Deepdene Care Limited

Woodtown House

Inspection report

Alverdiscott Road
East-the-Water
Bideford
Devon
EX39 4PP

Tel: 01237470889
Website: www.deepdenecare.org

Date of inspection visit:
11 September 2018
18 September 2018

Date of publication:
07 November 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 11 and 18 September 2018.

Woodtown House 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. Woodtown House provides accommodation and personal care to a maximum of 28 people with a past or present mental illness in one adapted building. At the time of our inspection there were 16 people living at the service.

This inspection was brought forward due to concerns raised by health and social care professionals about the lack of nursing cover on each shift; staff's lack of understanding of people's needs; poor documentation; lack of meaningful occupation for people and poor leadership and quality monitoring. As a result, a safeguarding meeting was held on 6 September 2018. The outcome of the meeting was that Woodtown House met the threshold for whole home safeguarding. This meant an increased oversight and scrutiny by health and social care professionals to ensure people were receiving appropriate care and support.

At the last inspection in May 2016, the service was rated as good overall. This inspection the overall rating has declined to requires improvement in safe, effective, responsive and well-led. Caring remains good.

There has been no registered manager in post since March 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There had been various managers in post since 2016 but none of them had gone on to register with CQC, despite them stating to the provider they were in the process of registering. The new manager was currently in the process of registering to become the registered manager.

Both people, staff and health and social care professionals felt there was a lack of meaningful activities on offer to aid people's mental health well-being. Daily notes also lacked detail about people's mental health well-being. For example, notes stated: 'Has been out…, unsettled when they returned and very vocal during mealtimes. Advised to eat in another room. Experiencing distressing thought disorder…'; 'Awake early and went out… Returned agitated, very confrontational' and 'Out for much of the day… On returning they seemed quite upset and frustrated.' None of these entries went into detail about what was distressing them, what support was offered or any interventions to help them with their mental health difficulties. We discussed both the lack of meaningful activities and detail in daily notes with the manager and provider, both agreed the lack of detail in daily notes would not enable any care plans to be updated with what helps at times of distress to guide staff appropriately.

The quality of the service was not continually monitored and improved. There was a clear lack of leadership, oversight and scrutiny of the service. Staff spoke about how it had been difficult with managers

coming and going, with it being unsettling at times. However, they spoke positively about how they had worked as a team. The provider explained how they had recognised that the leadership at Woodtown House was not strong enough. As a result, they had increased the regional support provided to the service from once a month to every two weeks. A registered manager from another of the provider's services also spent increased time at the home to provide some stability to the staff team.

Staffing levels met people's personal care needs. However, meaningful interactions were limited. We recommend the deployment of staff is managed more effectively in order for people to be able to engage in social activities. The service was also currently struggling to recruit a registered nurse, despite every effort having been undertaken. For example, via job searching websites and a recruitment agency. As a result, on occasions there was no registered nurse on duty. Due to the difficulty, the provider had made the decision to train senior support workers to run certain shifts and administer people's medicines with a registered nurse on-call.

Necessary online training topics were not up to date. Staff were knowledgeable, however due to the nature of the service and the people's complex needs this needed to be improved. For some new staff their induction had not been adequate enough for them to develop their skills of the service and the people living there. Due to management changes, staff had not received an up to date appraisal since July 2017.

The service provided safe care to people. One person commented: "I feel safe here" Measures to manage risk were as least restrictive as possible to protect people's freedom. People's rights were protected because the service followed the appropriate legal processes. Medicines were safely managed on people's behalf.

People received a nutritious and balance diet and enjoyed the meals. However, monitoring of people's weights had not always been completed. This potentially put people at risk of malnutrition.

Woodtown House continued to provide a caring service to people and was very much people's home. People had built strong relationships with staff. There was a happy atmosphere. People commented: "The staff are very caring" and "The cares good."

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

We found two breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have also made two recommendations.

Further information is in the detailed findings below.

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 entirely safe.

People's personal care needs were being met. However, meaningful interactions were limited due to how the deployment of staff was managed.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

People's risks were managed well to ensure their safety.

There were effective recruitment and selection processes in place.

Medicines were safely managed on people's behalf.

Staff ensured infection control procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Necessary online training topics were not up to date. Staff were knowledgeable, however due to the nature of the service and the people's complex needs this needed to be improved.

For some new staff their induction had not been adequate enough for them to develop their skills of the service and the people living there.

Due to management changes, staff had not received an up to date appraisal since July 2017.

People received a nutritious and balance diet. However, monitoring of people's weights had not always been completed.

People's health needs were managed well.

People's rights were protected because the service followed the appropriate guidance in terms of the Mental Capacity Act (2005).

Is the service caring?

Good

The service remains good.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Both people, staff and health and social care professionals felt there was a lack of meaningful activities on offer to aid people's mental health well-being.

Daily notes lacked detail about people's mental health well-being.

Care files reflected people's personal preferences and specific needs.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not well-led.

There had been no registered manager in post since March 2016.

There was a clear lack of leadership, oversight and scrutiny of the service.

Staff spoke about how it had been difficult with managers coming and going, with it being unsettling at times. However, they spoke positively about how they had worked as a team.

Woodtown House

Detailed findings

Background to this inspection

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

This inspection was brought forward due to concerns raised by health and social care professionals about the lack of nursing cover on each shift; staff's lack of understanding of people's needs; poor documentation; lack of meaningful occupation for people and poor leadership and quality monitoring. As a result, a safeguarding meeting was held on 6 September 2018. The outcome of the meeting was that Woodtown House met the threshold for whole home safeguarding. This meant an increased oversight and scrutiny by health and social care professionals to ensure people were receiving appropriate care and support.

This inspection took place on 11 and 18 September 2018 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience on the first day. The second day was with one inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses mental health care services.

Prior to the inspection we reviewed the Provider Information Return (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We had attended a safeguarding meeting with a number of health and social care professionals and the provider before the inspection. We reviewed the minutes of this meeting during our inspection.

We spoke with eight people receiving a service and seven members of staff, which included the newly appointed manager. We spent time talking with people and observing the interactions between them and staff. Following our inspection, we also spoke again with the provider to ask for additional information.

We reviewed three people's care files, three staff files, staff training records and a selection of policies, procedures and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in May 2016 safe was rated as good. This inspection found safe now requires improvement.

People told us that they were not able to go out of the home as much as they would like due to the staffing arrangements. We established the deployment of staff was the problem, with the activities worker being used as an extra member of staff instead of carrying out activities with people. We discussed our findings with the provider. They commented: "We were never aware that activities were not taking place as ultimately, the company were paying for the allocated member of staff… We are extremely frustrated to be placed in this situation given that we had provided the home with a way to ensure that this was always covered and to prevent the activities from being neglected. We carried out an investigation as to why this has been missed and it is evident that we are finding ourselves in this position due to a clear lack of management at the home. We found that although the home was provided with activities cover, they were utilising this support as an additional member to provide care to residents rather than planning activities on a regular basis."

We recommend the deployment of staff is managed more effectively in order for people to be able to engage in social activities.

People's personal care needs were met and there were sufficient staffing numbers for staff to assist them with these tasks. We observed this during our visit when people needed support. Since our last inspection in May 2016 the number of people living at the home had reduced to 16. As a result, staffing levels had been reduced following the provider carrying out a dependency assessment. This meant staffing levels across the day and night had been reduced by one. Staff felt the reduction had led to a reduced ability for people to engage in meaningful activities.

The manager explained that there was one nurse, a senior support worker and a support worker on duty throughout the day. In addition, there was the manager, administrator, activities worker, domestic and maintenance staff who supported the care staff. At night there was one nurse and one support worker on duty. Unforeseen shortfalls in staffing arrangements, such as due to sickness, were managed through regular staff and consistent agency staff. This was so people's needs could be met by staff members that understood them. In addition, the service had on-call arrangements for staff to use if concerns were evident during their shift. The on-call arrangements were shared between the manager and registered nurses.

The service was currently struggling to recruit a registered nurse, despite every effort having been undertaken. For example, via job searching websites and a recruitment agency. As a result, on occasions there was no registered nurse on duty. The provider had not initially discussed this with the commissioners. The commissioners contract that the home should provide 24-hour nursing care. Due to the difficulty, the provider had made the decision to train senior support workers to run certain shifts and administer people's medicines with a registered nurse on-call. At the time of our inspection, over a two-week period there were three shifts with no registered nurse on shift. However, due to the difficulty in recruiting a registered nurse,

one psychiatric clinic had needed to be cancelled in August 2018 due to there not being a registered nurse present. Professionals were concerned about this and how it potentially could have impacted on people. There is no evidence to suggest there was an adverse impact on people.

The service continued to provide safe care to people. People commented: "I feel safe here" and "Any problems, I would speak to the staff."

To minimise the risk of abuse to people, staff undertook training in how to recognise and report abuse. Most staff safeguarding training had lapsed and had been overdue since April 2018. However, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission. They told us they would immediately report any concerns to the manager or nurse in charge and were confident that action would be taken to protect people. A staff member commented: "I would go straight to (nurse) and report. I would also document all the details." Another staff member commented: "I would raise any concerns with (manager)."

People's individual risks were identified and risk assessment reviews were carried out to keep people safe. For example, risk assessments for behaviour management, falls, absconsion and accessing the local community. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, people had guidelines in place for staff to follow if a person was feeling distressed. These guidelines had been developed with support from key health and social care professionals to ensure staff were adopting best practice.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks, which included references from previous employers and Disclosure and Barring Service (DBS) checks, were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Learning from incidents and investigations took place and appropriate changes were implemented. For example, care plans and risk assessments were updated following a person going missing which involved calling the police. Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, health and social care professionals were requested to review people's plans of care and treatment. This demonstrated that the service was both responsive and proactive in dealing with incidents which affected people.

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicines. Each month, a local pharmacy delivered people's medicines to the home. When the home received these medicines, they were checked in by a registered nurse and the amount of stock documented to ensure accuracy.

Medicines were kept safely in a locked medicine room. The room was kept tidy and in an orderly way to reduce the possibility of mistakes happening. Medicines were safely and competently administered by registered nurses and senior support workers. Computerised medicines records were used and were appropriately signed by staff when administering a person's medicines. A weekly audit was undertaken to ensure people were receiving their medicines as prescribed.

Staff ensured infection control procedures were in place. Personal protective equipment was readily available to staff when assisting people with personal care. For example, gloves and aprons. A cleaning schedule was in place for domestic staff to follow to ensure the cleanliness of the home.

The premises were adequately maintained through a maintenance programme. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service, along with external contractors. For example, window restrictors, fire alarm, fire extinguishers and electrical equipment checks. People had personal emergency evacuation plans (PEEPs), which are individual plans, detailing how people will be alerted to danger in an emergency, and how they will then be supported to reach safety. Staff had received fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in May 2016 effective was rated as good. This inspection found effective now requires improvement.

The service understood that staff needed training and development, however this was not always up to date. Staff had completed up to date training for moving and handling, fire safety, first aid and breakaway and de-escalation techniques. However, many of the necessary online training topics were not up to date. For example, mental health awareness, safeguarding, equality and diversity and alcohol awareness. Staff were knowledgeable about these subjects, however due to the nature of the service and the people's complex needs this needed to be improved to ensure people were receiving the most appropriate care and support from competent staff.

In addition, for some new staff their induction had not been adequate enough for them to develop their skills of the service and the people living there. For example, induction consisted of one shadow shift and no mandatory training. They were not new to the care profession and were able to learn quickly through working with the staff team.

We discussed our findings with the provider. A new online training provider had been enrolled in April 2018, giving managers more control of their training in-house. The provider commented: "Given the feedback we have received from yourself, it is very clear that training has lapsed and despite making (manager) fully aware of his responsibility over staff training, this has been missed. In line with our review and following your comments, we have taken the stance to review training companywide on a fortnightly basis to bring training up to a satisfactory standard and thereafter, this will reduce to a monthly check from head office."

The new manager had arranged for staff to receive training from the North Devon Care Home team on subjects including, recordkeeping, infection control, nutrition and Parkinson's disease and dementia awareness. This training schedule was due to commence in October 2018.

We recommend a comprehensive training programme is implemented to ensure staff have access to current best practice.

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. However, due to management changes, staff had not received an up to date appraisal since July 2017. Staff did confirm they felt supported due to the strong team work which took place. However, staff had received up to date supervision sessions with the next ones scheduled for October 2018.

People were supported to maintain a nutritious and balanced diet. People were involved in choosing what they wanted to eat to meet their individual preferences. There were always alternatives for people to have, for example a vegetarian option. People commented: "Food's good"; "Really nice food" and "The food is lovely." Meals were cooked freshly on the premises and catered for people with special dietary requirements, such as reduced sugar due to their diabetes.

Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. One person's care plan identified nutrition being a risk factor. The action to be taken was for the person "to be weighed monthly." Records showed that their weight had not being monitored adequately enough. The weight chart showed that they had only been weighed over the past three months from July to September 2018. No further evidence of regular weighing before these. A social worker had also raised concerns about the lack of monitoring when they reviewed the person recently. The only reason given for the lack of monitoring was that the weighing scales had been broken from December 2017. It took until July 2018 for new scales to be purchased. The person had been seen by their GP in August 2018 with their care plan stating, "recent health evaluation…GP indicated weight was stable." A staff member confirmed that the GP was pleased with their weight. The lack of monitoring and urgency to purchase new weighing scales could have placed this person at high risk of malnutrition.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's legal rights were protected because staff knew how to support people if they did not have the mental capacity to make decisions for themselves. People's capacity to make decisions about their care and support were assessed on an on-going basis in line with the MCA. People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, for suitability of their needs and alcohol consumption. This demonstrated that staff worked in accordance with the MCA.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Three people had DoLS in place and another application was pending assessment by the local authority.

People were supported to see appropriate health and social care professionals when they needed. For example, GPs, mental health practitioners and psychiatrists. People were accessing GP appointments at the time of our inspection for check-ups on specific health conditions and due to the medicines, they were prescribed. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. People were encouraged to consider giving up smoking through nicotine replacement therapy to improve their physical health.

People's individual needs were met by the adaptation, design and decoration of the premises. The home was set over two floors. People had a variety of spaces in which they could spend their time, such as the lounge and dining room, and their bedrooms were personalised. Reasonable adjustments had been made to enable people to move around as independently as possible, such as grab rails and ramps. Aspects of the building needed redecoration and maintenance due to its age. For example, bathrooms being updated and paint work freshened up. A redecoration programme was in place. Some furniture needed to be replaced, such as a sofa due to it being ripped in places. The provider and manager were currently in the process of purchasing new furniture.

Good

Is the service caring?

Our findings

Woodtown House continued to provide a caring service to people and was very much their home. People had built strong relationships with staff. There was a happy atmosphere. People commented: "The staff are very caring" and "The care's good."

Throughout the inspection there were kind and friendly interactions between people and staff. Staff knew people well and were able to communicate effectively with everyone. Staff took time for people to communicate their wishes through the use of individual cues. For example, looking for a person's facial expressions, body language and spoken word.

Staff treated people with dignity and respect when helping them with daily living tasks. One person commented: "I've got my privacy. I can lock my door." Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example, by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific decisions about how they spent their time. One member of staff commented: "We promote independence and empower people to take control of their lives." For example, encouraging people to set personal goals they want to achieve.

Staff supported people in an empathetic way. They demonstrated this in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed staff talking to them about things of interest to them which provided them with reassurance.

Staff gave information to people, such as when certain things were due to take place. For example, when lunch would be ready. Staff encouraged people to help set the table and discussed the food choices available. Staff communicated with people in a respectful way. Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff offered care that was kind and compassionate. Staff demonstrated how they were observant to people's changing moods and responded appropriately. For example, if a person was feeling anxious. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. Staff recognised effective communication as an important way of supporting people, to aid their general wellbeing.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. They were able to speak confidently about the people living at Woodtown House and each person's specific interests. They explained that it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything. People confirmed they were treated as individuals when care and support was being planned and reviewed. One person commented: "They (the staff) asked me what I like and what I don't like. I know my plan is kept in the office."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in May 2016 responsive was rated as good. This inspection found responsive now requires improvement.

People said there was a lack of meaningful activities on offer to aid mental health well-being. Comments included: "Don't do shopping as much as they used to, shopping is only once a week, so not very fair, run out of things" and "Really bad that we can't go shopping, trying to go for a week. Go swimming, disabled disco, shopping. All got bus passes, only used them once";

Staff commented: "We need to be able to offer more activities. I wish we had more time to spend with people, even chatting would be good"; "Appointments take priority which means less time for people to go out. Sometimes I am the only driver on shift as some staff are not over 25" and "You often find the person down to do activities is drawn into the numbers to provide people with personal care." The main activities worker was currently off work which was also having an impact on the activities on offer.

Resident meetings in July, August and September 2018 consistently spoke of the lack of activities. Entries included: 'Residents expressed concern that there are hardly any activities taking place now due to the lack of staff on shift and asked when/if this is going to change' and 'Residents asked when (activities worker) would be back, it was explained that (another member of staff) will be stepping into the activity coordinator role for the time being so hopefully over the next few weeks the activities and outings should start to pick up again.'

In addition, the results of the surveys completed by people in July 2018, all responded in the 'social activities' section that they would you like to try something different and wanted staff to help and encourage them more. No action plan had been put in to place to address these negative responses. Care plans also documented the importance of people engaging in meaningful activities on a regular basis to aid their overall well-being. For example, one person's care plan spoke of the importance of activities in order to avoid social isolation.

Professionals also felt that people's personal care needs were being met but not their secondary needs, such as meaningful activity. Comments included: "Secondary needs are possibly being put to one side because of staffing issues e.g. residents going out, vocational and recreational input" and "In three reviews I have undertaken in the past three months all service users said they were not getting out." Throughout our inspection we noticed that people mainly spent their time in the dining room and garden drinking coffee and smoking with very little emotional stimulation. The lack of meaningful activity was having an impact on people's physical, psychological and emotional well-being to aid their recovery from severe and enduring mental ill health.

Daily notes also lacked detail about people's mental health well-being. For example, notes stated: 'Has been out…, unsettled when they returned and very vocal during mealtimes. Advised to eat in another room. Experiencing distressing thought disorder…'; 'Awake early and went out… Returned agitated, very

confrontational' and 'Out for much of the day… On returning they seemed quite upset and frustrated.' None of these entries went into detail about what was distressing them, what support was offered or any interventions to help them with their mental health difficulties. We discussed both the lack of meaningful activities and detail in daily notes with the manager and provider, both agreed the lack of detail in daily notes would not enable any care plans to be updated with what helps at times of distress to guide staff appropriately.

In addition, the service' statement of purpose stated: "To provide an environment enabling rehabilitation and recovery to take place within a caring, supportive and homely environment. To support and assist people with their reintegration back into the community and to promote individual's independence through safe and achievable steps towards having a more independent lifestyle. Service users should expect to have support and assistance in their development and progress in their recovery and rehabilitation." This was not being followed.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9.

Care files included personal information and identified the relevant people involved in people's care, such as their GP. Relevant assessments were completed, from initial planning through to on-going reviews of care. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. Care plans were clearly laid out. They were broken down into separate sections, making it easier to find relevant information, for example, physical and mental health, mobility and personal care. Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care records contained communication details explaining how people communicated and the need to speak clearly to ensure they could communicate their wishes. For example, how to communicate with a person who is struggling with their mental health.

There were regular opportunities for people, and people that matter to them, to raise issues, concerns and compliments. This was through on-going discussions with them by staff on a regular basis and through resident meetings. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. The service had not received any complaints. However, the manager recognised that if they received a complaint, they would attend to it in line with the organisation's procedure.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2016 well-led was rated as good. This inspection found well-led now requires improvement.

There has been no registered manager in post since March 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There had been various managers in post since 2016 but none of them had gone on to register with CQC, despite them stating to the provider they were in the process of registering. The new manager was currently in the process of registering to become the registered manager.

As a result of the lack of a consistent manager, the leadership and oversight of the service had been compromised. The manager was required to submit specific audits to the provider on a weekly, monthly and quarterly basis. This enabled good oversight of the service. The audits covered in varying detail, staffing arrangements, training, incidents and accidents, safeguarding, the environment and record keeping. We found the last weekly audit was completed in June 2018. This identified that staff training was not up to date. This continued to be the case when we carried out this inspection. Thus, meaning three months had passed and no action had been taken. The last monthly audit was completed in February 2017, we were unable to locate any more recent ones. We were also unable to locate any quarterly audits.

In February 2018 an external auditor carried out a 'mock' inspection at Woodtown House. They also identified staff training being out of date, the need to purchase weighing scales and a lack of meaningful activities for people. The outcome of this was an action plan being formulated to address the issues identified. New weighing scales had been purchased in July 2018. The other issues remained the case at this inspection. Therefore, the actions had not been addressed by both the manager and provider. This showed a clear lack of leadership, oversight and scrutiny of the service.

The provider explained how they had recognised that the leadership at Woodtown House was not strong enough. As a result, they had increased the regional support provided to the service from once a month to every two weeks. A registered manager from another of the provider's services also spent increased time at the home to provide some stability to the staff team. The provider accepted our findings that audits had not been completed for a significant period of time. As a result of this, they had put in place a contingency plan whereby they discussed audits in their monthly head office audit meeting. Thus, enabling them to catch any outstanding audits and monitor the home's performance.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17.

Staff spoke about how it had been difficult with managers coming and going, with it being unsettling at times. However, they spoke positively about how they had worked as a team, with one saying, "we pulled together." As a result of the management issues, staff meetings had not occurred on a regular basis. The

last one being in November 2017. The new manager was currently meeting with staff on an informal basis to get to know them and how they feel about the service. They planned to reinstate staff meetings shortly. Meetings took place as part of the service's handover system which occurred at each shift change.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working with staff. For example, GP and psychiatrist. Medical reviews took place to ensure people's current and changing needs were being met.

Resident meetings took place regularly. At these meetings, any potential arising issues were discussed. Such as about the food, care, activities and the environment. People's main issue was about the lack of activities. Surveys had been completed by both people and staff in July 2018. The surveys asked specific questions about the standard of the service and the support it gave people. The main issue was around activities (discussed in the responsive section of this report). No action plan had been formulated as a result of the findings.

The service had notified CQC appropriately. We use this information to monitor the service and ensure they respond appropriately to keep people safe. The provider had displayed the rating of their previous inspection in the home, which is a legal requirement.

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 There was a lack of meaningful activities on offer to aid people's mental health well-being. Daily notes lacked detail about people's mental health well-being. Regulation 9 (1) (b) (3) (b)

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 quality of the service was not continually monitored and improved. There was a clear lack of leadership, oversight and scrutiny of the service. Regulation 17 (1) (2) (a) (b) (c)