Premium Care Limited

Woodside Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Inadequate
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Woodside Hall Nursing Home is a care home for up to 59 people. It provides care and support to older people with nursing care needs, dementia or physical disability. At the time of our inspection there were 53 people living at the home. People we spoke with had mixed experiences about the home and the care provided. One person told us, "Yes, I'm very happy, the staff are very nice and helpful, I like the informality, they are so kind." One person told us, "Staff don't have time to sit and talk with us."

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The director provided day

Summary of findings

to day leadership. The clinical lead was responsible for meeting all clinical needs and provided support and guidance to the registered nurses. The clinical lead was in the process of submitting an application to the CQC.

Staff treated people with kindness and compassion. However, we observed a few interactions where people's dignity was compromised. These were brought to the attention of the director and clinical lead to address with care staff. We found the provider needed to make improvements in this area.

Mental capacity assessments were not always completed in line with legal requirements. For example, assessments of capacity did not record how the decision was reached. We found the provider needed to make improvements in this area.

Many people had bed rails in place. Where a person could not consent to the bed rails, we could not see that a mental capacity assessment had taken place. Documentation did not record whether the bed rails were in place in people's best interest to promote their safety. We have asked the provided to make improvements in this area.

Staffing levels were insufficient. Call bells were not always answered promptly, often people were waiting over 15 minutes. One person told us, "I press it but they don't come quickly." Throughout the inspection, we heard call bells continually ringing.

People's medication was stored safely and in line with legal regulations. For people prescribed creams, staff did not consistently record when creams were applied. The provider has been asked to make improvements in this area.

The delivery of care and treatment was recorded and each person had an individual care plan which detailed the support required to maintain their health and wellbeing. For example, these included management of diabetes and moving and transferring.

The provider regularly sought feedback from people, relatives and staff. Audits of the feedback obtained did not record what action had been taken to make improvements. The provider has been asked to make improvements in this area.

Incident and accidents were consistently recorded, however, they were not reviewed on a regular basis to monitor for any emerging trends or patterns. The provider has been asked to make improvement in this area.

People were encouraged to do activities that were meaningful to them. They were dressed in accordance with their lifestyle choice. One person told us, "I'm wearing my favourite outfit today." People were wearing their glasses and hearing aids. They were encouraged to bring furniture and items of importance into the home with them. An activities coordinator was in post and we observed a wide range of activities. People were seen playing games of cards and enjoying the commonwealth games on TV. We saw that people had formed a rapport with staff and with other people who lived at the home. People were seen sitting together enjoying afternoon tea in the sunshine.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report. We have shared our findings with the local authority.

Summary of findings

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

Woodside Hall Nursing Home did not provide care that was consistently safe.

People's medication was administered by nurses and people commented that they received their medication on time. Where people were prescribed topical creams, recordings failed to reflect that it was applied.

Staff did not report incidents where people had sustained large bruising from an unknown cause to the local authority for their consideration as to whether it required a safeguarding alert.

Woodside Hall Nursing Home completed mental capacity assessments under the Mental Capacity Act 2005 (MCA). Specific decisions were explored but we could not see how that assessment of capacity were reached. Where people had bed rails in place. We could not see that staff had completed mental capacity assessments to determine whether the person consented to the bed rails and whether bed rails were in the person's best interest.

Is the service effective?

Requires Improvement

Woodside Hall Nursing Home did not provide care that was consistently effective.

People and their relatives had mixed feelings about being involved in the design and formation of care plans. Some people felt fully involved in their care plans whereas others did not and some relatives felt they were not involved at all.

People had their nutritional needs assessed and food was prepared in accordance to individual preference and dietary requirement. .

People received appropriate support from healthcare professionals when required. Examples seen, included referrals to other professionals such as General Practitioner's (GPs), speech and language therapists (SALT) and the tissue viability nurse.

Is the service caring?

Inadequate

Woodside Hall Nursing Home did not consistently provide care that promoted people's dignity or privacy.

People's privacy and dignity was compromised. People commented that due to their call bells not being answered in a timely fashion, they often had to go to the toilet in their pad.

We observed care practice throughout the inspection which did not promote people's dignity. For example, one person was transferring from a chair to a wheelchair. Staff had not drawn the curtains which meant people sitting outside or walking past could see what was happening.

Summary of findings

Staff were able to tell us how they would promote someone's privacy and dignity, but we found this was not embedded into practice

Is the service responsive?

Requires Improvement

Woodside Hall Nursing Home was not consistently responsive.

Care plans and risk assessments were not always reviewed on a monthly basis. A sample of care plans and risk assessments that had not been reviewed since May 2014. Therefore, the changes to the person's health and social care needs were not recorded and available for care staff as a source of guidance.

An activities coordinator was in post. People were seen enjoying a wide range of activities. Where people preferred spending time in their room, we saw that the activities coordinator was spending time with people on an individual basis.

'Resident' and staff meetings were held on a regular basis. These provided a forum for people and staff to discuss their concerns, make suggestions and air their opinions.

Is the service well-led?

Requires Improvement

Woodside Hall Nursing Home requires improvement to be a well-led organisation.

Call bells were found to be continually ringing. A recent complaint and feedback from a satisfaction survey found this to be issue. Management had not fully identified the concerns or taken action to improve the response to call bells despite receiving information of concern.

Incident and accidents were recorded but were not analysed for any emerging trends, themes or patterns. Feedback from people, staff and relatives was sought. However, where action had been taken following the feedback to make improvements, this was not recorded.

Woodside Hall Nursing Home

Detailed findings

Background to this inspection

We visited the home on 23 and 25 July 2014. This was an unannounced inspection. During the inspection we spoke with 13 people living at Woodside Hall Nursing Home, five relatives, three nurses, five care staff, the activities coordinator, the clinical lead and the director. We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms, lounges and the dining room.

To obtain the views of people, we used various methods. We spent time observing the delivery of care in communal areas. Observing staff interactions and spending time talking with people and their relatives.

The inspection team consisted of two adult social inspectors; a specialist nursing advisor and an Expert by Experience, who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we contacted the local authority and commissioners of the service to obtain their views. We reviewed all information we held about Woodside Hall Nursing Home. No concerns had been raised and the service met the regulations we inspected against at their last inspection in 2013.

During the inspection we spent time reviewing the records. These included quality assurance audits, staff training and policies and procedures. We looked at seven care plans and risk assessments. We also reviewed four staff files and other relevant documentation to support our findings.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Woodside Hall Nursing Home. One person told us, “I feel very safe here. I can tell the staff anything.” However, we found care practice which was not safe. Woodside Hall Nursing Home has been asked to make improvements so that people receive safe care at all times.

Medicines were stored safely. There were two clinical rooms which were appropriately equipped so that medicines could be kept safely. When medication was being administered to people, medication trolleys were used. Staff required key access to the medication trolley and we observed staff appropriately locking the medication cupboard and trolley after use.

People commented they received their medication on time. One person told us, “Oh yes, I always get my medication on time.” Medication administration charts (MAR charts) showed that people’s medicines were in stock and people had received their medicines as prescribed.

Many people were prescribed topical creams (a medication that was applied to the skin surface). Staff were not consistently recording on the MAR charts when people’s creams were applied. We asked staff members if they recorded this elsewhere. We were informed the MAR chart should be signed to indicate the cream was applied. Therefore, we were not confident staff were signing the MAR chart to reflect that cream was applied. This has been identified as a breach of regulation (Regulation 20) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).

Recordings failed to reflect when a persons cream was applied. The action we have asked the provider to take can be found at the back of this report.

There were clear processes in place for the handling of controlled drugs (CDs). Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines were called controlled drugs (CDs). CDs were stored in a locked cabinet within a locked cupboard. The home ordered CDs appropriately and we saw that the stock levels of CDs were checked on a weekly basis and signed by two nurses. The nurse informed us, "All CDs that are administered are witnessed by two nurses."

Systems were in place to record accidents and incidents. The clinical lead told us, “Staff are extremely excellent at reporting and informing us.” We reviewed a sample of incident and accident records. In June, six incidents had occurred when people had sustained bruising from an unknown cause. On one occasion, a resident had suffered a bruise about 5cm x 5cm.Local policy reflects that not all bruising from an unknown cause should be reported as a safeguarding alert, but such incidents should always be reported to them for consideration. We have identified this as an area of practice that requires improvement.

Staff told us they felt confident in reporting an suspected adult abuse or safeguarding concerns. Staff were able to tell us how they would respond to allegations, and also knew the lines of reporting in the organisation. Policies and procedures were in place for safeguarding and whistleblowing. These were up to date and appropriate for this type of service. For example, the safeguarding policy corresponded with the Local Authority and ‘No Secrets’. ‘No Secrets’ is the "guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse". The guidance demonstrated best practice to follow and included information on the definition of adult abuse.

Risks to people were assessed and risk assessments developed. These included the nature of the risk, worst outcome, objective and actions taken. Risk assessments included areas of health and care such as medication, choking, nutrition, and diabetes. One person had been identified at risk of spitting out their medication. The risk assessment recorded clear guidance for staff and how the person could be safely supported to take their medication.

People told us they were enabled to make day to day decisions and staff asked their consent before providing care or treatment. Staff we spoke with had an appropriate level of understanding of the MCA. They were able to explain how they gained consent from people and enabled people to make day to day decisions. Training records confirmed that all staff had received training in MCA and this was refreshed annually. Five members of staff training was due for refreshing. The director confirmed that training would be organised for those member of staff immediately. Despite training being due for refreshing, we found this had no impact on staff's ability to deliver safe care.

Staff considered people’s ability to make specific decisions, for example, what to wear. Recordings demonstrated that

Is the service safe?

staff recorded the outcome of these decisions as either yes or no. The Mental Capacity Act 2005 (MCA) says that reaching a decision on capacity is based on the person's ability to communicate, retain, weigh up and understand the decision. The MCA is also decision specific, however documentation did not always reflect what decision was being made. The provider had a checklist in place for MCA which asked can the resident understand the decision to be taken. There was no reference to what the decision was, how the information had been presented to the person. Recording reflected the answer as either yes or no. Therefore the assessments were not completed in line with the requirements of the Mental Capacity Act 2005 (MCA). Observations throughout the day found that this did not impact upon the delivery of care and treatment and was an issue with recording only. This has been identified as a breach of regulation (Regulation 20 (1) (a)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). The action we have asked the provider to take can be found at the back of this report.

Observations of care identified that many people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. Bed rail risk assessments were in place for all people where bed rails were used. The risk assessments looked at the nature of the risk, objective and actions taken to reduce the risk. Many people had consented to the use of bed rails and we saw that the risk assessment was signed to indicate their consent.

For people who could not consent to bed rails, mental capacity assessments had not been completed. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom (bed rails). If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored. We brought this to the attention of the clinical lead. The clinical lead agreed that an assessment of capacity must be recorded to evidence that bed rails are implemented in the person's best interest. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

Accommodation was arranged over three floors with a passenger lift between all floors. All areas were fitted with a fire detection system. Records confirmed this was regularly checked. Dedicated maintenance workers were employed by the home. Their role included checking fire equipment to make sure it was in safe working order and protected people who lived at the home.

There were dedicated sluice rooms where soiled equipment and laundry could be decontaminated. Cleaning equipment such as bleach and disinfection was also stored in the sluice rooms. During the inspections, we observed the sluice room to be left unlocked on several occasions. Risk assessments completed by the provider reflected that the sluice room should be locked at all times to prevent unauthorised access. We brought this to the attention of the registered nurse. We have identified this as an area of practice that required improvement.

Before staff worked unsupervised, all the relevant checks had been completed. Staff files confirmed that staff had completed an application form, references were obtained, forms of identification were present and a disclosure and barring check had taken place. Nurses employed by Woodside Hall nursing Home and agency nurses all had registration with the nursing midwifery council which were up to date.

Requires Improvement

Is the service effective?

Our findings

People told us their health care needs were met and if they ever felt unwell, care staff acted promptly and sought medical advice. Although people spoke positively of Woodside Hall Nursing Home, we identified an area of practice which was not consistently effective.

Each person had their own care plan. Care plans demonstrated that people's health and social care needs were assessed and plans of care were developed to meet those needs. Each section of the plan covered a different aspect of the person's life, for example personal care, medication, communication, continence, mobility, nutrition, swallowing and memory. The general care and support plans provided guidance to staff. For example, one person wished to be supported to apply their make up each morning.

People's physical and general health were monitored by staff. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, tissue viability nurses or dieticians and when referrals had been made. People we spoke with confirmed if they felt unwell, the nurse on charge would be informed and if required their GP would be contacted.

People told us they felt listened to but were not always familiar with their care plan. People commented they felt involved and consulted about their care. One person told us, "Yes they keep me updated." Relatives had mixed experiences about being involved in their loved ones care plan. Where appropriate, relatives should be involved in the formation and review of care plans. This could be if their loved one has provided consent for their involvement or if their loved one is unable to consent to their own care plans. Two relatives felt involved in their loved one's care and were aware of their care plan. One relative told us, "Yes, I'm kept up-to-date with any medication changes and when they had to call the GP. I've seen the Care Plan to make sure I was happy with it." Two relatives felt that they were not involved. One relative told us, "Not a lot no, no care plan and not involved in any planning." We brought this to the attention of the clinical lead and director. The clinical lead informed us that care plans were now being sent out to relatives/representations to encourage their involvement and showed us a sample of letters sent out to relatives. The relatives could not recall if they were sent a letter regarding their loved one's care plan but advised they did not feel involved or familiar with their relatives care plan. We have therefore identified this as an area of practice that requires improvement.

Woodside Hall Nursing Home assessed people's nutritional needs and provided food and drink that met people's individual preference and dietary requirement. People were provided with a variety of meal options and could also make request. Menu options included roast chicken, leek and potato bake, omelettes, jacket potatoes', bruschetta, homemade cakes and soups. A weekly menu was displayed within the dining room. Staff went round each day asking people what they would like for lunch and supper. A menu was available on the day to remind people of the options. Two options were always available but people could also make additional requests. This information was then fed back to the chef. Within the kitchen, the chef had information available on the dietary requirements of each person. For example, whether a pureed or soft diet was required. People were offered a glass of sherry or alcoholic beverage of their choice. Where people requested alternative meals, we saw that their right to exercise choice was respected and an alternative meal was provided.

Where people had been assessed at high risk of malnutrition or had nutritional needs, food and fluid charts were completed. We reviewed a sample of food and fluid charts. Staff consistently recorded the intake of food and drink throughout the day. The intake of fluid was calculated daily to record their overall fluid intake on a day to day basis.

Lunch was served in dedicated dining areas. People had the choice of eating in their bedroom or the dining room and this choice was respected by staff. Where required, staff provided one to one support. We observed positive interactions between staff and people. For example, people were offered the choice between a beaker and a glass. Support with eating and drinking was offered discreetly. For example, one staff member asked "Would you like me to cut that up for you."

Most people received effective care from staff that were appropriately trained. We looked at the induction and training programme for staff. Training records confirmed that staff received essential training in fire safety, MCA, manual handling, food hygiene, safeguarding and infection control. Records demonstrated that training was on-going

Requires Improvement

Is the service effective?

for all staff. A few members of staff training required updating. For example, some staff's training in infection control had run out in June 2014. The director had identified that staff's training required updating and was in the process of organising training dates.

Nursing staff confirmed they had received clinical training and support. Training records confirmed nursing staff had received wound care training and assessment of skin integrity. Nursing staff were overseen by the clinical lead who ran workshops and meetings on care topics such as nutrition and continence care.

Staff had regular supervisions. Supervision is a formal meeting where training needs, objectives and progress for the year were discussed. Staff confirmed they found supervision a useful tool and could discuss any concerns. Documentation confirmed that staff received supervision every three months. Staff we spoke with commented that if they had any worries they could approach the clinical lead for advice or guidance.

Inadequate

Is the service caring?

Our findings

People we spoke with had mixed experiences about the care received. Some spoke highly while seven people felt their dignity was not always maintained. We have identified that Woodside Hall Nursing Home did not consistently promote people's privacy and dignity. We observed care practices which compromised people's dignity. We have asked Woodside Hall Nursing Home to make improvements in this area.

People had mixed comments and feedback about the care and treatment they received. One person told us, "Yes, I'm very happy, the staff are very nice and helpful, I like the informality, they are so kind, and it's very relaxed." Another person told us, "Yes I'm very comfortable. The staff are very kind." A third person told us, "No I'm not happy at the moment. I press my call bell but sometimes they take a while to respond and I really need the toilet"

The majority of relatives felt that their loved one was receiving good care. One relative told us, "Yes, it's those little extra things like making sure their drink is close by." Two relatives expressed concerns for their loved one. One relative commented, "People are in bed till 11 a.m. then back in bed at 2 p.m." The relatives expressed this was what they observed and it concerned them. Another relative told us, "I'm not too happy at all. I think they are wasting away here." During the inspection, we identified eight people had not yet received personal care at 11 a.m. After lunch we observed that some people had returned to bed. One person told us, "There isn't much to do really, so I go to bed, I don't mind."

We looked at people's care plans to see if it was there preference to return to bed after lunch and what time they wished to get up and go to bed. Documentation did not confirm this. Information was also not available on what the person preferred, if they preferred a lie in or liked to get up early. Therefore, we were not confident Woodside Hall Nursing Home was meeting people's personal preference. The above issue meant that there had been a breach of the legal regulation (Regulation 17 (1)(a)). The action we have asked the provider to take can be found at the back of this report.

People's privacy and dignity was not consistently maintained. We observed care practice which compromised people's dignity. We observed staff supporting a person to move from a chair to a wheelchair. We saw that this move was undertaken in an undignified manner. A screen was pulled around the person to provide some privacy. The person was sitting next to a French door which looked out into the garden. Staff had not drawn the curtains which meant that people in the garden or people walking past could see what was happening. We have identified this as an area of practice that requires improvement.

During the inspection, call bells were heard continually ringing. People living in nursing home often have complex care needs and many require assistance from staff with all tasks. When talking to people, a common theme identified was that people felt call bells were not answered in a timely manner. One person told us, "I press my call bell but they don't always come and I have to go to the toilet in my pad." Another person became upset whilst talking to us. They told us, "I can be in such pain when I need the toilet but they don't always come quickly enough when I need the toilet." It was found that people's dignity was compromised as they were not supported to attend the toilet in time. People found this extremely distressing and for them it clearly impacted upon their self worth. We brought this to the attention of the director and clinical lead. They acknowledged that call bells were continually ringing and questioned how this can be improved. The above issue meant that there had been a breach of the regulation (Regulation 17 (1) (a)). The action we have asked the provider to take can be found at the back of this report.

During the inspection, we identified concerns with the response time to call bells. We asked the director, how long a call bell should be ringing for. We were informed, "For no longer than five minutes." We asked a member of staff what an acceptable amount of time is for a call bell to be responded to. They replied "25 minutes." The call bell printout documented that often call bells were answered in seconds but examples were identified where people were waiting, five, 10, 15 and 25 minutes for the call bell to be responded to. This could place people at risk of not receiving assistance when they required help. The above issue meant that there had been a breach of the regulations (Regulation 9 (1) (b) (ii)). The action we have asked the provider to take can be found at the back of this report.

During the observation of lunchtime, we observed practice which was not dignified. One staff member was supporting

Inadequate

Is the service caring?

a person with eating and drinking. There was no interaction and the staff member did not communicate with the person enquiring whether they liked the food, what was on the fork and whether they had finished their mouthful. We brought this to the attention of the director who recognised our concerns. The above issue meant that there had been a breach of the regulation (Regulation 17 (1) (a)). The action we have asked the provider to take can be found at the back of this report.

Practice was identified which compromised people's dignity but people we people spoke felt that their privacy and dignity was respected. One person told us, "Yes, they shut the door, close my curtains, always explain things to me and always knock." Another person told us, "Yes as far as I can tell, I'll have my door shut but they always knock." People were supported to maintain their personal and physical appearance. People were dressed in the clothes and in the way they wanted. A hairdresser visited regularly. People were wearing hearing aids and glasses along with footwear of their choice.

People could bring their own furniture into the home if they so wished and staff encouraged people to bring objects and pictures of importance. People decorated their rooms according to their wishes. For example, pictures were displayed on the walls and people had brought their own bed spreads and items of importance. The director told us, "We want people to feel like this is their own home."

Woodside Hall Nursing Home had policies giving guidance to care staff on privacy, dignity and people's rights. Privacy, dignity and people's rights were covered during staff's induction. One staff member told us, "When I started I was asked to always knock and I always do. I stay with them when they are on the commode if they want me to or I will leave if they want me to. People have different responses when I ask. Some people want their door shut and always have their bells with them. Others want their doors left open, especially in this heat. One person told me they liked their door open to watch the world go by. It's people's personal choice." Staff we spoke with commented on how they respected people's privacy and dignity. However, observations throughout the inspection found that this practice was not fully embedded and staff did not consistently promote people's dignity. We have identified this as an area of care practice that required improvement.

Requires Improvement

Is the service responsive?

Our findings

People commented they enjoyed spending time in the garden and conservatory. Activities were arranged and people told us they enjoyed the stimulation. However, we identified areas of practice which were not responsive and required improvement.

Care plans and risk assessments were not consistently updated. The clinical lead told us care plans and risk assessments should be updated monthly or sooner. Policies and procedures confirmed this. Most documentation was reviewed on a monthly basis. However, four care plans out of seven had not been updated or reviewed on a monthly basis. Since the last review, people's healthcare needs had changed along with changes to the way care and support was delivered. Therefore, people's care plans did not reflect the changes in their care needs and how staff should provide the support required. We brought this to the attention of the clinical lead. It was acknowledged that they had not been updated and this would be made a priority. This meant there had been a breach of the relevant regulation (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). The action we have asked the provider to take can be found at the back of this report.

People were encouraged to make their views known about Woodside Hall Nursing Home and the care they received. 'Residents meetings' were held every three months. These provided a forum where any concerns, issues or ideas were discussed. We saw at the last meeting in July 2014, the BBC panorama programme about poor practice in care homes was explored. The minutes reflected that if anyone had any concerns to contact the director.

Staff meetings were held on a regular basis. We looked at the minutes from the staff meeting held in July 2014. Issues such as medication and care plans were discussed. The minutes demonstrated how improvements in medication and care planning could be made. Staff commented that staff meetings provided the form for any practice issues or concerns to be addressed and discussed.

The director told us they had information available on advocacy services but that currently no one was using the support of an advocate. The director commented that advocacy services had been used in the past with good effect and they were aware of how to make a referral when required.

A dedicated activities coordinator was employed. During the inspection, a wide range of activities were observed taking place. These included bowels and arts and crafts. A shop was also set up in the dining room for people to purchase toiletries and other items. We observed people sitting outside enjoying the sunshine. A group of people were seen playing a game of cards while others were observed watching the commonwealth games in the TV lounge.

Many people residing at Woodside Hall Nursing Home were receiving end of life care or end stage dementia which was provided in the comfort of their bedroom. It is important that people have access to activities which are meaningful and important to them. One person was identified as spending all day in their room. We sporadically checked on them throughout the inspection. At no time was the TV or radio on for them. We noticed they also would be unable to tell the time as the time on their clock was incorrect. We looked at the care plan to see what activities they enjoyed. Documentation reflected that they enjoyed listening to the television. We were therefore not confident that this person was supported to engage with activities which they enjoyed. We have identified this as an area of practice that required improvement.

Requires Improvement

Is the service well-led?

Our findings

People had positive experiences of the care provided while others had mixed experiences. People commented that they found staff approachable and were aware of the staffing structure. Staff commented they felt well supported and could approach management with any concerns. During the inspection, we identified concerns with Woodside Hall Nursing Home quality assurance framework and culture of the organisation. We have asked Woodside Hall Nursing Home to make improvements in this area.

People received care from a team of eight to ten care staff in the morning. Seven care staff in the afternoon and four care staff during the night. Two registered nurses were on site at all times. During the inspection, it was identified that staffing levels were stretched. It was observed that staff worked on a task basis with set tasks having to be done at set times. We did not see any evidence of flexibility or staff taking time to spend with people. One person told us, "Sometimes they get overworked and can be a bit quick." Another person told us, "I like a chat. They try but somebody soon calls them. I'm out of area so don't have many visitors." Observation of staff interactions found that staff were under continual pressure to ensure the needs of all 53 people were met. It was clear though staff worked hard and this was reflected by some of the positive comments made by people. However, we have identified this as an area of practice that required improvement.

All people had call bells to summon assistance. During the inspection, concerns were identified with the response time to call bells being answered. We identified that concerns had already been raised with the management team about the call bells. A recent complaint was raised due to a person not receiving care in time and having to go to the toilet in their pad. Satisfaction survey feedback from staff, people and relatives confirmed they had concerns with the response time to call bells. Management had been informed of the concerns. However, there was no evidence that these concerns had been linked explored to see how improvements could be made. Therefore, we were not confident that concerns were being identified and responded to.

Accidents and incidents were recorded appropriately. However, there was no evidence that incidents and accidents were reviewed on a regular basis to monitor for any emerging trends or themes. The clinical lead told us, "We don't currently audit incidents or accidents but this something we can start doing." Therefore, there was not an effective quality assurance framework in place to review and monitor accidents and incidents. The above issue meant that there had been a breach of the regulations (Regulation 10 (1) (b). The action we have asked the provider to take can be found at the back of this report.

People, their relatives and staff were regularly asked to complete satisfaction surveys. Feedback was analysed by the director to monitor for any emerging trends or themes. We looked at the last audit dated April 2014. Where feedback was negative, we could not see the action taken to improve practice. The director told us that action had been taken but this was not recorded on the audit. Therefore, there was no evidence which demonstrated how Woodside Hall Nursing Home was improving following feedback from people, relatives and staff. The above issue meant that there had been a breach of the regulations (Regulation 10 (2) (b) (i)). The action we have asked the provider to take can be found at the back of this report.

We saw records of audits and meetings that had taken place. The clinical lead completed monthly medication audits and matron audits. Weekly checks for hygiene of commodes, catheter stands, wheelchairs and moving and transferring equipment were completed. Where any shortfalls were identified, audits were shared with senior management for any action points to be addressed

There was a staffing structure which gave clear lines of accountability and responsibility. There was always a trained nurse on duty who took a lead role in ensuring people's clinical needs were met. There was also a senior care worker on duty who was responsible for ensuring other care staff knew what their role for each shift was. Staff demonstrated a clear understanding of their roles and responsibilities. In between, each shift, staff had a handover which provided staff coming onto shifts with the information they required to do their job safely.

The director had been supported by the provider. Every month, the provider visited Woodside Hall Nursing Home and completed monthly reports. As part of these reports, the provider spoke with staff and people. The premises were inspected and incidents would be reviewed. Following each monthly report, planned improvements

Requires Improvement

Is the service well-led?

would be identified. The last visit in June 2014 identified for the carpets in certain areas of the home to be replaced. The director informed us, "We have received quotes to get a new carpet."

Staff were supported by senior management. One staff member told us, "I get brilliant support. We work as a team. We keep up to date with developments and are always learning." Another staff member told us, "It's good here and the training is really good." Woodside Hall Nursing Home had gained the Investor in People Award. This is a national accreditation services can achieve that shows they value and develop their staff.

When we asked the provider what was good about Woodside Hall Nursing Home, they told us they were proud of being able to have student nurses on placement. They had been reviewed by a University and Nursing and Midwifery Council (NMC). An educational audit found Woodside Hall Nursing Home was suitable for student nurses to be on placement. One student nurse told us, "I'm really enjoying being on placement here, its teaching me a lot."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Suitable arrangements were not always in place to ensure the privacy and dignity of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The provider had not taken steps to ensure that people were protected from the risks of unsafe or inappropriate care and treatment because not all care records were accurate and fit for purpose.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have suitable arrangements in place for acting in accordance with the consent of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not protect service users against the risks of inappropriate or unsafe care as there was no effective operation of system designed to monitor the quality of the service.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services** **The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs.**