Woodcote Hall Limited

Woodcote Hall

Inspection report

Woodcote
Newport
Shropshire
TF10 9BW

Tel: 01952691383

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodcote Hall is a residential care home providing personal and nursing care to 46 people at the time of our inspection. The service can support up to 56 people over the age of 18 years.

Woodcote Hall is a large building set in a rural location. The home has mainly single rooms, but a number of shared rooms are available. The home supports a high number of people living with dementia and mental health conditions.

People's experience of using this service and what we found
Known risks to people's health had not always been assessed and planned for and people were not always kept safe from the risk of avoidable harm. Where incidents had happened, lessons had not been learnt because the provider's procedures were not followed. People's prescribed topical medicines were not always stored safely.

The provider had made improvements since our previous inspection in reducing the risk of cross infection within the home. However, some further improvement was needed in this area to ensure risks of cross infection were prevented.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The systems in the home were not used effectively. People's ability to make their own decisions had been poorly assessed. However, the provider was aware and was taking steps to address this.

The completion of staff training needed improvement to ensure staff had the skills and knowledge to support people's specific health conditions. The provider had started to work in partnership with a range of other health professionals and agencies to ensure people's needs were able to be met. Referrals to health care professionals were not always made in a timely way to maintain people's health and wellbeing.

Work was ongoing in updating people's care plans to ensure they met people's needs. People did not have end of life plans in place, so their wishes may not be known about how they wanted to be cared for at the end of their lives.

Governance arrangements had failed to ensure risk was safely managed, or that people's rights were promoted when making decisions about their care or that their care records were accurate, legible and met their specific needs. The provider had placed other managers from within their organisation to take over the day to day management of the home.

People were supported by sufficient numbers of staff who had been recruited safely. Visitors were screened for symptoms of COVID-19 before entering the home. Visits had recommenced following the changes in

Government guidelines to enable people to see their loved ones. The home environment was clean. Domestic staff had designated areas they cleaned throughout their shift. People and staff had access to COVID-19 testing.

People were supported by staff in a way that was caring, friendly and kind. Our observations showed staff knew people living at the home well and they shared positive interactions with them.

People were able to engage and be involved in social and leisure activities in the communal areas of the home. Complaints were responded to in line with the provider's policy.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The provider changed the legal entity of Woodcote Hall in April 2019. No changes were made to the corporate provider of the home. The last comprehensive inspection rating for the service before their change of legal entity was requires improvement (published 18/01/2019).

Our previous inspection of Woodcote Hall was a focused inspection on 20 and 26 April 2021. We inspected but did not rate the service. The provider was in breach of regulations relating to managing people's safety, consent and the governance of the home.

Following our previous inspection on 20 and 26 April 2021, we served the provider and registered manager with a warning notice for regulation 12 and regulation 17. We serve a warning notice to tell the registered persons they were not complying with a condition of registration or a regulation. We told the registered persons we required them to be compliant by 7 June 2021. Because this inspection took place on 26 May 2021, we did not inspect the service against the warning notice. We will return at a later date to confirm compliance with the warning notice.

The provider completed an action plan after the previous inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and sustained and the provider was still in breach of regulations. However, we acknowledge the short timeframe between the previous inspection and this one. The provider's improvements to the service were yet to be fully implemented and embedded in the culture and practice.

Why we inspected
This inspection was prompted in part due to an incident at the home and the management of that incident. We also received ongoing concerns from the local authority about failure to identify risks to people's health and the management of the home. A decision was made for us to inspect and examine those risks by completing a comprehensive inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the full report.

The provider has taken action to mitigate risk within the home.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified ongoing breaches in relation to the management of risk, consent and the governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
The provider has already sent to us an action plan detailing what they will do to improve the standards of quality and safety. We will return to the home to ensure they have complied with enforcement actions taken by us in serving two Warning Notices on the provider. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Inadequate**

Woodcote Hall

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Woodcote Hall 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 had a manager registered with the Care Quality Commission, but they were not present for this inspection. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced. However, we gave short notice of the inspection from the car park outside the home. We needed to know of the COVID-19 status in the home and discuss the infection, prevention and control measures in place prior to us entering the home.

What we did before inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and two visiting professionals. We spoke with 13 members of staff including the nominated individual, care and domestic staff, the peripatetic manager, area managers and administrator. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with external health professionals who visit and monitor the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first comprehensive inspection since this service changed their legal entity. This key question has been rated inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection people had been placed at risk of avoidable harm due to poor risk management. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Insufficient improvement had been made to ensure people were safe. Whilst we acknowledge the provider was working to make improvements, they had not prioritised people's safety and further incidents of harm to people had occurred.
- The provider had risk management processes in place. However, during a recent incident these processes had not been followed. The incident had placed the person at significant risk of harm.
- The registered persons had failed to ensure the management of risk kept people safe. Procedures for staff to follow in relation to people's diabetes were not safe, people's weight fluctuations were not always addressed, and risks associated with people's anxieties or agitation were not fully explored to try to find the causes.
- Some people had been prescribed supplements to ensure they received enough nutrition. Staff told us people often refused these, and the registered manager had not explored other options to support them. Not all staff had received nutritional training so were not aware of what alternatives they could provide or support they could give.
- People's care plans were not up to date which put them at risk of receiving unsafe support. One person's care plan indicated they walked using a frame. However, other information in their care plan indicated the person had no mobility and required hoisting. This contradictory information failed to give staff the information they needed to maintain people's safety.
- People's daily records did not always contain important information. For example, staff had recorded an incident in a separate log but there was no reference to the incident in the daily notes and no evidence of any follow up or action. This placed people at risk of harm. When people had displayed distressed behaviours there was often no reference to why this behaviour may have occurred or how to support the person if this happened again.
- The provider had failed to ensure actions were completed following a fire risk assessment in October 2020. This was addressed on the day of our inspection.

● Some health and safety maintenance forms had been prewritten and photocopied, so were not fully completed at the point of testing. However, they did show the testing had taken place.
● Staff had failed to recognise the storage of people's wheelchairs in a corridor restricted safe access. This would present a hazard in the event of an emergency evacuation.
● We were not fully assured lessons were being learned in order to improve care. Although the provider had accident and incident reporting procedures, they had not ensured these were followed. The registered manager had failed to investigate or take actions to mitigate risk following a significant injury at the home. Therefore, unsafe practice had not been identified and lessons could not be learned from the incident to prevent it happening again.

We found this was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection, the provider has kept us up to date on the improvements they are making. Risks to people are being reviewed and managed to help ensure their safety within the home.

Using medicines safely
● At our previous inspection, we found prescribed topical creams left in areas where people could access them. At this inspection we again found prescribed topical creams and also suppositories had been left in the care office with the door and door gate left open. The care office is located in the main communal area of the home. People living with dementia could have accessed these and become ill.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection the community medicines team has supported the provider to review the management of medicines at the home and continues to work with them.

Preventing and controlling infection
At our previous inspection, we found people were placed at risk of avoidable harm due to poor infection control practices. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The infection prevention and control throughout the home was much improved since our previous inspection. However, we did find areas of the home where effective cleaning would be difficult due to unpainted or flaking paint on bathroom cupboards, the area around and on the home's kitchen door and handrails with unfinished ends and sections missing.
● Although staff practice and use of personnel protective equipment (PPE) was much improved we found hand hygiene was still not a priority for some staff, especially when changing tasks.
● We were somewhat assured the provider was meeting shielding and social distancing rules.
● We were somewhat assured the provider was making sure infection outbreaks could be effectively prevented or managed in the future. The provider had started to implement individual risk assessments to help manage the isolating and cohorting of people should an outbreak occur at the home.

We found although some practices were improved, further infection prevention and control improvement

was needed, and those improvements made needed to be sustained and embedded in the culture of the home to protect people from the risk of infection. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our previous inspection, the provider has appointed four staff as IPC leads who will take responsibility to help lead on IPC for the home. The provider has also completed hand washing competencies with staff, arranged supplementary IPC training and ensured moving and handling equipment is cleaned after each use.

● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors were screened for symptoms of Covid-19 before entering the home.
● We were assured the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to protect people from avoidable harm and abuse. However, the registered manager had not consistently applied this in their practice. The registered persons had failed to ensure staff consistently had the skills they needed to ensure people's health conditions and needs were not neglected.
● Staff had received training to be able to recognise the signs of abuse and the procedures to follow if they had concerns. We found staff had a good understanding of these but told us when they had previously raised concerns, they did not feel management had always responded to protect people's safety.

Staffing and recruitment
● On the day of our inspection, we saw there were enough staff to support people's needs.
● Since our previous inspection the provider had to use agency staff to cover temporary shortfalls in staffing. The provider had put measures in place to ensure the safety of people whilst agency staff were at the home. The management team ensured the skills mix of permanent and agency staff was safe, agency staff did not work alone and were partnered with Woodcote Hall staff and agency staff were included in the provider's COVID-19 testing regime.
● The provider had ensured staff recruited to the home were suitable and had checked their past employment history. Staff had a Disclosure & Barring Service (DBS) check completed before they started to work at the home. The DBS checks are used to vet staff and help prevent unsuitable people from working in care.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first comprehensive inspection since this service changed their legal entity. This key question has been rated inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

At our previous inspection, the provider had failed to ensure capacity and best interest decisions were made in a way which protected people's human rights and followed current legislation. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of regulation 11. Not enough time has passed since our previous inspection for the provider to make and embed the necessary improvements.

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.

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.

- At our previous inspection, the provider's processes for assessing people's capacity and decision making were not followed and therefore did not meet the principles of the MCA.
- People's capacity assessment and best interests' forms were prewritten and photocopied, which meant they were not individual to each person. We also found incidences where these records had been completed after the date of the intervention.
- We found contradictory information about people's capacity to make decisions. This could impact on

people's human rights if staff do not support people with decision making correctly. One person had been assessed as having capacity to consent to having an alarm on their bedroom door. However, a best interest decision had been made which stated the person did not have the capacity to consent to this, so the decision had been made for them.

● Another person was deemed not to have the capacity to contribute to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision yet was assessed as having the capacity to consent to having their COVID-19 Vaccination. This conflicting information and poor assessment of the person's capacity could significantly impact on the care interventions given.

● Records we viewed did not show people were valued as an individual because they were not always involved in the decision-making processes. We also found people's families were not always consulted when decisions needed to be made on people's behalf. This does not support a person-centred approach.

This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was made aware of all discrepancies with regards to people's consent records. They have sent us an action detailing how they will address this, and a programme or reviews have been put in place to ensure inappropriate records are removed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Although people's care plans contained assessments of their health needs, there was often nothing directing staff how to best support them to meet their needs. Some people had specific health conditions which required monitoring by staff. These people's care plans did not always contain detail for staff to follow or signs to look out for if the person became unwell.

● Staff told us they did not often read people's care plans. They told us they relied on information from shift handovers, allocation sheets and other staff, because they knew the information was current. One staff member told us they could not remember when they had last looked at a care plan.

● We saw some people had poor oral health care plans which would not protect them against the risk of dental problems. Where people did not have teeth or dentures their care plans stated staff should encourage them to rinse their mouth out regularly. However, staff had no instruction about what to use, how often they should do this and there was also nothing about brushing or cleaning their gums.

Staff support: induction, training, skills and experience

● Although staff had received some training, we found most had not completed the required training set by the provider. This was being addressed by the provider.

● The provider's training matrix showed just under half of all staff had not been given any first aid training. This puts people's health at risk because staff may not have the confidence or ability to react immediately to an incident, injury or illness. Since our inspection, the provider has arranged this training.

● Not all staff had received the training they needed to help support people's specific needs, such as diabetes, blood sugar testing, nutrition and wound care.

● Since our inspection, the local authority and community NHS Teams have organised specific training for staff to ensure they can meet people's individual needs. The provider has been receptive and is working with the local authority to facilitate this.

Supporting people to eat and drink enough to maintain a balanced diet

● The lunchtime experience for people was more positive than we observed on our previous inspection. People were not kept waiting an excessive amount of time before they received their meal.

● Since our previous inspection the provider had made referrals to community nutritional professionals to

ensure people who needed it, got the support they needed to eat safely. The local authority and community health teams have been supporting the home with the management of people's nutrition and hydration.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Prior to our inspection we received concerns from the local authority that other health agencies and professionals had not been allowed full access to the home. The provider told us they had not approved this practice. Since our inspection, the feedback we have received confirms relationships have improved and they are now given access into the home to see people to help address health needs.

● Throughout the COVID-19 pandemic, staff had worked with the district nurse team to manage wound care. Feedback was positive and they confirmed staff completed actions as requested. However, staff had not received training in wound care which impacted on their knowledge of when to recognise they needed extra support. The provider has now organised training in this area.

Adapting service, design, decoration to meet people's needs

● Although Woodcote Hall is an older building, the provider has made adaptations to help people move around the home. Corridors have handrails for people to hold onto, which helps with their safety whilst they are walking. Whilst some signage was in place, it was not fully designed to benefit people with dementia or visual difficulties orientate themselves within the home.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first comprehensive inspection since this service changed their legal entity. This key question has been rated requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● Confidentiality of people's information was not always maintained. We found personal care information left out on the desk in the home's care office and displayed on white boards in the care office. The care office had a lockable door and a gate across it to restrict access, but this was not always kept shut so staff, residents and visitors could access information they had no right to.

● At our previous inspection, not every person had been provided with suitable equipment to help them keep independent whilst eating their meals in the lounge area. At this inspection, we saw staff ensured people had equipment available to help aid their independence. People were reminded to use their mobility aids and encouraged to eat independently.

Ensuring people are well treated and supported; respecting equality and diversity

● The provider had failed to ensure people received high quality care from staff who they could demonstrate were suitable to carry out their roles. We identified multiple breaches of the regulations which demonstrated the provider's approach to people and staff was not caring.

● People's equality, diversity and human rights (EDHR) needs were not always identified. One person had identified as a specific religion and staff had stated they refused to attend the religious services. However, there was no indication of how they wanted to or if they wanted to practice their faith despite not attending services.

● Staff interactions with people were focused in the dining area at the home. This was where music was played, singing was a frequent occurrence and most people spent their day. This therefore left people in other areas of the home, people in their rooms and people in the lounge not receiving regular stimulation from staff. This was discussed with the area manager who told us they had already identified this and were looking at the different areas of the home people could use.

● We saw some positive interactions between staff and people where people appeared happy and comfortable around staff and clearly enjoyed their company. One staff member told us, "I love the residents, they're all so different in personalities, humour and what they like to do."

Supporting people to express their views and be involved in making decisions about their care

● People were not always supported to contribute to making decisions about their care. The registered persons had failed to ensure people were always involved in decision making processes about care interventions such as COVID-19 vaccines.

● We did however see staff helping people to make decisions about their day to day support. People were

given choices with daily activities such as what they wanted to do, where they wanted to sit, what food and drink they preferred. People were encouraged to go to the dining table for their lunch. When one person was reluctant the staff member went and got their food and showed it to them saying, "Come on, let's go sit at the table." The person then got up and went to the table willingly.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first comprehensive inspection since this service changed their legal entity. This key question has been rated requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans did not always contain key information for staff to know when to raise concerns relating to specific health or medical conditions, such as diabetes. Information had not been consistently documented about how to safely manage the conditions. Therefore, staff were not always responsive to changes in people's conditions.
- During the inspection, we saw some positive examples of people receiving personalised care to meet their needs. For example, we saw a staff member support one person who was clearly confused and had started to become agitated. The staff member helped the person to feel safe and in control by using their knowledge of the person's personality when talking with them.
- Following our previous inspection, the provider had started to make improvements to people's care plans to ensure they were person centred and specific to their needs. This is a work in progress, and we will review this at our next inspection. In the meantime, the provider is working with the local authority and community teams to ensure people's care needs are assessed and they receive the support they need.

End of life care and support

- People did not have end of life care plans in place. These identify people's wishes for what they want to happen at the end of their lives, such as personal, cultural or religious arrangements. Therefore. Staff would not have the information about people's wishes for what they wanted at the end of their lives.
- People had recommended summary plan for emergency care and treatment (ReSPECT) forms in place which were completed by their GP. These capture people's wishes to ensure they get the right care and treatment in an anticipated future emergency in which they no longer have the capacity to make or express choices.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- We saw some information around the home was presented in a way people could understand, such as arrows pointing to bedrooms. People's access to accessible information was limited but staff told us it was provided if required.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were able to participate and be involved in group or individual social and leisure activities in the communal areas of the home. Activities were focused around the communal areas, which left people in their rooms with limited social interactions.

● In line with Government guidance for the COVID-19 pandemic, the provider had facilitated visiting both outside and inside the home. One staff member told us, "It has really lifted their [people's] moods, they're so happy when they come back from a visit."

Improving care quality in response to complaints or concerns

● The registered manager had responded to complaints in line with the provider's complaints policy and had given apologies when needed. The provider had a clear complaints policy in place, which informed the complainant of what they can expect when they raised a complaint.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first comprehensive inspection since this service changed their legal entity. This key question has been rated inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

At our last inspection people's health, safety and wellbeing were placed at risk due to quality systems not being used effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At our previous inspection, despite the provider having quality assurance systems in place, these had not been operated effectively to help identify concerns to people's health, safety and wellbeing. At this inspection, the provider had started improvements to the areas of concern we had found at our previous inspection. One external professional told us, "The management team have a good handle on improvement, needed but have a huge job to do."
● However, the registered persons had failed to demonstrate continuous learning and a focus on improving care. Despite input and feedback from the local authority, local health agencies and the Commission, they had not made required improvements to ensure they fulfilled their regulatory responsibilities.
● The provider's quality systems had failed to ensure people's care records were accurate and up to date to minimise the risk of errors. Staff told us they knew a lot more about people than was recorded in their care plans. One staff member said, "I don't look at the care plans, there is no point because they're so difficult to read and all wrong." We found care plans were difficult to read due to being handwritten and they contained contradictory and out of date information which can mislead staff as to what the persons needs are.
● The provider's improvements to the service were yet to be fully implemented and embedded in the culture and practice. We will assess these at our next inspection to ensure the required improvements had been made.

This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our previous inspection and due to incidents of concern at the home, the provider had taken

appropriate action related to the registered manager who had subsequently resigned from their post. The provider has put in a peripatetic home manager who has been supported by the area manager. The provider has taken a transparent and proactive approach in identifying and taking action to ensure people's health and wellbeing is not at risk.

● Since our inspection the provider has updated and shared their action and improvement plans with us and the local authority. They will continue to work with external agencies to ensure the health, safety and wellbeing of people who live at the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● At our previous inspection we found the culture was an open one and feedback from staff and relatives had confirmed this. However, at this inspection some staff told us they felt the 'old' managers had not been accessible and they had not been free to challenge ways of working within the home.

● Staff told us they felt the 'new' management team was taking the home in a positive direction and giving them more autonomy. The provider told us they wanted to give more responsibilities to staff to ensure they were fully involved in people's care and what happened in the home. Some staff were already taking responsibilities for infection prevention and control and in reviewing and updating people's care plans.

Working in partnership with others

● Since our previous inspection we had learnt action had not always been taken in a timely manner to help improve people's health, safety and wellbeing. Partnership working with other health and social care professionals was inconsistent and not always pro-active. Professional advice had not been consistently sought and so good practice was not always implemented as a result.

● Current feedback from external stakeholders was positive in terms of collaboration, access to the home and information sharing. The provider had been working with and continues to work with stakeholders to improve partnership working for the benefit of people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider has been open with people, relatives and staff about the outcomes from our previous inspection and what they plan to do to put things right. The current management team understand their responsibilities under duty of candour and have worked proactively and openly to make changes and improvements.

● We are aware the registered manager had failed to notify us of at least one reportable incident since our previous inspection. This was identified by the provider who subsequently informed us.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were kept involved in the relationships which were important to them. Staff continued to facilitate telephone and video calls so people could speak with their loved ones.

● Relatives were free to telephone the home to seek updates on their family member and staff kept relatives informed of their health.

● Staff had the opportunity to discuss any concerns. Prior to our inspection, the provider had spoken with all staff so they understood the improvements which were needed at the home and to get them involved in making those improvements.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure capacity and best interest decisions were made in a way which protected people's human rights and followed current legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure service users were protected against the risk of cross infection. The provider had not ensured adequate risk management to ensure people were protected from the risk of harm. The provider had not ensured all staff had the skills and competence to meet people's needs safely. The provider had failed to ensure the safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Although governance systems were in place, the registered persons had failed to use these effectively to improve the safety and quality of care where needed. The registered persons had not ensured potential risk to people was mitigated by the governance systems they had in place. Accurate records were not maintained in relation to decisions made about people's care

and treatment.
The provider had not ensured records relating to the care and treatment of service users were complete, legible and accurate.