HC-One Oval Limited

Woodlands View Care 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was carried out on 3 January 2018 and was unannounced. At their last inspection on 20 June 2017, the provider was found to not be meeting the standards we inspected. At this inspection we found that although some improvements had been made there were some areas that continued to not meet the standards.

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 112 people living there.

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.

The provider changed in December 2017. HC One limited, purchased some Bupa Limited Homes including Woodlands View Care Home.

Medicines were not always managed safely. Some people received care in a person centred way but we observed some people who did not. People, and their relatives where appropriate, were not always involved in planning their care. People gave mixed views about the activities provided.

There was a complaint's process which people and their relatives knew how to use. However, people were not confident that they would receive feedback from the registered manager.

There were not always sufficient staff available to meet people's needs in a timely way. Most people were supported in a safe way, however, some assessments and processes did not always promote this.

Staff knew how to recognise and report any risks to people's safety and staff were recruited safely. However, staff were overdue updates to their training.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005, however, this was not consistent. People gave mixed views about the food and relatives raised concerns about staff response to changes in people's health at times.

People were addressed by staff with respect and kindness. We found that confidentiality was promoted. Further development was needed to help ensure people's dignity was always promoted.

There were systems in place to monitor the quality of the home. However, they had not identified the areas that required improvement that we found on inspection. People, relatives and staff were not all positive about the running of the home.

Following our inspection we were made aware of an incident on 03 February 2018 involving a fire on one of the units at the home. One person sadly died during this incident. We are working with other agencies looking into the circumstances surrounding this.

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.

Medicines were not always managed safely.

There were not always sufficient staff available to meet people's needs.

Most people were supported in a safe way however, some assessments and processes did not always promote this.

Staff knew how to recognise and report any risks to people's safety.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who were overdue updates to their training.

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

People gave mixed views about the food.

Relatives raised concerns about staff response to changes in people's health at times.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were addressed by staff with respect and kindness.

Further development was needed to help ensure people's dignity was always promoted.

People were not involved in the planning of their care.

Confidentiality was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Most people received care that met their needs but we observed some people who did not.

People gave mixed views about the activities provided.

People and their relatives, where appropriate, were not always involved in planning their care.

There was a complaint's process which people and their relatives knew how to use. However, they were not always confident that they would receive feedback from the registered manager.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

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

People and staff were not positive about the running of the home.

The location had recently been taken over by a new provider.

Woodlands View Care Home

Detailed findings

Background to this inspection

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

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

The inspection was unannounced and carried out by two inspectors, a specialist adviser 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. A specialist adviser is a professional with expertise in the areas we were inspecting.

During the inspection we spoke with 10 people who used the service, six relatives, 14 staff members, the deputy manager and the registered manager. We received information from service commissioners and health and social care professionals. We viewed information relating to 10 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

Our findings

When we inspected the service on 20 June 2017 we had 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 management of people's medicines.

Medicines were not always managed in accordance with the prescriber's instructions. We observed staff working safely in the administration of medicines and there was a checklist for each medicine round prompting staff to monitor the records, storage and for any issues. We saw that there was a staff signature list and protocols for medicines on an as needed basis. However, we also found that some medicines which expired shortly after being opened were not dated on opening which made it impossible for staff to know when they must be discarded. We also found that some quantities of stock did not tally with records of medicines received into the home and administered. For example, there were more than expected which meant people may have not received doses of medicines. In addition we found some medicines recorded in the controlled medicines book were not in the building. Staff told us that these had been returned to the pharmacist but could not find where this had been documented.

Staff were knowledgeable about risks associated with people`s daily living. They were able to tell us names of people who were at risk of falls, at risk of developing pressure ulcers and at risk of malnutrition. We also observed that staff asked for a speech and language therapist assessment for people who were having difficulties swallowing their meals. However risk assessments were not always completed appropriately to offer guidance to staff how to mitigate the risks. For example for people who had falls staff completed a fall risk assessment tool to establish how high the risk was. We found that some people were at high risk of falls, however there were no detailed risk assessments or care plans developed to detail what measures and actions staff had to take to mitigate the risk in order to help reduce and prevent future falls. We found that assessments were not consistently completed across the home and some were not up to date to reflect people's changing needs.

We also noted that where people were assessed as needing bedrails in place, there was a requirement to have padded bumpers fitted. However, we saw several examples where people only had one bumper fitted. A staff member told us new ones had been purchased and they were going round replacing the missing ones. This placed people at risk of entrapment and injury.

Therefore this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities)

Regulations 2014.

People were supported by staff who knew how to keep people safe and were confident that the registered manager would respond to any concerns of abuse. Staff knew how to recognise and report abuse however, training was not up to date. There was information about safeguarding people from abuse displayed around the home to help raise awareness and we found that unexplained bruises or other incidents had been reported and investigated.

People who were at risk of developing pressure ulcers had appropriate risk management plans in place to support staff in understanding how to mitigate these risks. For example, people had appropriate pressure mattresses in place and staff regularly checked if these were set at the right setting. Every person who required a pressure mattress had their weight recorded and the setting on the mattress appropriately adjusted if they gained or lost weight to help ensure that the effectiveness of the mattress was maximised. In addition, staff regularly repositioned people who were not able to change their position in bed. We found that this was effective in preventing people to develop pressure ulcers and in healing those for people who had moved into the home with a pre-existing pressure ulcer.

We observed staff to be working safely. We saw staff carrying out correct moving and handling procedures and they ensured people were safely seated and had their walking aids close to them before they left. However, moving and handling assessments were not always accurate, up to date or consistent and this was an area that required improvement to help ensure people received the appropriate and safe support.

Accidents and incidents were recorded on an internal system while the new provider's systems were being implemented in the home. This helped them to identify themes and trends. This system also checked that all remedial actions had been taken.

People told us that there were not always enough staff to meet their needs. Two people told us they did not like to use their call bell to summon assistance because staff were working short and were busy. They told us they waited patiently until they saw staff walking on the corridor to ask for help. One person said, "I don't use the bell because they are always short. They will come eventually. I don't want a wash first thing in the morning but now is getting late [was 11:45]." Another person who had no call bell near them said, "I don't want that bell. I am not going to use it. They are so busy bless I rather wait to see someone on the corridor [to ask for help]." A third person told us, "Sometimes we wait a long time for the bell. You call and then you can wait 20 minutes before someone comes in." Their relative added, "If I am here I just go and get them and they come but [person] can't do that."

We noted that people's needs were mostly met in a timely manner and call bells were answered promptly. However, we did also observe instances where two people had waited up to an hour for the toilet, causing one to be incontinent and one person waited for over one hour to be repositioned to help ease pain in their back. They only received assistance when we requested staff support them. Staff told us that there were not always enough staff to meet people's needs. They told us when the home was fully staffed they managed but during periods where the home was short staffed due to last minute absences, it was a challenge. We were told that the home used agency staff when they were unable to cover shifts with regular staff but when it was short notice it was not always possible.

The registered manager told us that they had between 500-600 vacant care staff hours and around 420 vacant nurse hours. They told us that the previous provider regularly sent through applications for staff to interview however, this had ceased during the handover period. They told us that they informed the new provider of the staff vacancies and recently held a recruitment open day to drum up interest but it had been

unsuccessful.

We noted that one unit had frequent admissions and discharges and supported people with changing needs as they offered intermediate and rehabilitation beds. As a result this unit was very busy and staff told us that they struggled to keep care plans up to date as they focused on the care. We noted care delivery on this unit was good. We discussed this with the management team who acknowledged that the unit needed an additional staff member to manage the admissions and discharges, to liaise with the numerous health care professionals and to update records and they hoped to get this approved by the new provider.

Therefore due to the strain that the staffing shortages were putting on people and staff this was a breach of Regulation 18 of the Health and Social Care Act (regulated Activities) Regulations 2014.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable to support people who may be vulnerable. All pre-employment checks were completed to help ensure staff were fit for the role. This included written references, proof of identity and qualifications and criminal record checks.

Systems were in place to help ensure effective infection control. However, a relative told us that they had concerns about how staff managed and communicated a recent diarrhoea and vomiting outbreak which we were informed of by the home that had affected 16 people. The relative told us, "In terms of the diarrhoea, the unhygienic practices I witnessed could easily transfer bugs including washing the mop bucket in the kitchen sink. The same sink where I have seen staff just rinse out crockery and cutlery left in it, and turn down on the drainer instead of putting into the dishwasher where it can be properly cleaned." During the inspection we saw staff following infection control guidelines. This included handwashing and the use of gloves and aprons.

Staff had received training and we noted staff worked in accordance with guidance. For example, with the use of gloves, aprons and handwashing. However, we did note that training updates were due and some areas of the home needed further cleaning such as flooring. This had been identified through the audit process.

Lessons learned were shared by the senior management team to unit managers at daily and clinical meetings. Unit managers then shared this information with staff on units during handover.

Requires Improvement

Our findings

When we inspected the service on 20 June 2017 the principles of the Mental Capacity Act were not consistently applied. At this inspection although we found that some improvements had been made, the quality and consistency of these assessments varied across the service.

People and their relatives felt that some staff could benefit from further training. One relative said, "[Person] has difficulties (anxiety) which some members of staff can deal with and others don't know how to, they could do with more training. They don't seem to understand [health condition] at all." We raised this with the management team who told us that they had identified this as an area that needed development, however, no action had been taken at the time of inspection.

Staff told us that they received an induction training when they started working for the service. They told us they felt that the induction training was not effective in helping them understand their role and what caring for people in a home meant. One staff member said, "The induction training was mainly about company`s policies and procedures and very little about other subjects. I had to research and learn about things myself. I am passionate about care and I was interested to learn but had no training since my induction and that`s over a year now." Another staff member said, "I was lucky I worked in care before. The induction is not thorough and I don't think it gives staff an understanding of what care is about." They continued, "I had no training other than fire since I came here (over 2 years)." The registered manager told us that they offered up to a week of shadow shifts where new staff worked with experienced staff. However, due to staff absences this sometimes did not happen as new staff worked as part of the rota.

Staff told us they felt supported by the unit managers and seniors on a daily basis to carry out their roles effectively, however supervisions were not carried out regularly. One staff member said, "I only had supervision after six month (after starting date) and none since then (employed over a year ago)." Another staff member said, "Supervisions are not regular. I had one in October 2017 but they don't happen often."

The registered manager told us that they had identified that the training for staff had lapsed and we saw evidence of e-mails to the provider`s training department confirming that they requested this to happen. However since the beginning of 2017 there had been few training sessions made available for staff to refresh their knowledge about current best practice.

Some external training sessions had been arranged for staff for End of Life training, however the registered manager had not explored other resources available in the area such as training provided by the local

authorities. We found that only 52% of the staff had been considered in-date by the provider with their safeguarding training, 73% in moving and handling people and 73% in basic food hygiene.

Due to infrequent supervisions and overdue training in many areas, this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

The management team demonstrated an understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They knew what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. However, the appropriate applications and documentation was not consistently in place for all relevant aspects of people's lives.

Some peoples` mental capacity was assessed appropriately. Where people had a diagnosis of dementia, staff assessed if they were able to understand and make decisions about receiving care and support in the home. Where these people were assessed as lacking capacity, best interest decisions were documented to help ensure the care and support people received was in their best interest. However, this was not consistent across the home and some people did not always have the appropriate documentation in place. This was an area that required improvement.

People were supported and encouraged to make their own choices. We heard staff ask, "Can I help you cut up the food?" "Would you like me to move your chair a little?" We found that staff were knowledgeable about the principles of the MCA and the need of best interest decisions to ensure the care and people received was in their best interest. We heard staff asking for people`s consent before they delivered any aspect of 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.

We found that on some occasions MCA assessments had not been carried out for decisions which could have affected people`s lives. For example, one person told us they felt trapped by the bedrails used for their bed. We checked the person`s care plan and we found that staff recorded, "[Person] doesn't like the bedrails up but understands why they are up." There were no MCA assessments carried out for the person or best interest decisions in place to detail why the bedrails were required. The person`s care plan detailed that staff should consult them for every decision regarding the care they receive. We asked staff to tell us if they thought the person had capacity and they said they did not think the person had capacity because the person was anxious and constantly asking about their family. This person had a diagnosis of dementia recorded in their care plan but no plan to support this need and staff were unsure if indeed the person had dementia. The person had been admitted in November 2017. They also had a DNACPR form completed in October 2017 where the health care professional recorded that they discussed this with the person who took the decision not to be resuscitated. This implies that they had capacity but there had been no action taken to listen to their preferences and ensure their needs were met in relation to the use of bedrails and contact with their family.

We observed that there was a wide use of bedrails and a high number of people were assessed as requiring these. One person told us, "I feel trapped and I can't get out of bed and sometimes I don't know what is happening." Another person said, "I can walk but I don't feel too well today, I don't need these (bedrails)." The reasons were not clearly detailed in records if people needed bedrails to keep them safe. For example, a person had a risk assessment in place for bed rails, they also had a MCA assessment carried out for the use of bed rails, however in the best interest decision there was no detail of what other options had been considered and if the use of the bed rails was the least restrictive option. This was an area that required improvement.

We saw that staff involved health care professionals in people`s care when it was a need for it. One person told us, "The GP only visits once a week I think but if you are ill then they will come out." Staff told us about involvement from GP, dieticians, chiropodists and opticians. On the day of the inspection we saw people who were using a rehabilitation service provided in the home were visited by a physiotherapist and a person had a speech and language therapist (SALT) assessment at lunch time. The professionals we spoke with praised the staff working at the home and told us they felt people made good progress with their mobility because staff followed their recommendations when supporting people. One health care professional told us, "Staff are very receptive and enthusiastic. We have very good communication and relationship with staff. [Staff member] is extremely knowledgeable about people here." However, relatives had raised concerns that at times they felt there was a delay in people receiving medical input. They told us it could take them requesting a GP more than once for staff to act on their concerns. We noted that on one unit some people were not feeling well and when we asked staff about what they were doing in relation to them feeling unwell they did not know. When prompted, one staff member told us that they would raise it with the nurse. We shared our concerns with the management team. This was an area that required improvement.

The home was designed in a way so that people could move around easily, whether this was independently or with the use of mobility aids. Equipment was available in bedrooms and bathrooms to enable people to be independent where possible. There was an appropriate supply of mobile equipment, such as hoists or commodes, to help ensure there was not a delay for people waiting for assistance. There were call bell points available in all rooms in case people needed assistance. There were lounges with sufficient seating on each floor and plenty of dining space so people could eat together if they wished. Bedrooms were personalised in most cases and there was also an accessible garden. The windows had a privacy screening put onto them, effectively a darker sheet of film which reflected light back from the outside but did make the room slightly darker. One relative told us, "We asked to have a panel removed. They told us if they removed it we would have to pay to have it replaced when the room was vacated. A cheek really because we didn't ask and we weren't given a choice."

People and their relatives gave mixed views about the food. One person said, "The food isn't very good but I can have what I want from the choices so today I'm just having scampi and mash." Another relative told us, "They aren't very flexible. On every fourth Sunday they have either pork or salmon [person] doesn't eat either so I asked the chef but they can only have omelette or baked beans or something like that so now I bring in a roast dinner every 4th week." The registered manager told us that the new provider would be implementing a new menu through consultation with people, possibly by May 2018.

We found that the mealtime experience varied across units. On three of the units, most people received the support they needed. However, on Newton Unit we found that the mealtime experience and monitoring of people nutritional needs was an area that required improvement. We saw that at breakfast people had a variety of choices and those that had porridge were also offered a variety of cooked foods. Staff knew people's preferences and offered options they knew they enjoyed. For example, one person was offered egg and bacon and another scrambled egg on toast. When they couldn't decide on the type of egg, both

scrambled and fried was given. Lunch looked and smelt appetising. The meal choice process varied across the home, some were given a visual choice, others offered the choice at the time but on one unit they were asked what they wanted for the following day. In addition, when the meals on this unit were brought out, staff did not remind people what it was they had chosen the previous day and it was just put on the table. One staff member took a lot of time and trouble finding out what one person wanted, the person had communication difficulties. When the staff member discovered the person wanted ice cream they walked away, returning 10 minutes later with no ice cream.
A meal was taken to a person in bed, the food was left and the door closed firmly behind the staff member. The person had quite extreme tremors. We opened the door to see how they were coping and found that they were lying almost flat. A staff member went in to the room and said, "Why haven't you eaten your lunch?" The person tried to express something about their face (we had observed the person repeatedly rubbing their face). The staff member offered pudding, with no response, removed the food and left the person to it. We asked the staff member about this and they told us this behaviour was not normal and the person normally ate well. However, there was a lack of compassion, time and encouragement to support the person. We also noted that this person was recorded as losing weight which indicated it had not been an isolated incident for this person to not eat or have heightened anxiety. We raised this with the management team. This was an area that required improvement.

We noted that although the tables were set nicely on some units, on one unit people were not given the option of moving from the lounge chair they sat in and were given overlap tables rather than sitting at the dining tables. In addition, no condiments were available on tables or offered for people to add to their food independently. The mealtime experience was an area that needed to be further developed on this unit in particular.

Drinks were offered regularly on most units and we observed senior staff informing staff that beakers and cups must be empty before being taken from people. Fluids were recorded and tallied with a target quantity that people should try to consume in a 24 hour period. However, we noted on one unit people did not have drinks available and we observed one person who looked dry mouthed and told us they had a sore throat. There was one cloudy glass of water available and they told us they needed a drink but the water tasted horrible.

People had their weight monitored regularly and staff used a tool to identify if people were at risk of malnutrition (MUST). People`s care plans however were not detailed on what actions staff needed to take when people gained or lost weight. We found that some people were weighed weekly in case they were identified as losing weight. However when we looked at the tracker kept by the unit managers to monitor people`s weight we saw that some people had lost significant amounts of weight from one week to another. Staff told us that one person had previously been weighed whilst they had a cast on and when the cast was removed they had a difference in weight. However this information was not documented to be readily available for visiting health professionals.

Staff told us that if a person was identified losing weight they commenced a food and fluid chart to monitor their intake and if the person continued to lose weight they involved the GP and Dietician in people`s care. We found that this had not happened every time. For example a person had been weighed on 16 November 2017 and was 57.8kg in December 2017 they were 55kg. Staff told us they should have monitored this person`s food and fluid intake and refer them to the GP however this had not happened. There were different textures of food available for people to meet their dietary needs including soft diet, puréed diet and fortified diet. Staff were knowledgeable about people`s dietary needs and were able to tell us if they had to involve more specialist support for people like SALT team. However the management of nutritional intake and record keeping was an area that required improvement.

Some people needed assistance to eat but staff supported them in an unhurried and calm manner. For example, we heard one staff member chatting and laughing with someone while they sat with them while they drank their tea.

Requires Improvement

Our findings

When we inspected the service on 20 June 2017 we found that people's 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 required improvement.

People received care from staff in a kind, caring and respectful manner. One person told us, "Staff are excellent, very kind to me" Another person said, "They are really nice and they help me get on my feet." Staff were friendly, courteous and smiling when communicating with people. We observed sensitive and kind interactions between staff and people who used the service. The way people related to staff demonstrated good relationships between them based on respect and trust. However, people told us that due to being busy staff were unable to spend time with them. One person said, "They are so busy they don't have much time to talk to me." Another person told us, "They come in and check on me but they don't have time to stop. It's very lonely in here." One staff member said, "I love my residents, it's so nice looking after people. I think some days they recognise me, they tell me they like my smile, especially [person]."

Staff treated people with dignity. One staff member said, "They always knock on my door and I can have female staff. They are very good." They addressed people using their preferred names and we found that staff knew people well. Staff knocked on bedroom doors and greeted people when they went in. Bedroom doors were closed when staff provided personal care to people. However, we did note that all bedroom doors were open when we arrived in the morning and it was not documented that this was people's preference and not for staff convenience when checking on people through the night. As a result we saw some people in an undressed state which did not serve to promote dignity and privacy.

We also found that in some units people's belongings were not kept tidy and clothes were lying around the room. We also found that continence pads were on display for ease of staff when delivering personal care and support but this did not promote dignity and privacy. This was an area that needed development to help ensure people's belongings were respectfully looked after and rooms were kept in a way that people liked. This was an area that required improvement.

In most cases, people looked well groomed, their hair looked clean and combed. There was a relaxed and happy atmosphere in the home. The relaxed manner staff approached people with created a sense of calm and a warm homely feel in the home. Staff were familiar with how people communicated and responded appropriately. One relative told us, "I think staff do the best they can." They went on to say that their relative had complex needs. However, we noted that some people did have dirty finger nails and on one unit the

atmosphere lacked the warmth and atmosphere found on the other three units. This was an area that required improvement. We raised this with the management team.

There was a regular church service at the home and people could choose to attend. However, for people whose religious beliefs or faith could potentially influence the care and treatment they received this was not incorporated in their care plans.

There was little evidence in how people influenced and participated in their care delivery. Some people signed their care plans to agree for their records to be shared with other professionals, however there were no records to indicate they reviewed their care plans. We saw that some people`s relatives signed care plans and also had meetings with staff to discuss the content of the care plans, however the outcomes of these meetings were not recorded and care plans were not updated.

In most cases people were encouraged to maintain relationships with family, friends and partners. Visitors were encouraged and invited to events and staff knew about who was important to people. However, we noted in one instance a person was worried about their spouse. There had been no plan developed to support the person with this or to maintain contact through phone calls to ease their worries.

People's records were stored in cupboards in locked 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 propped open making records accessible to people who were authorised access.

Requires Improvement

Our findings

When we inspected the service on 20 June 2017 we found that people did not always receive person centred care and activities did not meet people's needs. At this inspection, although we found some improvements to activities, people did not always receive person centred care.

People's care needs were met in most cases. One person told us, "They (carers) know what I like – they should do I've been here long enough. They don't have time to talk but they know what I like so they just get on with it." However a relative told us, "[Person] had wet pads and wet sheets, the night carers changed the pad but not the sheets and by lunchtime the next day the sheets had still not been changed." This person spent most of the time in bed. We noted that requests for support were responded to when requested in many cases. However we did need to prompt staff at times to avoid further delays for people. This was in relation to using the toilet, changing a pad and repositioning to reduce discomfort. Care was not always person centred. People told us that they were not able to have a bath or shower when they wanted. One person said, "I have asked for a bath, I write it down, I asked on 22nd December because I wash my hair in the bath too, and I still haven't had one." and then went on to tell us, "I asked again this morning and the carer (who is very nice) told me 'don't even think about it, we are so short staffed." Another person told us, "You can't get up when you want to, you have to wait for them. It's alright as I have a pad I suppose. I have to wait for two of them."

Relatives had also raised concerns with the CQC about the lack of baths or showers. Another relative told us, "There have been days when [person] wants to get up at 12 and still no one has come by 3pm." People's preferred times to get up and go to bed were not reflected in care plans and people told us that they just wait for staff. Care was delivered on an as needed basis, not always when people wanted. We heard one person calling for a member of staff for more than 5 minutes. The unit manager went into the room and the person told them, "I don't want to be lying on my back anymore, it's uncomfortable." This was at 10.34am. The unit manager told the person that a member of staff would be along to help soon. By 11.10am no one had come and person was still calling intermittently. We informed a member of staff who told the person they would find someone to help but had another person to help first. At 11.40 the person was being helped to get up, over one hour since we first heard them ask for help.

On some units, people's care plans were detailed to enable staff to support people appropriately. We noted that the plans included sufficient information for safe and appropriate care to be followed. On one unit there was a daily portrait available which gave staff the relevant information at a glance. However, on other units, some plans were sparse or not updated. These care plans were not effectively completed to assess and

address people`s needs. There were assessments carried out by staff regarding people`s mobility, personal care needs, nutrition and other areas, however care plans were not consistently completed, updated and reviewed. For example, where people lacked capacity to take certain decisions or had restrictions to their freedom applied in order to keep them safe, the care plans had no detail for staff on how to ensure that the restrictions were minimised. People`s care plans detailed that DoLS authorisations were in place, however there were no records to detail if these were granted or just applied for or if there were any conditions attached to DoLS authorisations.

We found that for people who only temporarily used the services in the home care plans were not fully completed and risk assessments were not always in place. For example, one person moved in the home In November 2017. When we reviewed their care plan found that they only had their care plans partially completed and areas to address their nutritional needs, mental health wellbeing and continence were left blank. We noted that the person had lost 1kg in one month; however this had not triggered staff to commence a nutritional care plan for the person. Staff told us they should have updated the care plans weekly or when people`s needs changed, however because senior staff often worked as part of the staffing numbers on the floor they had not updated care plans.

We also found that one person had asked for support to change their appearance as they were very conscious about it. However there was nothing in their care plan about investigating the issues or how they were supporting the person to resolve their concerns. We asked staff and they told us that as the person hadn't mentioned it again they had taken no further action to address it. This indicated that staff were dismissive of the person's feelings, concerns and care needs.

People and their relatives told us that they hadn't seen care plans, and had not been involved in care planning. A relative told us, "We haven't ever had a one to one meeting to discuss how they are going to help [person]." They went on to say that they had never had any care plan reviews or review meetings

Therefore due to the lack of person centred care in some units and the inconsistent care planning, this was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People gave us mixed views about the activities available. One person told us, "The library lady comes once a month and the carers are very kind and bring me lots of books." Another person told us, "I really miss going out and about – they don't do much. Even just going out for a coffee and making a friend would be good. " A relative told us, "Activities are just a bit of paper, they write out this stuff on a list but you never see anything being done, nothing to get [person] out of bed." We noted that people were asked about their interests and hobbies but we could not see how these were incorporated into the scheduling for activities, outings and events. We spoke with an activities organiser who demonstrated a good amount of knowledge about the people they supported. However, for people who spent most or all of their time in bed, the variety of activities was limited. Although time was spent chatting to people, there was not much else offered to people being cared for in their beds. This was an area that required further development to ensure people received sufficient stimulation to prevent isolation and promote wellbeing.

Activities and events in the home included art and crafts, games, quizzes, flower arranging, outside entertainers and pet therapy dogs. We were told that sometimes the units arranged 'joint' activities for those who were mobile and able. Also a pub lunch where one resident from each unit goes out to lunch with one member of staff. This was a social activity but could be better arranged in terms of 'buddying' with other members of the 'house' communities. A quiz was being enjoyed by three people on one unit and the people sitting together chatted. Others were sitting in the lounge area watching a film.

The service supported people at the end of their life. Some people had their wishes documented in their care plans, some did not have any information in place to guide staff on how to support people when they reached the end of their life. We discussed this with the registered manager who told us that they were working with the local hospice to train staff and as part of this they were going to visit the home to audit the end of life care plans.

There were complaints documented. We noted that these had been investigated and responded to. However, some relatives said that they didn't always get feedback from complaints made. One relative said, "I don't rate the overall manager. I did complain about a carer who said she would be back in a minute and just didn't come back, then found out she'd gone off duty and hadn't told anyone we needed help. I complained but the manager said it would be dealt with but never came back to me."

Another relative said, "[Person] should be on food assist and we know for sure that it hasn't been done for at least 4 meals – the caterer complained to the main manager and the last meal there was assistance but the manager hasn't fed back on the problem. The trouble is [person] is in so much pain eating isn't easy." We noted that we had not seen a record of these complaints indicating that they had not been recorded as a formal complaint.

Requires Improvement

Our findings

When we inspected the service on 20 June 2017 we found that there were areas of the quality assurance systems that required improvement. At this inspection, we found that the service was not meeting the standards and had not made the required improvements.

There were quality assurance systems in place to help identify and address shortfalls in the home. These included internal audits and checks. There had been regional manager and quality visits from the previous provider. We found these audits, checks and visits identified where things needed action and the action plans were effective in resolving the issues. By using these audits and sharing the findings and lessons learned with the staff team, they told us that it had made improvements to the home. For example, a reduction in urinary tract infections. However, people had been admitted to hospital with urinary tract infections where relatives told us they felt there had been a delay in treatment being sought which indicated staff may not have identified possible infections. In addition, they had not identified or addressed the areas that required improvement that we found on inspection. This was in relation to consistent person centred care, gaps in care plans and management of medicines.

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

People and their relatives were not positive about the registered manager or the management of issues. One relative said, "Not very easy to talk to." Another relative told us, "Sometimes not very accessible." Relatives told us that the unit managers were, "always available." And said, "I can ask anything."

Staff told us they felt that the senior managers were not as approachable as the unit managers. They told us that they did not feel listened to or supported by the senior managers. One staff member told us, "The manager here [Unit] is good but I don't feel the others are listening. We don't get a single thank you for the extra shifts we do or for doing two peoples` job when we are short. I don't feel valued and appreciated by them [senior managers]. The team here [unit] works very hard and gets things done." Another staff member said, "No they don't listen. They are telling us they are recruiting but they take on anyone who walks through the door and then they leave in five minutes. I didn't see any new staff employed in three months. We are not enough."

The provider had recently changed. HC One limited purchased some Bupa Limited Homes in 2017. In

December 2017 the provider changed from Bupa Limited to HC One limited. There had been letters sent to people, relatives and staff advising them of the changes and the regional manager had been in contact with the registered manager. However, there had been no formal audit or review of the service by the new provider at the time of the inspection. Following the inspection we contacted the provider to seek assurances that the necessary support and systems would be implemented to ensure the service was able to comply with Regulations. They told us that they would immediately compile an action plan and make the service a priority.

Staff told us they were anxious because they were not updated or consulted before a new owner bought the home. Staff told us they were reassured by the registered manager that they will not be affected by the change of ownership. One staff member said, "We receive no information about who is it, what is going to change because something will change. I received no letter and it was no meeting about this. They [managers] are saying the change is not affecting staff but I don't know what to believe."

We noted that there was a leadership structure in the home, with unit managers supporting the registered manager and deputy manager and also a clinical manager providing support and guidance. We were told that the registered manager, clinical manager and deputy manager walked around the home, checking on people and standards and guiding staff on a regular basis. One staff member said, "They're not afraid to help out either if needed."

People and their relatives were asked for their views in relation to the running of the home through occasional meetings or cheese and wine evenings and there had previously been a survey. No one we spoke with had been to a relatives meeting recently and one relative told us, "There have been no relatives meetings since the summer, probably August." We noted that there had been a cheese and wine evening on 30 November but was only attended by a few people.

The service worked in partnership with other agencies to help ensure people received the appropriate support. We noted that there was contact with the local authority who had a contract with the service to provide permanent and intermediate care beds. They last carried out a monitoring visit in July 2017 and were due to revisit the home to follow up on the outstanding actions.

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.

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 People did not always have their medicines managed safely and risk assessments were incomplete in some cases.

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 Systems in place had not addressed issues from previous inspection or identified shortfalls found at this inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's needs and staff training and supervision was overdue in many cases.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not consistently receive care that met their needs and care was not always person centred.

The enforcement action we took:

TBC