Woodchurch House Limited

Woodchurch House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 11, 12 and 14 December 2018. The inspection was unannounced.

Woodchurch House is registered as a domiciliary care service and a care home. A domiciliary care agency provides personal care to people living in their own homes. Under this arrangement people's care and housing are provided under separate contractual agreements. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. In this case the Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Woodchurch House is registered to provide nursing, personal care and accommodation for up to 60 people, and at the time of the inspection there were 57 people living there. Most people were receiving personal care from staff and had rented their accommodation within Woodchurch House. They also received support from nurses who were employed by the registered provider under a separate agreement. It was arranged over two floors, with each floor having its own communal lounge area.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Woodchurch House was last inspected on 16 and 17 October 2017. We found continued breaches of legal requirements in relation to Regulation 9, 12, 17, 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one other breach found in relation to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider sent us an action plan which detailed how they planned to address the breaches of regulations.

At this inspection we found that the provider and registered manager had made improvements to the service. However, further improvements were needed in three of the five domains.

Action was not always taken to protect people from risks. There were insufficient risk assessments in place to manage the risks of smoking at the service and national best practice guidance had not been followed.

People were put at risk from abuse. The registered manager had not followed up on all safeguarding concerns reported to them and the registered manager had failed to notify us of a notifiable event in a timely manner.

Effective systems were not in place to consistently assess, monitor and improve the quality and safety of the

service. The provider had made some improvements to systems. However, these had not been fully embedded, which meant further improvements were required.

People's care plans had been reviewed and updated to ensure that their care and support needs were clear and their preferences were known. However, not all care plans consistently reflected each person's specific healthcare need.

People's needs were assessed and their care was delivered in line with current legislation.

People were supported to eat and drink enough to maintain a balanced diet.

Referrals were made to health professionals such as GP's and speech and language therapists.
There were enough staff to meet people's needs. People were responded to in a timely manner and staff could spend time with people.

Staff were recruited safely. Staff received training which ensured they had the skills and knowledge to deliver effective care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received their medicines safely. People were protected by the prevention and control of infection. The service was clean and smelt fresh.

People received care that was responsive to their needs. Relatives told us they knew how to complain if they had any issues or concerns.

Staff knew how to support people if they needed to in order for people to have a pain free and dignified death.

People, their families and staff were encouraged to be involved with the service. There were links with the local community schools and the local hospice.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Registration Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

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 always safe.

Action was not always taken to protect people from risks. When risks were identified they were not always effectively managed.

People were not always protected from the risk of abuse because the registered manager had not taken adequate steps to follow up on concerns raised with them.

There was enough staff to meet the needs of people living at the service.

Medicines were being managed safely.

People were being protected from the prevention and control of infection.

Is the service effective?

Good

The service was effective.

Staff and professionals and ensure people had access to health care and treatment.

People had their care delivered in line with current legislation and best practice guidance.

Staff had the skills and experience to meet people's needs. People's nutrition and hydration needs were met.

Staff knew how to seek consent from people and were knowledgeable about the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were communicated to in a kind and compassionate way.

People were involved with decisions about their care.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care and treatment met their assessed need.

People received information in an accessible way.

People were supported to take part in activities that interested them.

People told us they were confident to raise complaints about the care and support they received.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had not notified CQC of all significant events.

Governance systems were not always effective in ensuring shortfalls in service delivery were identified and rectified.

People, their families and staff were encouraged to be engaged and involved with the service.

There were good links with the local community

Woodchurch House

Detailed findings

Background to this inspection

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

This inspection took place on 11, 12 and 14 December 2018 and was unannounced. The inspection team consisted of one adult social care inspector on the first day and final day. On the second day there was one adult social care inspector and an expert-by-experience. The expert-by experience had personal understanding of older people and those living with dementia.

Before our inspection we reviewed information we held about the service including previous inspection reports. We did not ask the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 12 people who lived at Woodchurch House and observed their care in communal areas, including the lunchtime meal, medicine administration and activities. 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.

We spoke with 12 people's relatives throughout both days. We inspected the environment, including communal areas, bathrooms and some people's bedrooms. We spoke with seven care staff and senior care staff, the cook, the manager, the provider and a general practitioner.

During the inspection we reviewed six people's care plans and associated records. We also looked at nine staff files. These included supervision records, recruitment and training records. We reviewed medicines

records, risk assessments, accidents and incident records, quality audits and policies and procedures. We asked for further records to be sent after the inspection, which we received in a timely manner.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2017 we found that the provider and registered manager continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because they had failed to take appropriate actions to mitigate risks to people's health and welfare. Risks to people's health and safety had continued not to be suitably assessed and managed to ensure safe care was provide. At this inspection we found that improvements have been made but there were shortfalls in other areas.

Woodchurch House had a no smoking policy that stated, "It is the policy at Woodchurch House Nursing Home that smoking is not be permitted in any part of the buildings of the Home by residents, staff, and visitors alike." Despite this policy being in place, during the inspection we smelt stale cigarette smoke on the 2nd floor and outside the suite that was allocated to the registered manager. Staff told us, "I have smelt cigarette smoke whilst on shift down the end of the 2nd floor." Another member of staff told us, "We have seen smoking materials in the manager's room." The provider told us, "What the manager does when she has finished work is up to her." This went against the provider's own smoking policy. Whilst smoking in care homes is exempt from "Smoke Free" legislation there should be robust risk assessments carried out to ensure the safety of people and staff. There were no risk assessments in place to allow smoking inside any of the rooms at the service, neither were any of the rooms suitable for smoking to take place either by residents, visitors or staff. This placed people and staff at risk if a fire broke out at the service as a result of these actions. The provider told us that smoking would cease immediately following our inspection.

Another person's care plan stated that a weekly urine test should be carried out so that infection could be detected at the earliest opportunity. Despite the test being recorded in the person's care plan as needed to be carried out, this was not recorded. This meant the person had not received care and treatment to meet their assessed need.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This is a continuing breach of legal requirements in relation to Regulation 12.

Incidents involving people were recorded and action taken to look for trends. Where needed, steps were taken to help mitigate risk. For example, extra monitoring and redeployment of staff was implemented to help reduce incidents from taking place. However, not all incidents where alleged abuse had taken place were shared with the local authority safeguarding team. On one occasion, staff heard noises coming from a room and found two people having an altercation. One person was had an injury that needed attention from a nurse. On another occasion, two people were found to be having a physical altercation in a corridor on the first floor by the nurse's office.
The provider's own safeguarding policy stated, "When a suspected incident of adult abuse is reported, the manager/senior person must take it seriously and request statements from witnesses to establish the facts, in order to decide whether the allegation has some substance requiring referral and further investigation. With both of these incidents, steps as detailed above were not followed. This meant that the local authority

safeguarding team was not consulted at the earliest opportunity so that they could decide whether further investigation was required. During the inspection, the registered manager ensured us that they would discuss these incidents with the local authority.

The Provider had failed to report an allegation of abuse in line with the procedures agreed by the local Safeguarding Adults Board. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

All staff had received safeguarding training and were able to describe how they would recognise abuse or neglect. Staff knew of the service's whistleblowing policy if they felt any concerns were not being addressed appropriately.

At our last inspection we recommended that the provider and registered manager reviewed recording systems for pain relief patches and PRN medicines (as and when required medicines) following good practice guidance. At this inspection, we saw improved practices and staff recorded the different regions where pain relief patches were applied which reduced the risk of skin irritation. When people were given medicines as and when required this was now being recorded on people's daily notes and the reasons for them being given. Topical creams and lotions were applied as prescribed and recorded appropriately. There were no skin integrity concerns during this inspection. Medicines that had special legal requirements were stored securely and had been checked daily and weekly to ensure stocks were correct and that safe practices were followed. The medicines rooms and fridges were maintained at suitable temperatures and these were recorded daily. Where some people received their medicines covertly or without their knowledge, there were proper authorisations and best interest decisions documented.

At our last inspection we recommended that the provider and registered manager reviewed staffing levels on a day to day basis to meet people's changing needs. At this inspection we observed staff attending to people in a timely manner. We observed mealtimes on two days of the inspection and on both occasions this part of the day was relaxed. People received their meals with minimal delay and the dining experience for people was enjoyable with some chatter heard and people were smiling. There were suitable numbers of staff on shift to meet people's needs. Staffing rotas showed that a nurse was allocated on each floor along with senior carers and activity co-ordinators. One person told us, "I think there is enough staff, they always come when I need them."

Robust recruitment procedures were in place. Files contained the required health checks and Disclosure and Baring Service (DBS) background checks. DBS checks help employers to make safer recruitment decisions. Within files there was also application forms, full employment history, records of interview and references. All nurses were registered to practice with the (NMC) Nursing and Midwifery Council. These recruitment procedures ensure staff working at Woodchurch House were of suitable and qualified character.

The premises were clean and well maintained. Measures were in place to prevent and control the spread of infection. These included the registered manager assessing, reviewing and monitoring the provision that needed to be made to ensure that good standards of hygiene were maintained in the service. There were records to show that checks took place to help ensure the safety of people, staff and visitors.

Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been reported. Portable electrical appliances and firefighting equipment were properly maintained and tested. Health and safety audits were completed and that these were reviewed by management to see if any action was required. These checks enabled people to live in a safe and suitably maintained environment. Staff told us everything was in working order. The business continuity

plan detailed the steps staff should take in order to keep people safe in the event of emergencies.

Good

Is the service effective?

Our findings

People and relatives told us they thought the care and support they received met their needs. One person told us, "I am confident in the staff's abilities." A relative commented, "[Loved one] has had support to visit the dentist and the hospital."

At our last inspection in October 2017 we found that the registered provider and manager were in breach of regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because improvements were required in relation to staff training and the recording of people's food and fluid intake. Records designed to monitor changes to people's mental health or behaviour were not properly completed. At this inspection we found that improvements had been made and these were no longer areas for concern.

People met with staff before they moved into the service to check that staff could meet their needs. The assessment included all aspects of the person's health and welfare including their sexuality, cultural and spiritual needs. Staff told us that they would discuss with people about their preferences and if the service could not meet their needs they would not be admitted to the service. The assessment was used as a basis to the person's care plan.

People's clinical and support needs were assessed using recognised tools following the guidelines from the National Institute for Health and Care Excellence. These included nutrition, skin integrity and dependency. People's care was designed following the guidelines from the assessment such as when people were at risk of losing weight, monitoring was put in place.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. People had been assessed and DoLS applications had been made as appropriate. Some people had DoLS authorised and where conditions were in place, these had been incorporated into their care plan. There was a system in place to ensure that when the DoLS authorisations were due to end, staff applied for them in a timely manner.

People were supported to make decisions about their daily lives including how they spent their time and what they had to eat. Staff told us that if people were unable to make simple decisions, they would use what they knew about their likes and dislikes to decide. People were encouraged to be involved in making

complex decisions about their care and their decisions were respected. People's capacity was assessed following correct processes. When decisions had been made in people's best interests these were recorded and involved staff, relatives and professionals that knew the person well.

Staff monitored people's health and referred them to healthcare professionals such as their GP, when required. One person told us, "When I was under the weather, the staff knew straight away. They called the GP and I was admitted to hospital."

People's weight was monitored monthly, when people lost weight they were given a fortified diet with higher calories and fat content and referred to the dietician. Some people had difficulty with their swallow, they had been referred to the speech and language therapist for assessment. Staff followed the guidance given by the professionals, we observed people being given thickened fluids to keep them safe.

People had access to health professionals, such as the chiropodist, dentist and optician when needed. People were supported to attend hospital appointments and raise concerns they have about their health.

People were encouraged to eat a balanced diet. The kitchen staff were aware of people's dietary requirements including pureed and vegetarian diets. People had a choice of meals, if people did not want what was offered they could choose an alternative. We observed the lunchtime meal, some people chose to eat in the dining room, whilst others preferred to eat in their own rooms. One person told us, "The food is always nicely cooked and well presented. Occasionally there is something I don't fancy, I always tell them and I get something else." Staff supported people with their meals when required, giving people time to enjoy their meals. People were encouraged to eat independently using equipment such as specialist cutlery and plate guards.

New staff completed the providers induction process. This involved completing a range of training programmes, whilst working through an induction booklet. Each new staff was assigned a mentor to support them in their induction and training, alongside the registered manager. Staff told us during induction they were given the time to get to know people and read their care plans. Staff that did not have a qualification in care completed the care certificate.

Staff told us they received training appropriate to their role. We viewed the training matrix, this showed that staff received a mixture of face to face and online training, which included first aid, fire safety, moving and handling, health and safety, person-centred care, equality and diversity, mental capacity and safeguarding. Staff received additional training aimed at meeting people's specific needs such as dementia care, falls management, skin integrity, diabetes, dignity, behaviours that challenge and end of life care.

Staff received ongoing support through regular updates, supervision and appraisals. Supervision in care settings is a process whereby through regular, structured meetings with a supervisor, care staff can develop their understanding and improve their practice. Competency checks and observed practice was taking place, for example regular competency checks were record for staff administering medicines.

Woodchurch House had been designed to meet the needs of people living there. Corridors were sufficiently wide for wheelchair access, and there was accessible outside space for those who enjoyed sitting in the garden. There was pictorial signage around the service to support people who may forget the use of a room, such as a toilet or dining area. People's rooms were personalised and individual, with photographs and personal possessions.

Good

Is the service caring?

Our findings

At our last inspection, people were not always treated with respect and their dignity was not always protected. At this inspection we found significant improvements.

People told us that they felt staff were thoughtful and caring. Various comments received included, "The staff are kind and caring, I like it here." Also, "The girls always treat me with dignity, I never have worry about that." A relative also told us, "Staff are respectful, and make this place feel homely."

Staff knew about people's background, their likes and dislikes and what their hopes and goals were. Staff told us they spent time with people to get to know them, throughout the inspection we observed staff spending time with people. One member of staff told us they had found out about where a person used to work, this helped them have more meaningful conversations. Another member of staff told us that one person liked a routine which helped them manage anxiety. There were descriptions of what was important to people and how to care for them in their care plan. Staff talked about people's needs in a knowledgeable way and explained how people were given the information they needed in a way they understood so that they could make choices. We observed staff involving people in the preparation of lunch, for example, peeling potatoes. We also saw people helping with laundry tasks. We could see people smiling and enjoying themselves as they felt valued helping around the home as they would in their own homes.

Staff supported people in the way they preferred. People responded well to staff and looked comfortable in their company. Staff interacted with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner. Staff treated people with kindness and compassion.

During the first day as we walked into the first floor lounge, we observed a member of staff speaking to two people. They referred to them as gentlemen and commented on how well dressed they looked and offered them both a newspaper to read with their tea.

People told us, and we observed that staff were respectful and knocked on bathroom and people's doors before entering. We saw staff put a screen around a person before hoisting them when in a communal area prior to them receiving personal care. A relative told us, "They always screen Mum when they are hoisting her." These actions helped to preserve people's dignity.

Staff spent time with people and gave them the support they needed. People could choose whether they wanted to spend time in communal areas or time in the privacy of their bedrooms.

People could have visitors when they wanted. People e supported to have as much contact with family and friends as they wanted to, some people had mobile phones so they could contact family whenever they wanted to. Staff told us that people who needed support were supported by their families or their care manager, and no one required any advocacy services. Information about advocates and how to contact an advocate was held within the service, should people need it. An advocate is someone who supports a

person to make sure their views are heard and their rights upheld to ensure that people had the support they needed.

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. People, who needed it, were given support with washing and dressing. People were supported to be as independent as possible. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their communication needs.

Some people required additional support to communicate. Staff used signs to assist people's understanding where possible. There were pictures and signs displayed of the activities on offer and of the menu to reinforce people's understanding.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially. Within people's care records there had been consideration to any additional provision that might need to be made to ensure that people's citizenship rights under the Equality Act 2010 were fully respected. An example of this was the manager establishing if people had cultural or ethnic beliefs that affected how they wanted their care to be provided. Another example of this was that the service provided meals that met their cultural needs and arranged visits from their Pentecostal church.

Good

Is the service responsive?

Our findings

At our last inspection, we found that the provider had failed to maintain accurate, complete and contemporaneous records in people's care plans. At this inspection we found significant improvements but there were still further improvements to be made.

People's health care needs were recorded on the service's computerised system and not located in different files which meant staff could confidently find and record specific details. People did have paper copies of fluid charts in their rooms but this was also kept up to date electronically meaning effective monitoring could take place. People at risk of having epileptic seizures now had clear guidance of what to do if such an event occurred. People who needed it, had undergone SaLT (Speech and Language Therapist) assessments. Guidance was stored in one place for staff to follow when supporting people to eat or drink. One person sometimes refused to follow advice given by the SaLT team and the care plan had clear information for staff to follow if this occurred; ensuring they were not left alone when eating for example.

People's care plans had been reviewed and now contained more person-centred detail. Within people's care plans were life histories, guidance on communication and personal risk assessments. In addition, there was guidance describing how the staff should support the person with various needs, including what they could and could not do for themselves, what they needed help with and how to support them. For example, one person liked support with washing and brushing of their hair but wanted staff to guide them rather than doing it for them.

Care plans contained information about people's wishes and preferences and guidance on people's likes and dislikes around food, drinks and activities. When people needed support with moving and handling there was information regarding the type of sling they needed and how staff should support them effectively. They also contained information about what was important to people. For example, one person said they did not mind a male or female carer but would like to know in advance who was supporting them with personal care. We observed this happening during the inspection. Health plans detailed people's health care needs and involvement of any health care professionals. Each person had a healthcare plan, which would give healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital.

Care plans were regularly reviewed and reflected the care and support given to people during the inspection. A relative told us, "They always involve us at reviews and we are kept up to date of any changes." One person told us, "I seem to get a review every month."

A local hospice supported the service during discussions about people's end of life wishes ensuring dignity was afforded at all times and this was recorded in their care plans together with any Do Not Attempt Resuscitation (DNAR) decisions. People also had a section in their care plan giving guidance about how any pain should be managed at the end of their life. A relative had complimented the service that been had provided recently to relative. They said, "Will be for ever grateful I was allowed to share so many moments with Dad." Woodchurch House had an end of life team that reflected on practice, discussed what went well

or what could have been done better. Some staff had completed training called "Six Steps to Success" which enabled staff to see when someone had entered the end stages of their life and how to ensure health professionals and family are involved and people receive a dignified and pain free death.

At the last inspection we had concerns about the lack of accessible information available to people of how to complain, especially in a format that could be understood by people with dementia for example. At this inspection we found improvements had been made. Complaint procedures were displayed on notice boards, in the foyer and in lifts. Pictorial formats of the procedure were seen making it easier for people to understand how and who to complain to if they needed to. A relative told us, "I needed to raise a complaint a few months ago. I saw the manager and it was resolved. I have had no issues since."

People were being supported to follow their interests and took part in activities which met their needs. To promote wellbeing and reduce isolation activities were planned and coordinated by activities coordinators based on each floor. One person liked to assist the home on a daily basis helping with tasks around the home, including the preparation of food for lunch times. We saw another person being supported with some knitting. A person told us, "I am glad I am able to still do my knitting. They provide me with all the wool I need." During the first day of the inspection there was a festive pantomime which many people enjoyed. "One person said, it isn't my cup of tea but I can go in my room if I wished to." Another person said, "This is really good, they are clever remembering all their words." People from the first floor were also supported to attend and join in. People who did not want to join in were supported in smaller groups, such as one group of three people being supported to draw. People who preferred to stay in their rooms were visited by an activities co-ordinator for one to one sessions including being read to.

The service also had a programme of introducing memory books for people. An external volunteer had spent time with people, exploring their lives and capturing special moments and arranging them chronologically in books. We saw staff interacting with people using their book. These books helped create conversation with people, helping people recall different times of their life they wished to remember.

Requires Improvement

Is the service well-led?

Our findings

People's relatives told us they thought the service was well-led. One person's relative told us, "After my experience, I would recommend living here" and I think it is managed quite well". Another relative said, "Recent changes in the ownership of the service had been positive, a lot of things have changed for the better." A person living at the service said, "I feel there has been lots of positive changes, the home is definitely cleaner and organised." However, despite these comments, we did not always find the service was well led.

At our last inspection in October 2017 we found that the registered provider and manager were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because further improvements in order to meet all of the regulations and to sustain compliance with the regulations.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, they were not aware of all of their responsibilities to ensure compliance with fundamental standards and regulations. We found they had failed to notify CQC of at least two events in a timely manner.

The failure to notify us of significant events occurring in the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had not always acted in a transparent and candid way. For example, when we made further investigations as to whether they were aware of people smoking at the service, they denied that this would ever take place. However, during the inspection the registered manager admitted that they had in fact smoked cigarettes in the suite that was provided for them as part of their employment but the provider was not aware of this.

Following the inspection, we spoke with the local authority safeguarding team to discuss potential safeguarding incidents that we had found. The registered manager had contacted them for further guidance concerning three separate incidents. However, a representative from the local safeguarding team told us that they had not been provided with a full and accurate account of the allegation to enable an investigation. For example, the registered manager failed to tell them that as a result of one incident, one person suffered an injury that had to be attended to by one of the nurses at the service.

During a senior manager meeting on November 13 2018, a practice development manager highlighted concerns raised by staff to the provider about management culture at Woodchurch House. Staff told us during the inspection that they felt that some senior members of staff did not carry out their roles fully and that there was an inconsistent approach to managing staffing issues. When we raised this at the inspection, these concerns had not been addressed by the provider. Following discussions with the practice

development manager, provider and the registered manager they told us, "An internal investigation would start straight away."
The provider told us systems were in place which continuously assessed risks and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents. The registered manager told us they felt it was a service where staff would raise any concerns with them, such as any safeguarding concerns. Staff did report concerns to the registered manager, however they or the provider did not consistently have sufficient oversight as these systems and processes as these did not identify all the areas of concern we identified throughout our inspection, such as how incidents and safeguarding concerns were being managed.

The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. This was a continuing breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service worked in partnership with other agencies in the local community to enable people to receive effective care with a collaborative approach. They had good relationships with care managers, GPs, and other health professionals when needed. Staff worked closely with the local hospice, and there were links with a local church who carried out regular services for people.

The registered provider took time to get people's views and took action to improve their experiences. There were resident and relative's meetings. One relative said, "They have friends and family meetings, and I have made suggestions." Relatives during one recent meeting highlighted that not all activities were enjoyed by everybody. It was decided that a feedback form should be introduced up so that the service could find out whether a particular event was successful or not.

The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service. The overall scores were analysed by the provider and responded to. For example, people wanted improvements to the afternoon tea refreshments round as this was not always happening. The registered manager added this role to the allocations list to ensure this happened daily.

Records demonstrated that there were regular staff meetings at the service and hand over meetings called, "huddles" were observed during the inspection. Weekly clinical meetings took place with a local GP to monitor people's health progress. Staff meetings also included information for staff about risks management and health and safety. Staff received appropriate supervision and told us that the registered manager was supportive and most said they were listened to.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating in the service and on their website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure to notify us of significant events occurring in the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The Provider had failed to report an allegation of abuse in line with the procedures agreed by the local Safeguarding Adults Board. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

Personal care

Treatment of disease, disorder or injury

governance

The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.