HC-One Oval Limited

Woodlands View Care Home

Inspection report

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Tel: 01438740230

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 11 December 2018 and was unannounced. At their last inspection on 23 April 2018, they were found to not be meeting the standards we inspected and were rated as requires improvement with well led rated as inadequate. This was because they had failed to take the action they assured us they would in relation to people's safety and welfare. At this inspection we found that they had made improvements in some areas however, they were not complying with all regulations and meeting fundamental standards. This was in relation to person centred care, promoting people's dignity and the management of the service.

Woodlands View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Woodlands View Care Home provides accommodation for up to 120 older people, this included people with nursing care needs and some people living with dementia. At the time of the inspection there were 102 people living there.

The service did not have a registered manager. An experienced manager had been managing the home for six months with the brief to improve and stabilise the service while the provider recruited a permanent manager. They did apply to register, however as a new permanent manager was employed they withdrew their application. The new manager explained that he was planning to apply to the Commission for registration. A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run.

The provider's quality assurance systems were not always used effectively and did not provide the management team with a complete overview of the quality and safety of the service. Systems had not identified shortfalls in relation to personalised care and ensuring people were treated with dignity and respect. People's care was not always fully carried out and not all needs were responded to. Care provided was not always person centred and people's care plans were not developed in a way that promoted this.

Staff supporting people knew how to recognise and report risk to people's wellbeing. However, not all staff were able to tell us how they would report concerns outside of the organisation.

People and staff were positive about the recently appointed manager and how the service was currently managed. Staff had received training updates in relation to fire procedures and oxygen management. Further development was needed for some staff with regard to evacuation techniques. Management reviewed accidents and incidents to reduce any reoccurrence.

People were supported by staff who were recruited safely. Feedback about staffing was not always positive.

Staff had received an induction, ongoing training and felt supported. Staff did not always work in accordance with their training and some updates were still needed.

Medicines were mainly managed safely and people received them promptly. However, there were some discrepancies that needed to be addressed. Infection control practice was adhered to by most staff but we did observe some not following their training in relation to this.

People enjoyed a variety of food which looked and tasted appetising but choices and preferences needed to be responded to by staff. There was appropriate access to health and social care professionals. Staff had an understanding of the Mental Capacity Act 2005 and adhered to its principles.

People told us that staff were kind and caring. However, communication, mainly on one unit, needed improvement. Privacy and dignity was not always promoted. Confidentially was promoted and visitors were made welcome.

The activities plan would benefit from further development in particular to prevent social isolation for people in their rooms but people who were able to participate in communal areas were happy with what was offered.

People were supported at the end of their life with compassion and care and complaints were responded to and people's views were sought.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were supported by staff who knew how to recognise and report any risks to people's wellbeing. However, not all staff were able to tell us how they would report outside of the organisation.

Staff had received training updates in relation to fire procedures and oxygen management. However, further development was needed for some staff in regards to evacuation techniques.

Accidents and incidents were reviewed to reduce a reoccurrence.

People were supported by staff who were recruited safely. However, feedback about staffing was not always positive.

Medicines were mainly managed safely and people received them promptly. However, there were some discrepancies that needed to be addressed.

Infection control practice was adhered to by most but we did observe some staff not following their training in relation to this.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who received an induction, training and felt supported. However, this training was not always up to date or put into practice by staff.

People enjoyed a variety of food which looked and tasted appetising. However, choices and preferences needed to be considered at all mealtimes.

Staff had an understanding of the Mental Capacity Act 2005 and adhered to its principles.

There was appropriate access to health and social care professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that staff were kind and caring. However, communication needed improvement.

Privacy and dignity was not always promoted.

Confidentially was promoted.

Visitors were made welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not always fully completed and not always person centred.

People's care plans did not always include information to enable staff to support people in a person-centred way.

The activities plan would benefit from further development but people were happy with what was offered.

People were supported at the end of their life with compassion and care.

Complaints were responded to and people's views were sought.

Is the service well-led?

Requires Improvement

The service was not well led.

This was the third inspection that the service had been rated overall requires improvement.

The quality assurance systems were being used regularly. However, they had not yet identified or therefore addressed the issues found in relation to person centred care and promoting people's dignity.

People and staff were positive about the recently appointed manager.

Woodlands View Care Home

Detailed findings

Background to this inspection

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

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

The inspection was carried out on 11 December 2018 and was unannounced and carried out by two inspectors, an inspection manager and two experts by experience. An expert by experience is a person who had experience of using this type of service or has a family member who has used this type of service.

During the inspection we spoke with 15 people who used the service, four relatives and visitors, 16 staff members, the regional manager, the interim manager, the quality director and the recently appointed manager. We received information from service commissioners and health and social care professionals. We viewed information relating to nine people's care and support. We also reviewed records relating to the management of the service.

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 due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 23 April 2018 we found that people's safety was not promoted. This was regarding fire safety and oxygen management, medicines management and staff not working in accordance with risk assessments. The provider sent us an action plan telling us how they would make the required improvements.

At this inspection we found that there were improvements regarding staff knowledge relating to fire and oxygen safety, medicines management and risk assessments and management for people. However, we found improvement was still needed in the management of infection prevention, some elements of medicines management and staff knowledge about individual evacuation plans.

People told us they felt safe living at the service. One person said, "I do feel safe because I have no worries here." Another person said, "I have a nice little room and feel perfectly safe because there is a good atmosphere" A third person said, "I feel very safe because I am so well looked after here. In fact, I feel so safe I sleep through the night which is very good." Relatives also told us that they felt people were safe. One relative said, "I think [person] is safe definitely because everything is in place to take care of them."

Staff understood how to keep people safe. This included how to recognise and report abuse within the organisation. Staff received training and information was displayed around the home. However, some staff were not sure how to report to external agencies, such as the local authority safeguarding team, if the need arose.

Where potential risks to people's health, well-being or safety were found, staff assessed and reviewed them regularly. Risk assessments were in place for areas including fire safety, oxygen management, falls, skin integrity, the use of equipment and the use of bedrails. The assessments were detailed and included controls put in place to mitigate risk to people's health and safety. However, we did note that one person did not have protective covers on their bedrails despite their risk assessment stating they were required to protect them from injury.

Staff were familiar with people's individual risks and were able to describe the type of support people needed. Staff told us they were informed in handover sessions and meetings if peoples` needs and risks changed. One person liked to smoke 8-10 cigarettes per day. The risk assessment indicated that the person asked staff to support them to go outside for a cigarette and that staff put a 'smoking apron' on the person to help protect them from accidental burns.

All accidents and incidents were reviewed to ensure all remedial actions had been taken and the risk of a further incident was reduced. The information was collated on a spreadsheet to show any themes and trends. Lessons to be learnt from events were shared with staff appropriately.

There were regular checks of fire safety equipment and fire drills were completed. Staff said they had several fire evacuation drills. Staff knew how to respond in the event of a fire and each person had a 'Personal

Emergency Evacuation Plan' (PEEPS). Staff were aware of these. However, some staff needed more prompting about how they would physically transfer someone in an emergency. For example, if they needed to use a hoist as some PEEPS were not clear. Staff told us how they thought they should do it but did not recall it had been covered in training. We discussed this with a member of the management team who told us they were disappointed with this as they along with other managers had spent a significant amount of time teaching staff. This was an area that required improvement to ensure it was embedded.

The management team ensured that other checks, such as electrical or health and safety assessments, were also completed to help maintain people's safety.

Oxygen cylinders were stored safely and secure in the clinical room. Where oxygen was in use there was a safety warning sign in place and staff were clear about the dangers of using oil based creams and moisturisers in the vicinity of oxygen cylinders. There was also a risk assessment on the wall in the clinical room.
People told us that they received their medicines on time and as they needed it. Medicines were stored safely and administered by trained staff. There were still areas in the management of medicines that needed improvement. We checked 12 boxed medicines and found that most stocks were correct with the records. However, two of those checked were not correct. We found handwritten entries were countersigned and allergies were recorded in accordance with good practice. We saw that there were care plans in place for medicines prescribed on an as needed basis so that staff would be able ot identify when and how the person needed the medicines, however, these were not in place for all as needed medicines. This was an area that required improvement.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. We saw that staff used gloves and aprons and the home smelt clean and fresh on the day of our inspection. However, we observed poor practice despite staff having received training in relation to infection control. This was an area that required improvement.

People and their relatives gave mixed views about staffing levels. One person said, "I have to wait such a long time for staff. Sometimes 10-15 minutes. But if I need the toilet it's too long. Staffs say well you have got a pad on but it's not the same, is it? They say there is only two staff on the floor." Another person asked us to open their curtains and told us, "I like to have them open first thing when I'm awake. I haven't been awake too long, just waiting for staff. It's always difficult for them, so many of us who need help. Especially weekends. It varies with staff. They are usually about but weekends less so." A relative told us, "I think there is enough staff and they are very good. I can't fault anyone even though they are rushed off their feet."

Throughout the course of the inspection we noted that there was a calm atmosphere and that most people received their care and support when they needed it and wanted it. However, we did also note that some morning care was being delivered very near to lunchtime and we were unable to determine if this was by choice or because staff were unable to support them sooner.

Staff told us that there wasn't always enough staff but told us this had improved recently. One staff member said, "Staffing levels have improved, this is down to the new manager. He has only been here for a few weeks but the differences are incredible." Another staff member told us, "It is much better now. It was really bad after the last inspection, they blamed us for it all. We were short staffed daily, it was so hard." Staff told us there were times when there was a high number of agency staff on duty and this was due to having staff vacancies. □

There had been an ongoing recruitment process and the management team told us that they had needed a

higher number of agency in recent months but had now been successful in recruiting new staff and some staff who worked there previously had returned. One staff member told us, "Since the new manager we have enough staff. The rota is shared with us now so we know who is supposed to be on duty." Staff told us that this meant that they were able to manage staffing on units much more effectively.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable for working in a care setting. They ensured all required documentation was received before a member of staff began employment. This included written references and criminal record checks.

Requires Improvement

Is the service effective?

Our findings

Training was provided to enable staff to gain the skills needed to care for people safely. This included training such as moving and handling and safeguarding, infection control and fire safety. Staff told us training was mainly delivered by e-learning with the exception of moving and handling which was a practical training. We saw that the percentage of staff undertaking training had increased each month since the last inspection. For example, in August training rates were at 48% but on the day of inspection this had reached 84%.

People gave mixed views about if they felt staff were skilled and knowledgeable to support people living at the home. One person said, "(Staff are) well trained. They seem to know what they're doing." However, another person said, "Do staff know what they're doing? They're alright for taking to the toilet but I'm not sure about dementia (training)." We also observed staff not always working in accordance with best practice in regard to dementia care, behaviour that may challenge and communication. We noted that training in relation to supporting people living with dementia and person-centred care was not completed by the whole staff team and further updates were due. This was an area that requires improvement.

Staff told us that they felt much more supported and could approach the new manager for more support at any time. One staff member said, "New manager makes us feel much better, he is so supportive." We saw that there were records of one to one supervision sessions for staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management team showed an understanding of when it was necessary to apply for authorisation to deprive somebody of their liberty to keep them safe. They had awareness of what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. The appropriate applications and documentation was in place in most cases. However, we did find that one person had a note that their medicines could be given covertly and there was no supporting capacity assessment or best interest decision for this. We spoke with a nurse who told us that this person did not need their medicines covertly, they just needed time and an explanation. They said that this note had been added at the social worker's advice but the process had not been needed. They told us that the note on the medicines record would be removed. We also found that staff were also knowledgeable about the MCA which indicated that they were equipped to work in such a way to ensure people's rights were respected.

Staff understood that people could make some decisions about their day to day life even if they had been

assessed as lacking capacity. Staff offered people choices about what they wanted to eat, what activities they wanted to join in with and how they wanted to spend their day. Staff acknowledged that this did not mean they could not make any decisions and how they wanted to spend their day, what to eat or wear. One person told us, "They always knock before they come in my room and give me choice. Like the two plates to choose dinner."

The home was designed in a way so that people could move around easily, whether this was independently or with the use of mobility aids. The environment had been decorated in a way that stimulated people's senses and gave people things to look at. Equipment was well situated in bedrooms and bathrooms to enable people to be independent where possible. There were large lounges with ample seating for everyone and a large dining room so people could enjoy a meal together if they wished. Bedrooms were personalised. There was an accessible garden that people could access. The environment had been nicely decorated to reflect the Christmas festivities.

People were supported to enjoy a variety of foods and dietary needs were known by staff. However, we were not clear that all preferences, likes and dislikes were noted. For example, one person told us that they didn't like mashed potato, but every day they had mashed potato. Staff had not noticed that every day the person left it on their plate and had not offered an alternative. However, one person said, "On the whole the food is good but not very imaginative but there's enough. Limited choice but staff are excellent finding a favourite or knowing what upsets you. On the whole staff know me. They know I don't like sponge pudding so they just bring me the custard." We heard a staff member speaking with someone saying, "I'll get you a milky coffee the way you like it, shall I?" which showed that they knew what the person enjoyed. Staff being aware of preferences, choices and offering alternatives was an area that requires improvement.

People and their relatives told us they food was good. One person told us, "Excellent. Hot, fresh, plenty of it. There's a choice." Another person said, "The food is excellent. I can say without fear or favour, it's excellent here." A relative said, "[Person] is usually a good eater and the food looks fine. I have to persuade them sometimes. Staff will feed [person] if I can't manage. They always tell me what they've had for breakfast." However, one person told us that they only enjoyed cups of tea and in the mornings, prior to breakfast, only water or juice was delivered. They had to wait until 9am for a hot drink. We noted when we arrived at 8am, no one had a hot drink or evidence of a hot drink prior to breakfast. This is an area that requires improvement.

We saw positive interactions during lunch and the food looked and smelt appetising. We sampled the food and found that it was tasty and hot. Staff were talking about lunch, including people, who were being assisted to eat. Staff remained sitting at the table next to people they assisted. Observations showed that staff were respectful and caring. However, we did note one staff member standing over a person while assisting them and then only sitting down next to them when we came into the room.

Assessments had been undertaken to identify if people were at risk from of not eating or drinking enough and if they were at risk of choking. We saw staff supporting people appropriately. People's intake and menu choices were recorded on daily care notes. Staff were aware of the reason for any weight loss. People had their weights monitored and if they lost weight they were referred to their GP or dietician for support. We saw that in some cases there was no fluid target set for people when staff were monitoring this. However, the amount of fluid people drank was kept as a running total and nurses were checking monitoring charts as part of their daily routine to ensure people were drinking enough or remedial action could be taken if they were not. This was discussed at handover meetings.

People had access to health care and social care professionals when necessary. For example, GP, speech

and language team (SALT) and a chiropodist. Feedback about the responsiveness of staff varied. A relative told us, "(Person) had a fall 10 days ago. Seven days later we had to ask the home to get a nurse as (the head injury) was oozing. Why wasn't it noticed and cleaned? Since then it's been cleaned and looked after." This meant that staff had not been sufficiently monitoring this wound and responding appropriately. One person who used the service told us they had a fall and received the appropriate medical support. They said, "The doctor looked to make sure all was well." One unit was used as a rehabilitation unit and had health professionals on the site daily. This included occupational therapists (OT) and physiotherapists. There were regular GP visits. A relative said, "The OT is very good." People and their relatives told us staff supported them with appointments. A relative said, "[Person] had to go for an X-ray and they organised it all for me."

Requires Improvement

Is the service caring?

Our findings

Staff were not always responsive to people's needs in a respectful and dignified way. We saw a person come out of the toilet with a wet patch on their trousers. Staff stood next to us but did not notice or react to offer this person assistance.

People gave mixed views on how staff respected their dignity. One person said, "I prefer staff I know, they are lovely because we are more like family. It works well." Another person said, "I wet the bed once last week, twice this, but staff didn't make me feel bad – just said don't worry, that's what we're here for. Just sorted it, very respectful and friendly, well looked after. One male carer did leave me 25 minutes when I said my pad was wet. He walked away, he didn't check like the other staff. I think they check the colour to see if it needs changing. That was a bit weird." A third person said, "The staff are always very good and always respectful. They ask me if they can do anything and if there are any little changes they need to know."

Staff did not always promote people's independence. One person told us, "I can manage a bit better on the toilet now though on my own. Just happened to see a higher toilet when the door was open so I asked if I could use that one and it's much better for me. I can do it myself which make me feel more human again." The use of a higher toilet seat promoted this person's independence but staff had not considered it.

Staff, particularly on one unit, did not follow best practice when communicating and supporting people living with dementia. Examples include staff not speaking to people when they walked into their room and staff not engaging in conversation with people when delivering care or helping them to move with a hoist. We observed a person calling out; they did not have access to a call bell. A staff member walked past their room and said, "They'll be with you in a minute", they did not stop to see if the person needed help. Another staff member's interactions were not engaging, they did not smile or use positive body language. One person was getting muddled and kept asking questions during lunch. The staff member answered but in a flat tone and did not engage or give explanations that the person could understand. The person had made a mess trying to eat their cake with their fingers, the staff member said, "Use your fork" but did not give reassurance. Body language, facial expression and tone of voice are key ways of communicating with people who may struggle to interpret speech due to an impairment such as hearing, sight or when living with dementia.

Therefore, due to people not consistently being treated with dignity and respect this was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us staff were mostly kind and caring. One person said, "They are caring and yes always kind." However, another person said, "There are one or two exceptions. Some hefty characters around. I've not seen anyone being unkind." Relatives told us that staff were kind and friendly. A third person said, "The staff are lovely always speak nicely to me."

People told us that they felt staff knew them well. One person said, "Staff know me a darn sight better than I know them." However, another person said, "I think if I had to complain it would be about changing the staff

about. It makes the staff unhappy and us residents. You get to know the staff like family and they get to know us. Then all change but it always works best when we know each other well. Why change?"

Some staff were calm and friendly with people and we saw them interact with people in a warm and caring way. One person who had only been at the home a short while told us, "I've been for short stays before. I went to another home too, but this is better. Just the staff I think makes it better. They are very good and caring." A relative told us, "Can't fault the staff and they are always respectful – even when [person's] door is open they still knock and ask before doing anything with them. Sometimes [person] gets confused and asks to go home but the staff explain this is home and chat to [person] until [they are] settled again. Even past staff come back to visit [person]."

People and their relative's involvement in their care planning and review was inconsistent. One person said, "I haven't seen (a care plan)." A relative told us, "There's no care plan as far as I know. A book was sent about the home." This was a service user guide given out with information about the home when people move in. Where relatives were involved they had power of attorney, the legal authority to make decisions on a person's behalf, about their care.

People's records were stored in locked offices to promote confidentiality for people who used the service. Bedroom doors were closed when care was delivered and in most cases staff knocked and spoke with people when they went into their rooms.

Relatives and friends of people who used the service were encouraged to visit at any time and felt welcome. One relative said, "They're all very pleasant to me which is good." Staff knew people's families and friends and chatted with them or about them with people and there was a regular flow of visitors in the home.

Requires Improvement

Is the service responsive?

Our findings

Staff were not always proactive in recognising things that may benefit people. A person was noted to break their glasses due to their complex needs. As a result, the family were at a loss how to help with this so agreed with staff that the person would not wear them anymore. This person was living with dementia, displayed behaviour that challenged and needed hearing aids Staff had not explored the possibility of assisting the person to have flexible glasses made for them to help with communication especially as they already found this challenging.

Several people were without socks or stockings. There was no information in their plans to state if this was preference and many were unable to speak with us due to their complex needs. It was a cold day and although the houses were warm inside, no consideration had been given to if people were dressed appropriately for the cold weather. One person also showed us their nails which were very long and unkempt. They said they had not asked anyone to do them but staff had not noticed that they needed to be cleaned and trimmed.

We saw that pre-printed handover sheets helped to ensure important information was highlighted. These included people's names, room number, primary health and support needs and nutrition or hydration support needed. In some cases, people's care plans included the needed information. However, many lacked specifics and detail to enable staff to provide a person-centred approach. Some personal information like the gender of staff people preferred to deliver their personal care was recorded.

People or their relatives where appropriate completed a life history document which gave personal information about people`s past lives, hobbies and interest. Many plans did not include times they liked to receive care, toiletries preferred or clothing types. Some plans, for example in relation to challenging behaviour were not evident at all. We noted that one person exhibited this type of behaviour as staff failed to approach them in a way that alleviated their anxiety therefore causing them unnecessary stress.

Another person's oral care plan was basic, even though they were nil by mouth. There was no plan in place to ensure proper oral hygiene such as swabbing the person's mouth or cleaning around it as needed. We saw that this person had congealed mucus inside their mouth which was unpleasant for them and increased the risk of sores or infection. We also found that this person required four hourly repositioning. However, although it was noted in their daily notes stating 'repositioned', there was no structure to this which meant repositioning may not have been done effectively to relieve pressure and therefore increasing the risk of the person developing a pressure ulcer. All bed rails checks completed in the past six weeks noted that this person was on their back. We noted other examples such as someone's belt done up but not into any holes which demonstrated a lack of care an meant that the person's trousers may fall down. We also saw a person be transferred into a chair using a hoist. The staff pulled the sling from underneath their legs, even though they were noted as having fragile skin. This increased the risk of an injury to the person's legs.

We spoke with one person who was anxious about not knowing where their mobile phone was. We asked staff and two staff members said that they didn't think they had a phone. When we visited the person later in

the day, a family member was visiting who had taken the phone home to charge it. Staff were not aware of the person having a phone and were therefore unable to provide them with any reassurance leaving the person in an anxious state for a longer period.

Feedback we had received prior to the inspection supported some of our observations on the day. This feedback was in relation to lacking person centred care and staff not paying attention to details. This was also our findings on the day of inspection.

Therefore, due to care plans needing to be more developed and the need for care to be provided in a more person-centred way, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service provided nursing care and supported people at the end of lives. Support plans were in place to help ensure staff had the information they needed to care for people appropriately. This care was led by the nursing staff and supported by care staff.

Some people experienced more stimulation and social interaction than others. This was partly to do with people's choices and partly to do with some people being less able to participate. People in the lounges were engaged in the activities on offer. We noted that some people stayed in their rooms through choice or health needs. We saw that the activities organisers did go to people who were cared for in bed but they did spend long periods of time without activities. One person said, "I do a lot of singing. We manage to get a paper every morning." Another person said, "I'm anti-social. That's me. Like my own company and have enough do with my radio. Staff have tried all tricks to get me to come into the lounge. They are trying already for Christmas Day lunch. We'll see." However, a third person told us, "They're always going by but rarely stopping to say 'how are you old boy?' Their priorities are different to mine. I'm lonely at times. There isn't a great deal to do." Another person said, "We just wait around and hope for the best."

People told us that there were quizzes and crafts available but many people told us they enjoyed their own company. One person said, "I'm quite happy just laying here (in bed). I used to knit and read a lot but I haven't been able to." Another person said, "We play games; I like Pretend Netball and Bowls. I went over to the see the school choir this morning and it was very nice with all the nativity songs." We saw the activity organiser spending time with people and repeating the music and singing activity which had been on offer in the lounge. Each unit had their own designated activity organiser. However, we observed very little contact for people who were in their bedrooms throughout the day of inspection and this was an area that required improvement to ensure they did not experience social isolation.

Complaints and concerns raised had been fully investigated. Letters of apology were sent to the complainants. This was shared with the staff team to help ensure this did not reoccur. People and their relatives told us that they knew how to raise concerns. One person said, "I would talk to anybody." One relative said, "I just speak to these people (indicating staff in the lounge) and they do it for me." We saw that the complaints process was displayed in communal areas. A relative said, "Communication between staff and family is very good. They are in contact with the family."

People, relatives and professionals were asked for their views through a survey. Feedback on this was mainly positive.

Resident and relative meetings were held and scheduled for the year. There were surveys issued to people and an electronic tablet in reception to encourage people to share their feedback.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 23 April 2018 we rated well led as inadequate. This was because they had failed to take the action they assured us they would to promote people's safety and welfare. We took enforcement action to force immediate improvement. At this inspection we found that action had been taken to improve people's safety. However, we found action was insufficient to fully address concerns and further improvement was needed. Whilst quality assurance systems had improved they were still not robust enough to independently identify and address shortfalls as part of driving continuous improvement and embedding them in practice. This is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Quality assurance systems that were in place were used more consistently. There was a working home improvement plan in place and areas identified for improvement were added to the plan with an action and time scale for implementation. For example, a recent care plan audit found there were no plans in place to guide staff on the management of a person's epilepsy or diabetes. This was immediately actioned and we saw that plans had been developed in these areas.

The temporary manager had taken steps to work in partnership with other agencies. Management from the home, senior management from the pharmacy, representatives from the GP surgery and the clinical commissioning group (CCG) had met to build relationships and improve ways of working for the benefit and safety of people.

The manager kept a clinical overview of all weight management, infections and pressure care requirements. There were daily meetings and unit walk rounds to help share information and ensure all necessary actions had been completed. We noted that the daily walk rounds had identified areas such as the sluice rooms being unlocked and checked medicines management and care plan content. The clinical service manager agreed that there was some work to still do with care plans.
However, of the daily walk round records reviewed, none had identified any of the issues we found on inspection in relation to person centred care and promoting people's dignity. This questioned how robust the process is. We acknowledged that the manager had only been in post a short while and was getting to know people and what was normal for them. However, members of the management team more experienced in the home had not addressed these issues either. We did note that these checks had identified some issues relating to communication between staff and people and this was planned to be addressed at meetings.

There was a regular regional manager and quality director visit and they carried out audits to ensure the home was working well. These reviewed all areas of the home. We saw that actions arising from these visits were shared with the home manager. Actions were added to the home improvement plan. We noted that actions were completed at the next month's visit. For example, updates they had identified in care plans, medicines management or issues relating to the environment. Shortfalls found at previous inspections and those found by the local authority were also added to the improvement plan to help the management team

track progress and take the required action. However, these visits had not identified or therefore addressed the issues we found on inspection in relation to person centred care and promoting people's dignity.

The home had been managed on a temporary basis by an experienced manager who had been charged with making the needed changes at the home. They had worked to address safety issues found at previous inspections, staffing and training concerns and to provide more robust oversight of the home, embed good practice and provide guidance to staff. We found that they had made improvements in the areas they were tasked with and had now handed the home over to a new manager following a handover period.

People and their relatives were positive about the new manager, changes to management and the service. The new manager had been in post four weeks, with two of these weeks being part of their induction. One person said, "He's a nice man, comes every day and speaks. I can talk to him." Another person told us, "The people in charge seem to have changed a lot recently."

The manager was visible on the units. People and staff told us that this was normal. One staff member said, "[New manager] is so supportive, he visits each unit daily in the morning to check that we are OK and have everything we need."

Staff also told us that the management team were approachable and available. One staff member said, "[New manager] is amazing, we feel as though we want to come to work now." Another staff member said, "We love that he is not a 9-5 guy. It means a lot that [manager] is so approachable." We found that training statistics had improved and management approach had boosted staff morale.

The management team worked with the local authority to ensure they were working in accordance with people's needs and obligations with the commissioning contract. A recent monitoring visit form the local authority had been carried out and the provider was working with them to address any shortfalls identified.

There were plans to start regular team meetings with the most recent being held by the new manager. There was an introduction from home manager, they discussed a way forward with the home. The meeting agreed a plan for monthly team meetings to be reinstated with staff to drive the agenda. It was agreed that rotas were returned to the units for better control for staff managing the shifts. The meeting notes recorded that staff morale remains low but there has been a recent marked improvement. On the day of the inspection we noted that there had been an improvement in staff morale and those spoken with were much more positive.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

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 provider had not ensured that care was delivered in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people were consistently treated with dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service has been rated as requires improvement for the past four inspections and the provider failed to identify and address the areas of breach found at this inspection.