HC-One Oval Limited

Woodlands View Care Home

Inspection report

Magpie Crescent
Stevenage
Hertfordshire
SG2 9RZ

Tel: 01438740230

Date of inspection visit:
24 April 2018

Date of publication:
15 June 2018

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?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 24 April 2018 and was unannounced. At their last inspection on 3 January 2018, they were found to not be meeting the standards we inspected. This was in relation to person centred care, governance systems and managing people's safety. Following the inspection we issued the provider with a warning notice stating that they must comply with the regulations by 1 March 2018. They sent us an action plan stating how they would make the required improvements. At this inspection we found that although they had made some improvements there were some areas that required improvement and continued to not meet all the standards. This was in relation to people's safety and governance systems. We also found that areas such as promoting people's dignity required improvement.

On 3 February 2018 there was a major incident at the home. An investigation into the incident remains on going and the Commission continues to work with other agencies in regards to this.

Woodlands View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 120 people in four adapted buildings. At the time of the inspection there were 87 people living there. One unit remained closed following an incident on 3 February 2018.

The service had a manager who was registered with the Care Quality Commission (CQC). 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. However, people and relatives we spoke with did not know the registered manager.

There were systems in place to monitor the quality of the home. However, they had not identified the areas of concern or those that required improvement that we found on inspection or fully addressed the shortfalls from the previous inspection.

Staff knowledge and procedures in relation to fire safety and oxygen management needed to be addressed. Medicines records were not always accurate and the process for reordering of stock was not robust. People had their risk assessed in most cases; however, staff did not always follow the assessments. Staff knew how to recognise and report any risks to people's safety internally. However, staff were not always clear how to report to external agencies.

There were additional numbers of staff on duty and this would reduce when the fourth unit reopened. There was a recruitment process in place. However, they needed to ensure employment gaps were consistently explored and references were always verified. Staff were due updates to their training and had not received any updates since the incident in February. However, staff supervision had recently commenced.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005; however, this was not consistent. Staff asked people for their consent before supporting them.

People told us that they enjoyed the food and their health needs were met.

People were addressed by staff with respect and kindness. However, people's dignity was not always promoted. People needed to be consistently involved in the planning of their care and consideration was needed to support people with their relationships. Confidentiality, in regards to records, was not always promoted.

People received care which they told us met their needs but gave mixed views about the activities provided. Care plans were in the process of being changed to the provider's new format and those changed included appropriate information to help staff meet people's needs. There was a complaint's process and we found that the response to complaints had been improved. Staff were more positive about the running of the home and the provider was providing regular support.

In response to our findings at this inspection we issued an urgent notice instructing the provider that they needed to take immediate action to address the concerns. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knowledge and procedures in relation to fire safety and oxygen management needed to be addressed.

Medicines records were not always accurate and the process for reordering of stock was not robust.

There were additional numbers of staff on duty and this would reduce when the fourth unit reopened.

People had their risk assessed in most cases; however, staff did not always follow the assessments.

Staff knew how to recognise and report any risks to people's safety internally. However, staff were not always clear how to report to external agencies.

There was a recruitment process in place. However, they needed to ensure employment gaps were consistently explored and references were always verified.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who were due updates to their training and had not received any updates since the incident in February.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005, however, this was not consistent.

People told us that they enjoyed the food.

People's health needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always promoted.

People needed to be involved in the planning of their care.

Consideration was needed to support people with their relationships.

Confidentiality was not always promoted.

People were addressed by staff with respect and kindness.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received care which they told us met their needs. However felt that staff were unable to spend time with them.

People gave mixed views about the activities provided.

Care plans were in the process of being changed to the provider's new format and those changed included appropriate information to help staff meet people's needs.

There was a complaint's process and we found that the response to complaints had been improved.

Is the service well-led?

Inadequate

The service was not well led.

There were systems in place to monitor the quality of the home. However, they had not identified the areas of concern or those that required improvement that we found on inspection or fully addressed the shortfalls from the previous inspection.

People and relatives did not know the registered manager.

Staff were more positive about the running of the home.

The provider was providing regular support to the management team.

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 action plan which the provider had sent us following the last inspection setting out how they would address the shortfalls.

The inspection was unannounced and carried out by three inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 13 people who used the service, six relatives, seven staff members, the deputy manager, the regional manager and the registered 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 3 January 2018 we found that they were not meeting the standards in relation to promoting people's safety and welfare. At this inspection we found that there were improvements made in these areas however, some issues remained. This was mainly in relation to fire evacuation awareness, drills, oxygen storage and knowledge, records and processes relating to people's medicines.

On 3 February 2018 there had been a major incident at the home in the form of a fire involving an oxygen cylinder which resulted in the deaths of a person who lived at the home and their visitor. Following the incident, the provider gave us assurances about how they had ensured safe practice was adhered to and staff had the appropriate knowledge and updates to ensure all staff had the skills in the event of an emergency. However we found that staff knowledge regarding fire procedures and oxygen management were not consistent.

None of the staff we talked to were able to tell us what the provider's policy said about fire procedures and staff gave different views and accounts on how they would respond in the event of fire. All the staff told us they had fire training when they started working at the home, however they confirmed they had no refresher training in the last year and no update since HC-One Oval Limited took over the home.

Staff were not aware that people had Personal Emergency Evacuation procedures (PEEPS) in place. One staff member told us, "I never saw these; I don't know what is in it." Another staff member said, "I never had a fire drill to practice evacuation since I work here (over a year). I don't know the fire or evacuation policy. I hope it's a full evacuation." A third member of staff said, "I know we have to go out and take anybody who is able to walk but leave the ones in bed safe and close the doors."

People`s PEEP's did not consistently provide sufficient information for staff to know how to evacuate people who were bed or chair bound or if people were able to walk independently were they likely to respond to the alarm. PEEP's instructed staff to use an emergency rescue and evacuation mat (a flexible stretcher for the safe movement of people with disabilities), however staff did not know where to find these or that they were supposed to use them. One staff member said, "In my training we were showed the rescue mat but I never seen one here and I don't know if it would be safe to use." Another staff member said, "I would hoist people if it would be safe to do so in their wheelchair. I never heard about the mat." Other staff said they would drag people on sheets or just leave people safely in their beds with fire doors closed and evacuate the ones who could walk. They told us they would rely on the responsible person to take charge of an evacuation, however we found that the unit manager in charge on the day of the inspection was not confident in describing how they would coordinate an evacuation. They told us they would try and evacuate people as quickly as possible and as many people as possible in stages moving them behind fire doors, however they said they would not aim to evacuate the building fully. They said, "Depends how mobile residents are. Who is able we will try and evacuate, as many as possible but not full evacuation."

Evidence of fire drills were not seen on the units and three staff told us they had experienced none since they

started working at the home. Three other staff said that they gathered outside the building when they heard the alarm but could not tell us what else happened when they had fire drills.

Staff were not knowledgeable about how to ensure safety for people who used oxygen. We asked staff if they had been provided with training and information about this and they said they had not. They told us they had no communication or updates from management regarding oxygen management or fire procedures since the incident in February 2018. One staff member said, "I didn't receive any memos or communication about oxygen or fire since the incident." We asked staff if they were aware that they should not use alcohol gels or any paraffin based creams on people who used oxygen. However they all told us they were not aware of this. One staff member said, "I know that the oxygen should be away from any heat source but I didn't know about the gel or creams. The nurses are dealing with the oxygen so I don't know what they do." Another staff member said, "We had no updates or I had none since the incident. I don't know if others did but I didn't know about the creams or the gel. We don't have cylinders locked to walls."

The provider's oxygen policy, and risk assessments in place, stated that oxygen cylinders were to be secured to the wall when not in use. This was in accordance with published guidance from BOC and HSE. We checked the storage of oxygen cylinders in two medicine rooms and found that all cylinders were free standing and not secured to the wall. Daily checks were recorded as being completed and these had not identified that the cylinders were not stored in accordance with the policy and risk assessments. Therefore the service had failed to ensure the safe storage of oxygen and therefore placed people at increased risk of harm.

At the last inspection we found that medicines were not managed safely. At this inspection, we found that there were control measures in place to help reduce the risk of an error or discrepancies. We found in all but one medicine we counted that the quantities were accurate. However, we found that the daily check records were not used consistently for all boxed medicines and two we reviewed, were not accurate to the quantity in stock. In addition we found that systems did not allow for robust reordering of stock when it was running low. For example, one person had only one tablet left. We asked if this had been ordered and we were told it had been. However there was no mechanism in place to ensure staff chased this to ensure the new box of medicine was available when the current one finished. This was an issue previously and we had also been made aware of additional instances of people running out of medicines in between our inspection visits. This meant that people were at risk of not receiving their medicines when they needed them.

Therefore, due to the risk to people's safety and welfare in regards to fire and oxygen safety and the continued issues with medicines, this was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they felt safe at the home. One person said, "I feel very safe here." A relative said, "I have never heard a carer raising a voice, they are very calm even when some residents are really difficult." Staff were not always knowledgeable about safeguarding procedures and were not confident in how they would report their concerns externally to local safeguarding authorities. They told us they would report to their line managers. One staff member said, "I don't really know any external authorities to report to, I never had the situation to think about this, but I would report to the nurses." We saw that where people sustained bruises or cuts these were reported to managers who tried to establish how these occurred. For example, a person was discovered by staff with a skin tear on their right arm and after a few weeks a similar skin tear on their left arm. Staff were able to establish that the person was crossing their arms and scratching their skin. We observed the person had a soft bandage around their arms on the day of the inspection which gave protection for their injuries to heal and prevented new injuries from occurring. We noted one person had a bruise on their arm and they told us, "The carer was really good, they checked it out and called the nurse but

I think I had just bumped it accidentally." Ensuring staff know how to report concerns externally was an area that required improvement.

Most of the staff had good knowledge about risks associated with people`s daily living. For example, staff were able to describe how they used appropriate and safe manual handling techniques to move people safely. However risk assessments in care plans were not always developed to ensure an accurate record on how to manage risks consistently. For example, not all manual handling assessments detailed for staff what size of sling people required when they needed hoisting.

One person had been identified as being at risk of choking. The risk assessment tool categorized the risk to be high; however the risk management plan had been left blank. We reviewed another risk assessment for a person who had been assessed as being at risk of choking. The risk assessment stated, "Staff to make sure that [Person] is sitting upright before offering food and fluids. Continue to observe for any choking episodes." The person's care plan stated, "[Person] needs to be sat upright when having their meals." Health professional guidance stated that the person should sit upright at a 90° angle and have sips of drink in between mouthfuls of food. We saw that the person had been lying in bed at a 45° angle with a plate of toast in front of them for a period in excess of 30 minutes. When we bought this to the attention of senior staff member and the unit they acknowledged that the person's care had not been delivered in accordance with their care plan, risk assessment and professional advice.

For another person who had been admitted to the home in February 2018 their care plan assessments said that they were at risk of falls and had falls before admission. However there were no risk assessments found in the care plan at all. When we asked one staff member about this person they told us they did not know them at all as they had not worked previous days and they did not have time to talk to the nurse in charge as yet to get more information.

Where people were assessed as having bedrails in place, the generic risk assessment stated that protective bumpers were to be fitted. However, we saw two people without bumpers fitted. One person told us that this was their choice, however, this was not reflected in the person's risk assessment or care plan. We noted that the another person who had bedrails without bumpers was quite anxious so we were unable to ask them if this was their choice however, they did not have this reflected in their risk assessment or care plan.

Therefore this was an additional breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Where people had a pressure ulcer or were assessed as being at risk of developing a pressure ulcer, management plans and care delivery helped to prevent an ulcer developing or aided the healing of an ulcer. We saw that people had the appropriate pressure relieving equipment and staff repositioned them appropriately.

Accidents and incidents were reported to the registered manager. There was a monthly overview on falls and the deputy manager told us that these had recently started to be discussed in monthly falls meetings. The manager looked for trends and patterns and looked at numbers of falls each individual sustained, time when falls occurred and location. We saw that where a person sustained several falls in a month actions were put in place to prevent reoccurrence. These included alarm mats, low raise beds, referral to GP and falls clinics. However we found that from January to March 2018 there were 35 falls occurring in people`s bedrooms and the majority of these were between 7.30- 14.00 hours. There was no evidence provided by the registered manager that they looked at this area and tried to understand and monitor this more closely to try and understand what was happening between these times that could have contributed to the high

number of falls in bedrooms.

We noted that during the inspection people received their care and support in a timely fashion. We asked people about staff response to pressing the call bell. One person said, "It depends very much on how busy they are, how quickly they answer. There's no point in ringing at mealtimes because they just can't come they are so busy." Another person told us, "They always come quickly but sometimes they have to go away again and they don't come back for maybe 20 minutes." A third person told us, "It's very difficult because I get constipation and they will answer a bell and then say they will be back because they need two but then they don't come back for maybe 20 minutes or more and I'm holding it, that's not good." Relatives also told us of concerns relating to staffing. One relative said, "They are often short staffed. They manage but I often come in and there are people calling out for a member of staff and no one around." Another relative said, "I have been here on a number of occasions and a resident has needed a member of staff and it's hard to find someone."

The registered manager reported that there was an active recruitment campaign underway in order to meet significant shortfalls in both nursing and care staff hours. In the interim period consistent agency staff were currently supporting the permanent staff team. The staffing progress was discussed at a weekly teleconference with members of the provider's management team.

Staff told us there was more staff deployed for shifts in the units than was previously allocated. This was because one bungalow was closed for refurbishment. Staff told us that staff working on nights often complained that there was not enough staff;. Staff told us during the night there was a higher agency use. One staff member said, "We are fine (day staff) but I know night staff are complaining that it is hard for them. There are more agency staff during the night which makes life harder for permanent staff."

We were told by the unit manager that the assessed number of staff required in one bungalow was eight in the morning and seven or six in the afternoon. On the day of the inspection there were nine staff listed on the allocation sheet however two more staff turned up in the morning. This was because they were utilising staff from the closed unit. The registered manager told us this meant that they could help get paperwork changed over to the new provider's paperwork. However we noted that care provision seen during the day was not an accurate reflection of care delivery when staff numbers return to the usual allocation. We discussed this with the management team and shared our concerns that previous issues may arise in the future.

The environment was clean and well maintained. One person told us, "It's always very clean and fresh, they (Domestic staff) are in every day." Staff were seen washing their hands and infection control procedures were followed. The management team said that this had been a focus and they were very pleased with the housekeeping team.

Recruitment practices were followed to help make sure that all staff were suitable to support people who may be vulnerable. However not all pre-employment checks were completed to help ensure staff were fit for the role. For example, some written references were not verified and employment gaps were not always explored. We noted that proof of identity and qualifications had been obtained along with criminal record checks.

Lessons learned were discussed with unit managers at daily and clinical meetings. Unit managers were then asked to share this information with staff on units. However staff told us that although they felt supported by the management, they did not always hear about changes to practice following incidents, complaints and updates.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service on 3 January 2018 the principles of the Mental Capacity Act (MCA) were not consistently applied and found that staff training had not been updated. At this inspection although we found that some improvements had been made in relation to MCA, the quality and consistency of these assessments continued to be varied across the service. We also found that although training was planned, it was yet to be completed.

Staff told us they received an induction training when they started working for the home. However the staff we spoke with had been working in the home over a year so their induction training had been provided by the previous provider. This meant that the part of the induction training where staff learned about the provider`s policies and procedures was not relevant anymore. Staff told us they had not been provided with any updates or communication about the new provider's policies and procedures. Staff told us they all had the training considered mandatory by the previous provider; however in the last year they had very few opportunities to attend any refresher training courses.

Staff told us they had supervisions and these were more regular than before. They told us they felt supported by the nurses and managers. Staff told us that they felt more supported than they had done previously. Records showed that where concerns had been raised about staff member's practice this was addressed with them on a one to one basis.

We found that not all the staff were knowledgeable about some of the subjects we tested their knowledge in. For example, safeguarding, MCA, DoLS and fire. One staff member told us, "I only had the induction training. Sometimes training is offered but mainly is on a Wednesday and I am not able to attend. I didn't have MCA or DoLS training. I would not like to guess what this is about. I assume they [people] all have DoLS in place." We asked this staff member if they knew if everyone lacked capacity and they said, "No, not everyone, but I am not entirely sure." Another staff member said, "Some people lack capacity but we still give them a choice. I don't know who has DoLS and what that is about."

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).

MCA and DoLS principles were not always followed by staff. For example, we observed a person who constantly asked to talk with staff because they felt they were detained in the home against their will. We asked staff if the person had capacity and one staff member said they felt the person had capacity when another told us they did not. At lunch time we were told by the unit manager that they had completed the DoLS application to give them authority to place restrictions on the person`s freedom. However the

manager then told us that the person had capacity to make the decision themselves which would mean they could not lawfully be detained. When we asked to see the document they told us they did not record the MCA.

'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well. People's DNACPR status was discretely indicated so that staff would be able to identify the action they needed to take promptly.

We heard staff asking for people`s consent before they delivered care and support. Some people signed consent forms in their care plan to agree with their records to be viewed by staff and other health and social care professionals. However we saw in one instance where the person clearly had capacity that they were not asked to be involved in reviewing and to consent to their care plan.

People were supported and encouraged to make their own choices. We heard staff ask, "Would you like to sit to the table or have your lunch in the lounge?" We noted staff gave people time to respond. We also found that a person was still in bed, having not had personal care, at lunchtime. A staff member told us that the person had requested to stay in bed.

People had access to health and social care professionals when needed. We noted that for people receiving intermediate care, there was a multidisciplinary team input and regular meetings. We saw that people were referred to the dietitian if there were concerns about people's weight and any risk associated with choking. However, we did see on one occasion that this guidance had not been followed.

People were positive about the food. One person said, "The chef is very good, if I ask for anything he will do his best to get it for me." Another person told us, "There is a choice of two things but if you don't want them they are so good they will get you something else like an omelette." Dietary needs and preferences were mostly catered for. One person told us, "I am not a big eater but I don't eat fish, meat or cheese and they work around that really well." A relative said, "[Person] is on fork mashable diet, was on pureed but better now and the chef is very good and will always give an alternative too." However another person said, "I suffer with constipation, really bad, I used to have prunes and porridge for breakfast that helped but now they don't give me that anymore I don't know why."

We observed the lunchtime meal served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were nicely laid with cloths and condiments were on the tables to support people to be independent.

People were offered several drinks and snacks throughout the day. Staff were monitoring people`s nutritional intake. People were weighed regularly and where a weight loss was identified staff involved the person`s GP and a dietitian to ensure they had specialist advise in meeting people`s nutritional needs. Staff also monitored people`s fluid intake. Records we saw evidenced the fluid target people had to meet to ensure good hydration. However this was not consistent and on one unit target amounts were not recorded. We saw on another unit staff discussing people who did not meet their target in morning handover so staff could encourage them to drink more. However on one unit we saw that staff recorded the amount people drank and ate at breakfast after 11.15am, and the recordings were 200 and 100 ml consistently. When we asked a staff member if they recorded the amount given to people or the amount people had drank they told us, "I know how much people had in the dining room because I served breakfast and I will leave the cup

of tea or drink on their table until they finish." We noted that best practice is for staff to record the amount people had at the time of breakfast and not hours later when the information could not be as accurate.

The home is made up of purpose built units and was suitable to meet people's needs. Homely touches in communal areas included a bread maker in the communal dining area and fish tanks in communal areas. There was plenty of seating for the lounge areas and the dining tables set in a way that encouraged getting together.

The décor was pleasant. One person told us, "They've done it nice." We noted there was equipment available to enable staff to support people appropriately. We found that bathrooms also included shower curtains in front of doors to help promote privacy.

The environment throughout the home was warm and welcoming. However, it was not always calm, for example, during breakfast there was music playing in the dining area and the TV was also on. This resulted in considerable volume of noise that staff needed to shout above to talk with people

Requires Improvement

Is the service caring?

Our findings

When we inspected the service on 3 January 2018 we found that dignity was not always promoted in some units of the service. At this inspection, we found that there had been improvements but there were some areas that still required improvement.

People received care from staff in a kind and caring way. People told us that staff were kind. One person said, "The girls are lovely, these carers are really good." Another person said, "The night carer will bring me a cup of hot milk before I go to sleep, I do like that, I've done it since I was little and the good ones still do it for me." Staff were friendly, courteous and smiling when approaching people. We observed sensitive and kind interactions between staff and people who used the service. Staff addressed people using their preferred names and it was clear that staff knew people well.

Throughout the day we noted there was good communication between staff and the people who used the service and they offered people choices. For example, where to sit, what to eat or drink, what activities to do. We heard staff discussing with a group of four people what they would like to have on TV. Eventually it was agreed that an Elvis Presley film was a good option.

However people`s dignity was not always maintained. Where people were cared for in bed their urinary catheter bags were positioned so that staff could easily monitor. This meant that the catheter bags were on clear view for any person walking past the room and did not service to promote people's dignity.

At lunch time we observed staff taking people to sit at the dining room tables, however they were not routinely asking people if they wanted to use the toilet before. We saw one person was helped by two staff to the table however none of the staff noticed that the person`s trousers were wet. We reported this to the nurse in charge who then asked staff to ensure the person received support. We also saw a person who had a hole in their trousers clearly caused by an iron (We could see the iron mark and where the material split where the iron melted the fabric) and staff took no interest all day to ensure the person changed in more dignifying clothes. We also saw a person who was walking in their nightclothes in the corridor and was looking for the toilet. We alerted staff. One staff member said they did not know the person, or even their name, so did not know how to support. They did not even speak to the person but stood there looking at them while they held on to the inspectors arm so that they could struggle across the corridor. We sent a member of our inspection team to find support at the staff members request, and after some debate between the staff members, they assisted the person to use the toilet.

People would benefit from staff supporting them more with relationships. We noted that one person's family lived overseas. They told us that they had a weekly telephone call. However, no one had considered a Skype call to allow them to see each other. They told us, "I can't use a computer and there's no one here to help me, no one has suggested it." The registered manager told us when we asked about the use of Skype, "We have iPads and this is something we were going to introduce." However, this had not yet happened and the person was not aware of the plans. We also found that three people who usually resided on the unit which was closed were good friends. One person told us, "I have a friend [name], [they] used to come and read to

me every Friday afternoon, I did so enjoy it. My other friend [name], we used to have a cup of tea together all the time and a chat, I do so miss them very much. I've only been able to make contact with them once in all these weeks. I used to go and sit with [them] and watch TV and I could hear and she would tell me about the pictures (she chuckled). It's very lonely now." Another person said, "My friend and I were separated after the fire, we are both still here (Woodland View) but we are in different places (units) I really miss [them]. It doesn't feel like 'home' anymore." We noted that one plan we viewed for another person had an evacuation care plan in place to ensure that people did not feel lonely or upset following the temporary move. However, this group of people had not had opportunities facilitated during a period of 10 weeks.

People's records were stored in cupboards in offices in order to promote confidentiality for people who used the service. However, we did note at times that the doors to these offices were not locked making records accessible to people who were unauthorised to access them. We also noted that store cupboards used for stored old care plans were also unlocked.

People's privacy was promoted. One person told us that they always closed the curtains, "And they just don't let anyone else in if I am having help." Another person said, "They are very, very careful with drawing curtains – they do it even when I am just getting up and they always do it if they are helping me with anything personal." We observed staff knocking on doors but most people in their rooms had the door either open or slightly ajar.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service on 3 January 2018 we found that people did not always receive person centred care and activities did not meet people's needs. At this inspection, we found that there had been improvements to the provision of care provided and some improvements to activities, however some people felt that the activities still required development.

People told us that staff supported them in a way they like. However people also said that staff were busy. One person told us, "I haven't done much walking because I need someone with me – they [staff] don't have time so now I can't walk." Another person said, "They are lovely but they don't have much time to talk." A third person said, "They are so busy here, they are lovely but they don't have much time to talk to us even though they do try." Another person said, "The carers are nice but they are too busy to talk, they don't really know me. I miss people." We noted that many people were encouraged out of bed but some chose to stay in their rooms. We saw that staff popped in and out for care tasks but were unable to stay for long.

There had been work to develop the care plans. The new ones were much clearer and provided staff, in most cases, with the appropriate information to support people in a way they liked and needed. However, the amount of involvement people had in the plans and care plan reviews differed across units. There was a section which prompted staff to ask people their views on the care they were receiving but this was not yet used consistently. One unit had only just commenced the care plan change over and the old style plans did not include information to support people well.

Care plans we reviewed had information staff needed in case people were nearing the end of their life. There were clear records if people had a DNACPR in place or if they wished to be resuscitated. People or relatives where appropriate were involved in making decisions about future treatment and if they wanted to remain in the home or be admitted to hospital.

People gave mixed views about activities. A person who was visually impaired told us, "Some of the carers really care and take notice and a carer took me into the garden when it was warm, she took her books to work and we sat together and I could hear the birds singing, it was wonderful and I even heard a robin." We asked if they went outside often and they told us, "I love the garden and the outside even though I can't see but I've only been out twice I think, it has to be with someone I trust." Another person told us, "The lady who does activities comes and plays Pam Ayres poetry for me, I like that it makes me laugh." Another person said, "There's nothing interesting to do here unless you like bingo." A fourth person said, "There's nothing much going on, I go to the lounge sometimes and there's a sing song which is better than nothing."

A relative told us, "The activities are not very interesting, to be honest sometimes it would be nice to see staff spending time with them as an activity." Another relative told us that a chaplain comes in regularly and that there was a Roman Catholic priest who also visits the home.

There were activities provided to people and we saw on the day of the inspection people were encouraged to join in musical quizzes and other activities. We saw a weekly activity planner with activities varying from

quizzes, music, arts and crafts and others. We saw that the activity organiser went to people's rooms for chats and one to one activities. A relative told us, "The activity staff are really brilliant. The things they come up with to entertain people is amazing."

People gave mixed responses about who they would go to if they had a complaint. One person said, "I know two of the carers very well I would go to them." Another person said, "I would ask [staff member's name] if it was something big." A third person said, "I don't know who I would talk to." We saw that where complaints had been raised, an investigation had taken place. Responses reviewed from recent complaints were clear in regards to what they would do about the complaint and offering an apology for concern raised. We noted that where appropriate, some complaints were accompanied by disciplinary notes showing that action had been taken in response to the concerns raised.

There were meetings held for people who used the service and their relatives to share their opinions about the service and facilities provided. However, these were not frequent, not well attended and not well documented so it was hard to find evidence where people had been able to influence the service they received. People and relatives we spoke with had not been to a relatives meeting but the board displayed times and dates of meetings billed as 'residents and relatives meetings' and offered morning, afternoon and one evening meeting during a 6 month period. We noted that there had been some communication break down during the incident in February 2018 and the registered manager had stated in a response to a complaint that they were looking at ways to ensure information reaches everyone in a more efficient manner.

Inadequate

Is the service well-led?

Our findings

When we inspected the service on 3 January 2018 we found that the provider was in breach of regulations in relation to how they monitored the service to make sure it was safe, effective and met people's needs. . We issued the provider with a warning notice stating that they must be compliant by 1 March 2018. At this inspection, we found that although the service had made some improvements in some areas, the service was not meeting all of the required standards. The management of the service had not ensured the necessary improvements were made. In particular this was in relation to fire and oxygen safety and management, medicines management, adhering to the principles of the Mental Capacity Act consistently and promoting people's dignity.

There were a range of checks undertaken routinely to help ensure that the service was safe. These included such areas as water temperature checks, safety checks on bedrails and wheelchairs, inspection of the call bell system, and fire checks. We noted that where issues had been identified through this system of audits they were passed on to the relevant person to address. Members of the management team undertook 'walk around' checks both during the day and night. These checks included making sure there were enough staff available, that staff were attired correctly, that people received the care they needed and that the buildings were appropriately secured for the night.

Where issues were identified this information was incorporated into staff supervisions. However, we noted that these checks had not identified the issues in relation to fire and oxygen safety. The registered manager had not taken the opportunity to test staff knowledge in relation to fire procedures or oxygen management, or test staff competency in these areas. In addition, the checks had not identified that they were not complying with their own policies and risk assessments or national published guidance. The provider gave us assurances following the incident in February that all appropriate checks, training and monitoring was in place to ensure that people's safety was a priority. However, we found that they had not completed these tasks.

Medicine audits were carried out monthly in each unit These were thorough and looked at all areas of medicine management. We saw that in March and April all the bungalows failed their medicine audits and the audits picked up on similar trends like no opening dates on boxes, hand written entries not signed, room and fridge temperatures not monitored and recorded. We saw that an action plan was in place to address these areas. However we found that these were still present in some of the bungalows. The registered manager told us they were following a 28 day compliance action plan which meant that they were sample checking medicines each day in the bungalows to ensure staff followed best practice when dealing with people`s medicines. They told us staff had been issued with competency assessments but these had not yet been returned. We also noted that the audits had not identified that the daily count sheets were not always accurate.

In addition, this was the third consecutive inspection where they service has been rated as requires improvement.

Therefore due to areas that had not been fully resolved following the previous inspection, and additional issues at this inspection and the significant concerns in regards to fire and oxygen management, this was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not sure who the registered manager was. One person said, "I don't know who's in charge or who the manager is." Another person said, "I don't know who the manager is." A relative told us, "Oh I think it is someone called [Name] but I don't see her much." The management team told us that there had been a real drive to carry out twice daily walk rounds. The registered manager now completed a record of what they had checked and any issues found. A member of the management team told us, "The walk rounds have become longer, they now last maybe up to two hours."

The regional manager also carried out visits and told us that they had been providing regular support to help the management team and staff transition to the provider's policies, procedures and paperwork. The registered manager and deputy manager told us that the provider had increased the support they offered and they felt much more confident compared to when we inspected in January 2018. The registered manager said, "After the fire it was like they put their arms around us all."

There was a service improvement plan where they were working through issues identified at the last inspection. Some areas, such as staff training were not yet completed. The registered manager told us, "HC Ones (the provider) full complement of training becomes available in May."

Staff told us that the management team was approachable and that they could talk to them at any time. They said that the management was always open to suggestions from the staff team and that they listened to everybody and always provided them with opportunities for improvement. Staff told us that there were regular staff meetings held to enable them to discuss any issues arising in the home. For example, records showed that topics discussed included communication, documentation, new paperwork being introduced and staff conduct. A meeting with the laundry and housekeeping team had identified that infections were reducing across the site and units looked cleaner.

There were management meetings held regularly between the registered manager and a member of the provider's senior management team to discuss such issues as recruitment, the performance of the service and any matters arising.

The service operated a system of auditing people's care records, their medicines and their overall experience on a monthly basis. This was 'resident of the day' and covered all aspects of a person's life at Woodlands View.

The maintenance department had a suite of monthly audits to complete. On the day of this inspection we noted checks were undertaken to ensure that all nurse call bells were operating properly. Other checks included boilers, pumps, hot and cold water systems, baths and showers, air conditioning, clocks and time switches. Record we saw were in a tick box format to indicate that the areas had been checked but we did not see a log of any issues identified or any action plan.

Portable appliance testing was undertaken on a rolling basis throughout the site. An Infection control audit in March 2018 had identified dust/cobwebs in various areas but no major concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people's safety was promoted.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured appropriate action had been taken to ensure people's were safe.

The enforcement action we took:

W imposed an urgent condition relating to fire and oxygen management.