The above identified training and supervision issues identified were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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). Staff knew about the requirements of MCA and DoLS. Care workers knew what constituted restraint and knew that a person's deprivation of liberty must be legally authorised. Records showed that some people using the service were subject to a DoLS authorisation.

People's care plans showed they and when appropriate their family were supported to be involved in decisions about their care and treatment. Staff knew if people were unable to make a decision about their treatment or other aspects of their care, health and social care professionals, staff, and family members would be involved in making a decision in the person's best interest. In a person's care plan a mental capacity assessment had been completed and there were details of decisions made in the person's best interests with family involvement. One care worker told us "We can't say they [people] can't make decisions. We have to help them to do that. For example, there is one person here who will always say no when you ask them, but if we give the person something, they will take it. You have to prompt and encourage. Ask the family as well."

Care workers were knowledgeable about the importance of obtaining people's consent when supporting people with their care and in other areas of their lives. We observed care workers involving people in day to day decisions including choosing what they wanted eat and drink and their decisions were respected. When we asked people if staff asked them for their consent. They told us "Yes they do, when they do my personal care, you know washing and showering."

People had access to a range of health professionals including; GPs, chiropodists and opticians to make sure they received effective healthcare and treatment. Staff arranged appointments with a doctor when they observed people showed symptoms of being unwell. A person using the service told us, "Yes, they're aware of my medical needs. The GP's changed...she was good." Some people's relatives were critical of the service provided by the current GP arrangements. A person's relative told us that they didn't see the GP much and that the previous GP "was brilliant. "The operations manager told us the service was in the process of arranging a better GP service for Woodland Hall to ensure the service was more effective. During the inspection people were supported to attend hospital appointments. A hairdresser visited the home regularly. A person using the service spoke of having enjoyed getting their hair done.

We found people's nutritional needs and preferences were recorded in their care plan. People with the potential risk of malnutrition had nutritional assessments in place, which were monitored at least monthly. Whenever needed people were referred to a dietician and Speech and Language therapist. People's weight was also monitored monthly or more often when required.

People's comments about the meals were mixed. Comments from people included; "The food is very good," "You get offered a full English breakfast," "To be honest, I'm not stunned by the food," and "There are menus but the food is monotonous." A relative spoke positively about the food. They told us "The chef is really good. If the food is not nice, I can tell her." A person using the service told us "I'm Muslim and they have no halal food so I usually scrape off the meat from the rice and just eat the vegetables. I'm satisfied with it though." We informed the operations manager who told us halal food was available and would look into the issue. The chef showed us a range of halal meals that were stored in the kitchen.

We saw the meals of the day were displayed in a menu located on dining tables. The menus were in written format with small black and white pictures which were not always representative of the food on the menu and not accessible to people who could no longer read or who had visual sensory needs and. There was a whiteboard on one unit for the weekly menu but blank. A care worker told us "I don't think it is in use anymore."

The chef had knowledge and understanding of people's individual nutritional needs including particular dietary needs, food allergies, cultural and other food preferences. A range of fresh fruit and snacks were available at any time. We saw people were offered a variety of drinks throughout the day, however on one unit we noted that not everybody was offered a drink at lunchtime and also observed that drinks were not always within easy reach of the people. The chef told us they regularly asked for people's feedback about the food and recorded the feedback received from the resident of the day and took appropriate action to meet people's dietary preference and made improvements were needed. During lunch time, we observed the chef had come upstairs to see if people were happy with the food.

Lunch was unhurried and relaxed. People were able to eat at their own pace and were provided with assistance in a sensitive manner. For example, one person who received one-to-one care took more time than other people to finish their meal. Their care worker was patient and sat with the person throughout to attend to their needs. The care worker never rushed the person to finish their meal. We observed a care worker supporting one person with their food by explaining to them what the food was and encouraging

him to eat. When the person took a mouthful we heard the care worker say words of encouragement "Well done, good, you are doing very well."

However, on occasions some people waited a significant period of time before receiving help with their meal. We saw a person had to wait almost three quarters of an hour to be assisted with their lunch and the person had their food placed at a distance, which made it difficult for them to reach the food and eat their meal. The person was left waiting for assistance with the food. After 20 minutes the person fell asleep with the food still in front of them. In that time two staff had come to the dining room whilst the staff were supporting people with their food and asked loudly whether anybody required assistance. They did not check to see whether anybody needed support and walked out of the dining room. That person who had been waiting for 20 minutes waited another 25 minutes without anybody attending to him. We then approached a nurse in charge making her aware of the situation and also informed her that the food must have gone cold. She reassured me that the person will be given another plate of food and he would be supported to have his lunch. This indicated that lunch was not planned in an orderly manner to ensure that people received the support they required in a timely manner.

On other units we also found there was an element of disorganisation amongst staff and indication that there were insufficient staff available during meal times to support people appropriately and promote a pleasant meal time experience. For example, we observed one person was being supported with their food. When finished, the care worker took the person's plate away but did not return to the person to check whether they wanted anything else. In the meantime, the person started to cough and as there was no other staff member available, one care worker who was already supporting a person with their meal had to get up and attend to this person. This meant the person being supported had their meal interrupted. Another care worker then gave the person a pot of yogurt and left it in front of them. The person was unable to open the yoghurt pot. It was only when an activities person came into the dining area and asked whether anyone needed any help, that the person was supported with having some yogurt.

The option of having two meal time sittings was discussed with the operations manager, who told us this would be looked into.

The environment of the home was suitable for people's varied mobility needs including those who were wheelchair users. The service has a passenger lift so people unable to use stairs could access the units and other communal areas. People using the service told us they were happy with their bedrooms, which we saw were personalised. One person told us "I like my paintings on the walls, my plants and my fridge."

Handrails were situated throughout the home to assist people to move freely within all communal areas of the home. Although there were some signs it was not hard to become disorientated when walking within the premises. We spoke with the operations manager about improving the signage in the home.

We noted the décor of the home in some areas was tired looking. In some units the décor was bland with old furnishings with no bright colours or pictures. Most people on one unit either had mental health needs or varying levels of dementia. There were no adjustments made to the unit to ensure it was a dementia friendly environment. There was little signage, contrasting colours, suitable lighting and pictures that could help people with their memory but also help people to recognise and navigate around the unit. We noted some areas of the service had been refurbished and some were currently in the process of being renovated.

We found the premises were clean and tidy. A relatives told us "Place is very clean." We noticed in two bathrooms that the hand cleanser had run out. We reported this to a housekeeping member of staff who addressed the issue promptly.

We found two patio chairs in need of repair and informed the maintenance person who removed them. The maintenance person told us each unit had a maintenance book where staff recorded maintenance needs which he responded to promptly.

Good

Is the service caring?

Our findings

People told us staff were kind and spoke about a number of staff who they felt were particularly kind and caring. Relatives also spoke positively about the way people were looked after. They told us "Staff are very gentle and see to [Person] that she is comfortable", "[Person] is well loved and looked after," "They maintain [Person's] dignity. When they give [Person] personal care, they make sure I wait outside. I am very happy" "I have 100% praise for Greenview [unit]," "Staff are kind. They are very decent staff," and "The warmth and caring feeling is coming back," and "They know when to change [Person]. Someone always tidies their room."

Care workers told us "I love giving people care, it is great," and "I try my hardest to give 110%, I take pride in providing care." When we asked people if they had formed positive relationships with staff they told us "Yes and no," and "Yes, with one or two but maybe in time with the younger ones." A person's relatives told us that "They [staff] know what [Person] likes. The staff are extremely kind and caring," "[Person] hasn't been eating well and a care worker said to me that they knew what [Person] likes and got [Person] ice cream which they enjoyed."

During our visit we saw some very positive engagement between staff and people. Staff were observed speaking with people in a kind, friendly and sensitive manner. We saw when talking with people they always tried to maintain eye contact and positioned themselves so that people could hear them. They also gave people time to respond. When staff hoisted people they told people what they were about to do and were careful when placing the sling prior to moving the person and were gentle when manoeuvring the hoist. However, we noticed some staff did not initiate much conversation with people and engaged with people only when carrying out tasks.

Staff understood what privacy and dignity meant in relation to supporting people with their care. Care workers told us "You close the door, explain to them that we are here to help. You ask them before you do anything. If they approve we will provide the care" and "You knock the door, ask for their consent, close curtains, and explain to them what you are doing. We give the care as they want it." A person told us "They're wonderful. They're kind. Wearing pads is the most humiliating thing and they do the changing so well and I never feel rushed." Care workers took their time when delivering care and did not rush the people when supporting them. Staff knocked on people's bedroom doors and respected people's choice when people chose to spend time by themselves. A person told us they preferred spending time with visitors in their bedroom rather than in the communal lounge. The operations manager told us they had plans to develop dignity champion roles for two members of staff to promote dignity within the service.

Staff had a good understanding of the importance of confidentiality and knew not to speak about people other than to staff and others involved in the person's care and treatment.

Personal preferences were included in people's care plans and prompts for maintaining people's independence. For example '[Person] is able to brush her hair independently with staff supervision. [Person] is able to choose what she wants to wear. [Person] likes to apply her own lipstick.' A care worker told us how

they supported people to make day to day choices; "When I support people with their personal care and dressing I bring a number of clothes in front of them so they can choose." During a meal time we observed a care worker bring two drinks which they placed in front of a person to allow them to choose. At lunch we observed another care worker offer a number of desserts for the person to taste and then make a choice.

People were supported to maintain the relationships they wanted to have with friends, family and others important to them. A person told us "I've been given some of the best friendships and made friendships here with all sorts of people." Relatives of people and records showed people had contact with family members. One relative told us "They [staff] always have time for you. I would recommend this place. You can come in anytime and they [staff] don't disturb you. They don't mind me bringing in food for [Person] and supporting them at lunchtime." Currently the service does not have wireless connection to the internet. The operations manager told us this would soon be connected so people will be able to access the internet and be able to contact family and friends electronically if they wished.

We were told by management staff that there was a keyworker system in place where people using the service were assigned a care worker whose role was to gain an understanding of the person's particular needs and to assist in co-ordinating and organising the service to meet those individual needs. However, no relatives of people we spoke with were aware of people's keyworkers. A person's relative said [Person] did have a keyworker but she left, I don't know who it is now." The operations manager told us that due to staff leaving and recent recruitment the keyworker role required review and development and steps would be taken to make the necessary improvements.

The service has a system where each day a person using the service is nominated 'resident of the day'. Those important to the person were informed when a person was to be the 'resident of the day'. They were invited to attend the service on that day and be involved in the review of the person's care plan. A person's relative told us about their experience of when a person was 'resident of the day' and confirmed they had been invited to review the person's care plan with staff. The activity co-ordinator planned a preferred activity with the 'resident of the day' and the chef provided them with a meal or food item of their particular choice.

People's care plans included information about people's religious and cultural needs and preferences. Staff and people using the service confirmed that people had the opportunity to meet with representatives of religions who regularly visited the home. Staff told us arrangements were made to ensure people's specific religious needs were met when requested. One person told us "I would like to go to church."

People's care plans included information and guidance for staff to follow about people's preferences and choices including times they liked going to bed and get up. A person using the service confirmed they chose when they wanted to go to bed. We found during the inspection that most people were in bed at 7.45 am which showed people had their choices respected and were not routinely got up early to meet the staffing needs of the service.

Care workers had a good understanding of equality and diversity, and told us about the importance of respecting people's individual beliefs and needs. Staff spoke a range of languages so able to communicate with most people where English was a second language. A person using the service told us "There are lots of languages (spoken) here."

On one unit we saw an example of multidisciplinary collaborative team work providing care and support for a person receiving palliative care. The care plan covered all aspects of care. There were clear instructions about the relatives and person's wishes in the event of the person's condition deteriorating and death. A Do Not Attempt Resuscitation [DNAR] form was appropriately completed and showed involvement from the

person's relative, staff and a doctor. A palliative nurse was involved and attended regularly to review the person and advised the staff. The GP had anticipatory medicine prescribed to manage the pain.

Care plans included some information about people's end of life care needs and wishes. A person's care plan stated '[Person] will be cared for in Woodland Hall. If their physical condition deteriorates GP to be informed and family will be contacted. [Person's] is for Cardio pulmonary Resuscitation [CPR].' However, care plans lacked detail about the care they would like to receive at the end of their lives and where they wanted to be cared for. There was little information that showed that discussion with family members and/or others important to people [when applicable] about people's end of life needs had taken place. The operations manager told us that end of life care practice would be developed by the service with liaison with a local hospice.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their end of life care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed with their participation and when applicable their family involvement, prior to them moving into the home. A person using the service told us they had been asked a range of questions about their needs and preferences before they were admitted to the service. A person's relative confirmed they had participated in the initial assessment of the person's needs. Local authorities who referred people to the service also provided assessment information which was important to management staff in identifying whether people's needs could be met by the service.

Care plans identified support people needed with their care and other aspects of their lives. When we asked people if they were aware of their care plan one person told us "Yes, I get shown it occasionally. It gets put right quarterly." Another person was not aware of their care plan. Care workers told us about how they gained an understanding of people's current needs. They told us they read people's care plans and gained up to date knowledge of people's needs and progress during comprehensive staff 'handover's' before each working shift. We listened to a 'handover' meeting. It was very thorough. Each person was discussed and their specific needs were communicated to staff by the nurse in charge. Care workers were fully involved in the hand over meeting and freely asked questions about people's care needs.

People's relatives told us that communication with people's care workers and permanent nursing staff was generally good, and they were kept informed of their relative's progress and of any changes in needs. They told us "[Person] only has to be slightly ill and they call me," "I was kept more informed about [Person] in the old days, the manager called me every week," "They always inform me if there is a doctor's appointment" and "[Person] wasn't eating and drinking, they made arrangements for [Person] to go to hospital. They are very responsive." We heard a nurse explain to a relative the person had not slept well so was tired today. The nurse informed the relative about the progress of the person's wound.

People's care plans included information about each person's health, support and care needs, what was important to them, their preferences, abilities and religious and cultural needs. Information was specific to people's preferences. For example a person's care plan included '[Person] likes to read her Daily Express newspaper. [Person] enjoys classical music and television and watching this in the privacy of her bedroom' and '[Person] likes to be greeted 'Good morning.'

Care plans included guidance for staff to follow to ensure people's needs were met. A person's care records included details about the steps the staff should follow to ensure their safe transfer. A care worker told us "When I want to transfer people safely, I follow the care plan". Another person's care plan stated '[Person] has a history of non-compliance with medicines'. The care plan detailed what staff needed to do to support the person to take their medicines including reading a note of encouragement from a relative. We also saw guidance for staff to follow to meet the needs of a person who sometimes challenged the service and had diabetes. A care worker told us that in accordance with a person's care plan staff made sure that a person with particular posture needs was assisted to sit in a chair that was comfortable and supported their back. Records showed that a person identified at risk of developing pressure ulcers received regular assistance with their personal care and was repositioned regularly by staff. There were no gaps in the recording of their

reposition changes. Wound records showed that wound dressings were changed regularly, topical cream applied as per prescriptions and clear photographs of the wounds were taken monthly with dates and size of the wound.

A care plan included guidance for staff to follow when a person had hallucinations, which included reassuring them and providing them with a specific drink. However, there was a lack of detail about what sort of hallucinations the person experienced. Also care plans did not include much information about people's background or people's preferred day routines so did not show person centred care or help staff to get to know people particularly those with dementia who might not be able to communicate their needs or speak about their past. Care plans were written in the third person not the first person so did not demonstrate they were directed by the person. Also, although there was some information in a person's mobility care plan about their mobility needs there was no specific care plan regarding the medical condition [Parkinson's Disease] and how its symptoms including mobility needs affected the person. Another person's care plan indicated they frequently challenged the service by 'swearing, hitting, punching and intending to bite'. Although there was some guidance about how staff should respond to this behaviour it was not detailed and included information such as 'use communication technique to calm [Person]' but there was no guidance describing what the communication technique was. This lack of person centred detail in the care plans and staff not having received training/learning in these subjects could indicate staff did not have the information they needed to provide people with the personalised care they needed.

The operations manager told us the format of people's care plans was in the process of being developed to be more person centred and detailed about people's needs.

Although people's care plans had been reviewed regularly by staff there was little indication from care records that people, and those important to them were regularly involved in care plan reviews. A person's relative told us "They [staff] contact me about reviewing [person's] care plan but I am not often available to do so." Another person's relative told us they had been provided with their relative's care plan to read. There was no evidence in an electronic care plan that relatives were involved with the care plan and regular care review meetings. The relative I spoke to told us "I haven't had any recent meeting about [Person's] care."

Also a person's relative told us about their experience of poor communication when a person was admitted to hospital and that lack of personal information about the person had led to them being provided with an item of food that did not meet the person's dietary needs. We discussed the importance of good communication about people's needs between services with the operations manager.

Fluid monitoring charts did not always have the signature of the nurse to confirm that they have set the target amount of fluid. In one chart the target amount had changed and the nurse could not give a clear rationale as to why it was changed and who changed it. At the daily meeting this omission had not been picked up.

An activity programme was displayed and people's activity preferences were recorded in their care plan. There was one activity co-ordinator employed by the service who organised some planned group activities including a sing a long and stretch and spent some one-to one time with people. However there were few opportunities for most people to take part in a range of activities, particularly those with complex needs and those who spent most of their time in their bedroom. People in the communal lounges spent a significant amount of time sleeping and we found few occasions when care workers initiated and supported people to do an activity or asked people what they wanted to do with their leisure time. A person told us "There are no activities."

Records showed some outings had taken place in 2016 and the chair of the Friends of Woodland Hall and the activity co-ordinator spoke of garden parties and entertainer events having taken place recently and of those that were planned. However, a person using the service told us they had not had the opportunity to go on an outing since their admission which they told us was disappointing as they had been informed prior to their admission that a range of activities and outings took place. Relatives told us they felt there was not enough for people to do. Comments included, "I have not seen a huge amount of activities," and "There is some occasional entertainment but generally little for people to do."

There was a sensory room and on the day of the visit it was not in use. A care worker told us the sensory room was "used by the activity coordinator on average weekly".

People's well-being and social inclusion were not always promoted as we found that people's social and leisure needs were not always met in a person centred way as some people did not have the opportunity to take part in social activities that met their needs and reflected their preferences.

The above identified care plan and social activity deficiencies in person centred care which were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy and procedure for responding to and managing complaints. When we asked people and relatives if they were aware of the complaints procedure there was mixed feedback; "No but I'd go to speak to anyone here," "No but I suppose I'd contact [provider] in Colchester as they're contractually responsible," and "I know what to do if I have a complaint although I have never needed to complain, I am very happy." A relative told us that they had raised a concern which was dealt with promptly by the operations manager.

Care workers knew they needed to take all complaints seriously and report them to the nursing and/or management staff. Complaints records showed that the recorded complaints had been acted upon appropriately and when there had been issues to do with people's care they had been investigated, reviewed and improvements to the person's care had been made. A person's relative told us "I have reported some issues and they are now resolved and have not happened again, I am happy now." However, two people's relatives told us their experience of the way their complaint had been managed had been unsatisfactory. A complaint was raised by a relative during the inspection about the care of a person using the service which management staff told us they would investigate fully.

Requires Improvement

Is the service well-led?

Our findings

Feedback from people using the service and their relatives as well as other information we gathered during the inspection showed that the service was not always well led. Comments from people were mixed. Most people we spoke with informed us that a few months ago they had not been at all positive about the service but felt that now the service was improving. Comments included "The new management seem to be focussing on the rota and admin stuff but they've got to learn about people," "There are times that I haven't been happy with the way things have been handled but things seem to be getting better," "I think they [the service] is getting back on track," "It's pretty good but it could be improved," "Having more staff and improving rotas would make it very good," "Morale is better now," and "It's not bad here but it could be better with more staff. There have been teething problems. There were two managers who didn't stay and everyone's doing their best."

The service had been run for many years by a registered manager, who left the service in early 2016. Following this there was a significant period of instability and inconsistency regarding the management of the service. That with significant environmental refurbishment, staff vacancies leading to a significant reliance upon agency staff, and other changes to the service were likely contributors to deterioration in the service and safeguarding issues.

At the time of the inspection the service management structure consisted of the operations manager who told us they were directing the management of the service until a manager was recruited. She was supported by a deputy manager who had recently been employed, a clinical lead manager and nursing staff. The regional director regularly visited the service and provided operational support to the operations manager and other management staff. During each shift there was one nurse in charge of one or two units. Their role was to administer care to the people as well as supervising the care being given by the care staff.

During this inspection, we found improvements had been made and others were in the process of being put in place. The number of agency staff had decreased and several permanent staff had been employed. However we found areas including; care plans, staff supervision and aspects of staff training and communication with people where improvements were needed.

Relatives also told us there were areas for improvement. They spoke of their frustration when trying to get through by telephone to a unit and/or particular member of staff they wished to speak with. Comments from relatives included "When I ring I don't know now who will answer, anyone picks it up, before I knew who would answer," "The phone is the real problem, I can never get through. The phone is not answered and when it is they keep me waiting before putting me through to the unit," and "You can never get through on the phone." Prior to the inspection we had on one occasion no one answered the phone when we rang the service. The operations manager told improvements were being made to the telephone system, cordless phones had been ordered and would be provided to each nurse on duty to improve communication.

The Friends of Woodland Hall had met regularly to discuss aspects of the service but not all relatives were in that group. People's relatives told us they had provided face to face feedback to management staff during

review meetings and other meetings but had not had the opportunity to participate in regular relatives meetings where they had the opportunity to raise issues, or been asked for their on-going feedback about the service in another way such as via a regular telephone call or email. We saw from records that meetings were scheduled for people who used the service and for relatives.

We saw that the provider had obtained feedback about the service from some people's relatives in 2016. However, an action plan had not been collated from the feedback which had highlighted areas for improvement including more organised activities outside the home, improving the variety of meals and communal facilities. The operations manager said she had plans to complete an action plan. Records showed feedback surveys were in the process of being distributed to people using the service.

People's relatives told us that day to day feedback about people using the service from permanent care workers and nursing staff was generally good but they were less positive about their experience of communication from management. They provided us with a range of examples where they felt communication from management staff had not been good. These included issues to do with significant changes to the service, response to complaints and on occasion's changes to do with the service provided to people.

The operations manager had a good understanding of the meaning and importance of quality checks of the service. She told us "Quality assurance checks are for learning, support and development." They told us that the provider's governance team carried out regular audits of the service, in which they evaluated the service in line with the CQC methodology of judging how the service was meeting the five key questions, is the service safe, effective, caring, responsive and well-led. There was a service improvement plan which included actions from a range of audits and checks including making care plans more person centred. The operations manager told us "I want to see the person in their care plan."

Staff carried out a range of checks to monitor the quality of the service. These included regular checks of care plans, record keeping, infection control, DoLS, health and safety medicines and training.

A mealtime audit had taken place in December 2016 which had checked whether people were offered choice, drinks, and staff engagement when supporting people with their meal. An action plan for making improvements had been put in place. Records showed a range of audits including living well with dementia, nutrition and choking risk, and activities had been planned to take place 2017.

Health and safety checks such as hot water temperature checks, thermostatic mixer valve servicing, legionella, cleanliness of the kitchen, environmental checks including window safety and fire safety had been carried out by service engineers and operational and maintenance staff. Visual checks of equipment such as bedrails and wheelchairs were also carried out. Action had been taken following these checks to resolve deficiencies such as faulty lights.

The Woodland Hall business continuity plan was completed in August 2016 and included an emergency plan for the service. Staff fire drills were carried out regularly.
The operations manager told us she and other management staff including the clinical lead manager had completed unannounced checks of the service during the night and at the weekend to observe people being supported by staff and to check the security of the service.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

Records and feedback from social care professionals indicated that the service was working closely with the host local authority in improving and developing the service. We saw an action plan had been completed in response to deficiencies in the service found during a visit that took place in December 2016 from the host local authority.

We heard and saw the management staff engage in a positive manner with people using the service. An on call system was in place so staff could access advice and support at any time. Staff we spoke with was clear about the lines of accountability. They knew about reporting any issues to do with the service to management staff.
Records showed the provider communicated regularly with the leadership via internal electronic communication 'I Communicate'. This provided information about policy changes, health and safety issues and other information to do with the provider and services.

Other communication systems were in place. Daily team briefings took place where people's needs, 'resident of the day', and some aspects of the service were discussed with staff including management, nursing staff, administration, and maintenance and domestic staff. Records showed that a range of matters to do with the service were discussed during these meetings.

Care workers spoke positively about management and told us; "The new manager [operations manager] who has come to help us is full of energy, she is on the go all the time. I hope she stays here for good because she is very kind and supportive," "Deputy manager is good and very helpful", [Deputy manager] is wonderful, approachable and hands on," "The management is very stable. We have [clinical lead] and [deputy manager] here now", "They [management] visit the unit and will give a hand to assist us", "If you have something to say, you can say it", "Manager is good. We had a few problems before but it is all settled now. [Clinical lead] explains everything" and "During the past few weeks there has been improvement in the place."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users must be appropriate, meet their needs and reflect their preferences. People lacked the opportunity to engage in a range of activities and care was not always person-centred. Regulation 9 [1] [a] [b] [c]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider did not receive training in all appropriate areas and supervision as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).