# The Whiteley Homes Trust

# Whiteley Village

## 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? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

About the service
Whiteley Village is a large community with two purpose built residential services and a homecare service supporting people within their homes in the village. The Eliza Palmer Hub is a care home service for people who require support with nursing care and 30 people lived there. Ingram house provide a residential service and there were 27 people living in this part of the service. Whiteley Village provided home care to 60 people in their houses and flats within the village. In total, 117 people received support in the residential services and the community.

People's experience of using this service and what we found
People told us there were not always enough staff to support them, particularly in the Eliza Palmer Hub. In this building and Ingram House, there were inconsistencies and shortfalls relating to risk management and medicines, but people told us they felt safe. There were activities for people who lived in the residential buildings but we found these were not always impacting positively upon them. We also found instances where information about how to meet people's needs was inconsistent or lacked personalised details. People gave negative feedback about the food they were served and the provider was in the process of making improvements to this at the time of our visit.

The governance across the services was not robust enough to identify and address the shortfalls found at this inspection. We saw positive examples of work to involve people and communicate with them, but we received feedback this was not consistent where there had been recent changes to the service. The quality of the service received was not consistent across the different parts of the community. People who lived in the Eliza Palmer Hub and Ingram House were not receiving the same level of care and personalised support as people who lived in the community. People who lived in the community told us they received personalised and safe care from staff who arrived on time.

People's healthcare needs were met and we saw evidence of staff working alongside professionals to meet their needs. Some records relating to people's healthcare needs and health appointments were not consistent with care delivery. Staff asked for consent from people and had a good understanding of the Mental Capacity Act 2005, but we found one instance where the correct process had not been followed, we received confirmation this was addressed after our visit.

People knew how to raise a complaint and despite sharing negative feedback with us, they told us they had productive meetings where they could raise these concerns. There were regular surveys and systems to communicate with people, relatives and staff. Complaints were documented and responded to and the provider analysed these for patterns and trends. There was a robust framework for accidents and incidents, to ensure these were escalated where required and monitored by the provider. Despite some inconsistencies in how end of life care was planned and delivered, the service had received accreditation in this area and we saw evidence of plans to develop and improve this area of the service.

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

Rating at last inspection
Good (Inspection Report Published 22 October 2016)

Why we inspected
This was a planned inspection based on the previous rating. However we had also been made aware of a specific incident, following which a person using the service died. This incident is subject to a criminal investigation which had not reached a conclusion at the time of this inspection. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of choking risks. This inspection examined those risks.

We found no evidence during this inspection that people were at risk of harm from this concern, but we did identify a need to improve record keeping. Please see the Safe, Effective, Responsive and Well-led sections of this full report.

Enforcement
We have identified breaches in relation to staffing, medicines and risk management, care planning, activities and governance.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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.

## 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.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service caring?**

Good

The service was caring.

Details are in our caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

# Whiteley Village

**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.

Inspection team
The inspection was carried out by two inspectors, three assistant inspectors, a directorate support co-ordinator, a specialist advisor nurse and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This service is registered with three services on one village site. There are two 'care homes' and a domiciliary care agency. People in the care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The domiciliary care agency provides personal care to people living in their own houses and flats within the village.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service including feedback received from the public, professionals and commissioners. We also reviewed statutory notifications. Statutory notifications are reports of incidents providers are required by law to notify us of. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with 20 people and three relatives. We also spoke with the director of care, the head of care, the

safeguarding manager, the registered managers for the residential and domiciliary services, the manager of the nursing service, two nurses, one team leader and six care staff. We also spoke with a chef, the volunteers' manager and the activities lead.

We reviewed care plans for 10 people, including records relating to medicines risk and personalised care planning. We checked five staff files, records of staff training, meetings and surveys. We checked records of complaints, incidents and safeguarding. We reviewed a variety of checks and audits and action plans.

After the inspection
We received email evidence from the provider and spoke with one relative.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement.

At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There were not always enough staff deployed across the service.

● People in the Eliza Palmer Hub, where nursing care was provided, told us consistently there were not enough staff. One person said, "Occasionally I do feel vulnerable. I ask myself, 'Should I wait a little longer?' Often I have to wait a very long time; over half an hour." Another person said, "You have to wait ages for someone when you call, there aren't enough staff." Another person told us, "They [staff] should pop their head round the door every two hours. Very often I am left for hours."

●Our observations in this part of the service showed people often had to wait for support. One person had woken up later in the morning and we observed them waiting for support for a long time because staff were occupied elsewhere. We met one person who told us their hair had been washed that morning, but staff had been rushed and they did not feel they had rinsed their hair properly.

● During lunch, people who required support to eat waited a long time when they required support from staff. One person waited for over 20 minutes for support from staff with eating, by which time they had fallen asleep.

● Staff in this building told us they were often rushed and found it difficult to provide care. One staff member said, "Sometimes it means we have problems with activities and care. We always tell the seniors." People told us staff were often rushed when providing support to them, particularly at busier times, which matched our observations.

● The building was recently built and there was a new call bell system in place. At the time of inspection, there was not a regular audit of the data from this. We reviewed recent call bell data that showed most call bells were answered promptly. However, at times people appeared to wait in excess of 10 or 15 minutes to receive care, after staff had done an initial check to ensure they were safe.

● The provider told us staffing levels had recently been increased in this part of the service, but our observations showed this had not impacted positively on people.

● In Ingram House, a residential building for people who did not have nursing needs, people and staff said care could be rushed and people sometimes had to wait. In this community, there had been a recent increase in staffing numbers following a review. We observed care needs were being met and call bells answered promptly. However, there was limited interaction between people and staff, with most people spending time in their rooms. Staff in this area told us they were often rushed and did not always have time to engage with people.

● There was a dependency tool used to calculate staffing numbers in each part of the service, with rotas showing the calculated numbers were met. However, our findings showed the calculated staffing levels were not always sufficient for all areas of the service.

● Staffing had been recently reviewed and there had been a recruitment drive which had reduced the use of temporary agency staff. After the inspection, the provider shared an action plan that included a review of staff deployment and increased call bell auditing. We will require further action to ensure the legal requirements of the regulation are met.

The lack of sufficient numbers of staff deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people received care in their own homes, there were enough staff and people told us they arrived on time. There was a system to schedule care calls which were geographically close to each other. People were visited by a consistent staff team that they got to know well.
● Staff files contained evidence of checks on new staff to ensure they were suitable to work in social care. Checks included references and checks with the Disclosure and Barring Service. However, we identified two staff files where there were historic gaps in the work histories provided. We gave feedback on this and it was addressed after our inspection. We will check if work histories are consistent at our next inspection.

Assessing risk, safety monitoring and management; Using medicines safely
●Management of risk and medicines was inconsistent across the different services within the community.
● People told us they felt safe when staff supported them. One person said, "Yes, [its safe]. I think they're good." A relative said, "Yes [person]'s safe. It's a relief for me."
● Despite this feedback, we identified shortfalls in the way risks were responded to in the Eliza Palmer Hub. We identified risks where there were no plans to inform staff of how to respond. We also found multiple instances where care record charts were incomplete.
● One person had asthma, their inhaler was stored securely where it could not be accessed promptly in an emergency, despite being needed urgently in the event of an asthma attack.
● Another person had a pressure sore with inconsistent advice on how to reduce this risk. Different sections of their care plan gave different information about how often they needed support to reposition. We also found there was no chart in place to monitor how often the person was supported to reposition.
● Whilst in most cases there were clear plans to reduce choking risk, one person's nutrition plan documented they required 'pureed moist foods'. We asked staff what this meant and they did not know. The person's care plan did not contain examples of foods they could eat safely.
● The provider could not assure us that medicines had been stored at a safe temperature. In the Eliza Palmer Hub, the temperatures of storage areas were not checked. The week before our visit temperatures had exceeded thirty degrees. This meant it was possible medicines had been stored at a temperature above the manufacturers' storage instructions. This could have affected the efficacy of people's medicines.
● In Ingram House, we identified two people who were prescribed topical creams, had multiple gaps on their medicine administration charts, so it was not clear if they had been administered as prescribed.
● There was not always guidance for staff on when to administer 'as required' medicines. One person was prescribed a medicine on an 'as required' basis and there was no protocol to inform staff about when to administer this. Where protocols were in place, they lacked detail. For example, a protocol for codeine for a person simply stated it was for 'pain'. It did not describe where the person experienced pain and how they would express this to staff.
● After the inspection we received an action plan to show the provider had introduced temperature checks where these were lacking. Records relating to risks and medicines had been reviewed and updated. We will require further action to ensure good practice relating to risks and medicines is consistent.

The shortfalls relating to risk and medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was a robust system to track and monitor incidents. Where incidents had occurred, staff completed forms promptly and shared these with management. Incidents were analysed and monitored in order to identify patterns and trends.

● People receiving care in their homes had information on risks, such as falls or environmental risks, and these had been assessed and reviewed. Staff were knowledgeable about how to keep people safe when supporting them within their homes.

Systems and processes to safeguard people from the risk of abuse;

● Staff knew how to identify and respond to safeguarding concerns. Staff demonstrated a good understanding of the agencies involved in safeguarding and who to contact if they were concerned.

● Records showed where there had been concerns, these had been escalated and reported appropriately. Records showed the provider routinely shared information with the safeguarding team and worked collaboratively where appropriate to create plans to keep people safe.

● The provider had learned lessons where things went wrong. As part of this inspection, we considered a recent choking incident and looked at how these risks were managed. Aside from the one person with inconsistent advice about food textures reported on above, we saw evidence that choking risks had been reviewed in response to this. Where people were at risk of choking, there were plans in place for staff to follow to support people to eat safely.

Preventing and controlling infection

● People lived in a clean home environment. In each area of the service, communal areas and people's rooms were clean with no malodours. One person said, "It's clean. It's a nice room anyway."

● The provider employed housekeeping staff and they were observed cleaning throughout the day, across both residential buildings. Staff followed cleaning schedules and signed off tasks to show they had been completed. Cleanliness was regularly audited and checked as part of the provider's audits.

● Staff followed best practice in relation to hand washing, for example we observed staff washing their hands before supporting people to eat.

● Staff had access to personal protective equipment and described to us how they used it to provide safe care. One staff member described how they put on gloves for supporting a person in the shower, then removing them and washing their hands, before they supported people to dress.

Requires Improvement

# 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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People did not always receive meals that they liked and records about people's nutrition were inconsistent.
- People gave us mixed feedback about the food across all areas of the service. One person said, "The meals are not good at all. We have been promised to get better food, I put up with it because I'm hungry." Another person said, "The food is terrible, even the toast is horrible. The menu is monotonous." However, another person said, "As a result of my complaint the food is getting better." Another person told us, "The food is improving; it used to be cold, now it's hot."
- The provider was aware of people's feedback about food and there had been recent work to improve people's dining experiences.
- There had been changes to the location of the kitchen following the recent building works and food was provided by a catering contractor. Some changes were made to ensure food was hot after feedback it was cold after being transported.
- Improvements had also involved changes to menus and changes to kitchen staff, but people's feedback showed these had not yet had a positive impact and work was ongoing. We will follow up on the progress of these improvements at our next visit.
- Care plans contained information about people's food preferences, but the level of detail varied between people. However, basic information about people's likes and dislikes were consistently recorded. Work was underway to ensure the improvements to menus involved people and people were regularly asked for feedback as part of this.
- Information about how to meet people's nutritional needs were not always clearly documented. One person used a specialist device to sustain their nutrition and this was referred to in care plans, but there was not a dedicated protocol for staff to follow.
- Another person had their fluid intake monitored but their records did not inform staff what their target fluid intake should be. The charts had also not been completed to show the person required thickened fluids, in line with their care plan. Staff were knowledgeable about this but the inaccurate information on the chart heightened the risk they may receive fluids that were not the right consistency.
- After the inspection we received an action plan to show these records had been improved. We will check if improvements to record keeping have been sustained at our next inspection.

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

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.

● People had consented to their care and this was documented. Staff asked people's permission before supporting them throughout the day. This showed people were given opportunities to consent to care tasks before they were completed.
● Where people were unable to consent, there was not always evidence of the correct legal process having been followed.
● For one person, there were no mental capacity assessments and best interest decisions around their care, despite staff stating they would lack capacity to make these types of decisions. After the inspection, we received confirmation these had been conducted and a DoLS application had been made. For another person, all the correct documentation was in place.
● Staff understood the MCA and had received training in this area, we also observed staff asking for consent from people before supporting them with tasks.
● Staff understood people's capacity to make decisions, despite assessments not always being in place. This reduced the impact of the shortfalls in documentation, but our findings showed the providers systems had not ensured the correct legal process was followed in every instance.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's care files contained evidence of assessments of their needs. Where people had come to the service, they had received an assessment that outlined their needs and preferences.
● Where a person recently started to receive care in their own home, they said they had a time where they got to know staff and their needs had been assessed and reviewed. Their care plan showed important information about their medical condition and preferences had been added to their care plan.
● In the two buildings where people received residential and nursing care, care files contained evidence of assessments in important areas such as people's skin integrity and malnutrition. These followed nationally recognised formats and we saw where these had been shared with visiting healthcare professionals. For example, a GP had recently reviewed malnutrition assessments for a person who was losing weight.
● In these parts of the service, we identified that care plans were inconsistent. However, the assessment process had been followed to established levels of need, despite care plans not always reflecting people's needs and preferences. We found important information about people's medical conditions and clinical needs were in place, but as reported in Responsive the plans sometimes lacked detail or accuracy.
● Where required, we saw evidence of input from healthcare professionals. For example, mental health professionals had input into care planning for a person living with dementia.
● People had access to healthcare professionals and we saw evidence of staff referring people for health

checks when their needs changed. People had check ups with opticians, dentists and chiropodists.

Staff support: induction, training, skills and experience

● Staff told us they had received training for their roles. One staff member said, "We have in-house training and other external specific training."

● The provider kept a record of all training and these showed staff completed courses in different formats such as face to face and e-learning. The provider's records showed most training was up to date, but there were some courses which had yet to be attended. For example, where a person used a feeding device care staff had not yet attended a course on this. However, staff we spoke with were knowledgeable about it and healthcare professionals had provided support and information.

● There had been recent recruitment at the service and we saw staff had completed an induction and the Care Certificate. The Care Certificate is an agreed set of training standards in adult social care. We will check to see if further training has become embedded at our next inspection.

● Staff told us they received regular one to one supervision and we saw evidence of regular one to one discussions where staff discussed their performance and identified training needs.

● Nursing staff told us they felt supported and had opportunities to develop their clinical competencies, with records supporting this.

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

● The Eliza Palmer Hub was newly built, but with decoration and personalisation still in progress. The environment was purpose built with wide corridors and lift access, but one person told us they found it difficult to go in and out of the building due to the numbers of doors.

● We observed decoration in this building was lacking, with no signage or items of interest for people. This made the environment appear clinical, which reflected people's feedback to us. Work was still in progress so we will check how planned decoration has impacted upon people at our next inspection.

● At Ingram House, where people received residential care, the environment was suited to the needs of the people living there. We observed some of the decoration was dated, but people said they were happy with the environment. There was signage to enable people to orientate themselves and people who used mobility aids were observed independently accessing communal areas.

Good

# 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.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were supported by caring staff who knew them well.
- People told us they were supported by kind and caring staff. One person said, "The staff are very nice, helpful and very caring." Another person told us, "The carers are very good." A relative said, "The carers and all the staff are so good."
- We observed interactions between people and staff that showed kindness and compassion. Our findings relating to staffing levels affected the level of interaction people had with staff, particularly in the Eliza Palmer Hub. However, despite being rushed, we observed staff were pleasant and kind to people and spent time with them where they could.
- For example, in the Eliza Palmer Hub staff noted one person appeared anxious so sat with them and held their hand. They then went to get an item the person liked to hold which comforted them.
- In the morning at Ingram House, a staff member talked to a person about how to relax after they had informed them they were worried. At lunchtime, staff chatted to people and encouraged conversations which created a pleasant atmosphere in the room.
- People who received care in their homes told us they received care from consistent staff who they got along well with. The provider's scheduling system ensured people were supported by a regular staff team. We observed staff engaging with one person in their home and they were kind and took an interest in their life and background.
- Care plans documented people's religion and cultural backgrounds and we saw evidence of people being supported to practice their faith.
- Records did not always show consideration of people's sexuality and gender identity in assessment and care planning. However, staff gave examples of how they had supported people in a way considerate of these needs. We will follow up on improvements to record keeping at our next inspection.

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

- Care plans across the service showed evidence of involvement of people and their relatives. Whilst the level of detail varied in different parts of the service, staff were observed offering people day to day choices when providing care to them.
- Staff described to us how they provided care that focused on people and their choices. One staff member told us, "When I get a new resident, I explain that I'm here for them, that I'm here to help and that's part of my job. It's not all task based but includes emotional support and doing little extras."
- Care plans contained lists of preferences for people and life stories that told staff about their backgrounds and what was important to them. In Ingram House, we read a life story for a person who had a background

in performing arts and staff had a good knowledge about this.

● Despite negative feedback we received about changes at the service, some people and relatives expressed they felt there had been recent improvements in how they were involved in decisions about these. People told us about recent meetings that were productive and provided a forum for their concerns. However, at the time of inspection improvements in response to their feedback had not yet been implemented.

Respecting and promoting people's privacy, dignity and independence

● People received dignified care. Aside from the impact staffing issues had in the Eliza Palmer Hub, people across the service received care that promoted their dignity. In Ingram House, people were well presented, wearing well fitted clothing with their hair done and personal care needs met.

● People told us staff provided personal care sensitively and respected their privacy. We observed staff knocking and waiting for permission before entering people's rooms. People and staff described how basic measures, such as ensuring curtains and doors were closed, were routinely carried out before personal care commenced.

● Where people received care within their own homes they told us staff were respectful guests. We observed staff waiting to be invited in and allowing people to take the lead in hosting us when we visited their homes.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as Good.

At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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 said their access to activities was sometimes limited. One person said, "There is a list of activities that don't involve much intelligence like bingo." Another person said, "I have never been much of a card player but it's fun. It passes the afternoon."
- Information about people's preferred activities and their participation in them was limited. One person living in Ingram House had a care plan for activities. The care plan said they liked to read the provider's magazine and needed encouragement to engage socially. There was a list of suggested board games the person liked but there was no record of them having participated in them.
- Another person lived in the Eliza Palmer Hub and was cared for in bed. We checked their care plan and this contained basic information about what their interests were and said staff should spend time with them regularly. Activities records confirmed the person had spent two weeks with no recorded activity, despite records showing they had told staff at the time they felt low in mood.
- In this part of the service, we observed every person was supported back to their room in the afternoon and no activities took place. Staff told us this was people's choice, but we observed there was not an alternative option for people who may wish to socialise.
- There were staff employed to take the lead on activities and they were supported by volunteers. They described how they worked with people to identify activities they enjoyed and we heard examples of how these had achieved positive outcomes for people. However, our observations showed people's access to activities was often limited to group activities.
- After the inspection we received evidence to show instances where people received regular one to one time from staff and befrienders. However, more work was required to ensure people's experiences of activities improved.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Care was not always planned in a personalised way. Whilst we saw evidence of care planned around people's medical conditions and needs, information was not always consistent with care delivery. The impact of these shortfalls were most significant in the Eliza Palmer Hub, where people received nursing care.
- One person had a care plan which recorded they used hearing aids and had a rolled towel to support one side of their body due to their mobility. We observed these were not in place as outlined within the care plan. When we asked staff this was put in place, but not in the way their care plan described.
- People's needs were being reviewed but care plans were not consistently updated in response to changes. The registered managers had identified this as an area to improve and a 'Resident of the Day' system had

been introduced to provide a robust review process. However, this had not been fully implemented by the time of our visit.

● End of life care was not always personalised. Whilst people did have care plans that recorded advanced wishes, these were not always delivered as planned. One person was in receipt of end of life care and had a care plan that recorded support they needed to remain comfortable and described how music calmed them. However, we did not observe staff carrying out these tasks during the inspection and we noted a 25-minute period of no interaction for them. Their daily notes did not contain evidence of these tasks being completed regularly.

● Senior staff had recently joined the service who had backgrounds in end of life care and aside from the instance above we saw positive examples of personalised end of life care. The service had recently won a Platinum accreditation in Gold Standards Framework in end of life care and we saw this system was being used in care plans. There were further plans to improve end of life care plans and we will follow up on the impact of these at our next inspection.

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.

● People said staff did not always provide information in an accessible manner. One person with a visual impairment told us, "New staff say, 'This is my name' whilst showing their badge. I tell them, 'I can't see your name.'"

● People's individual communication needs were planned for, but we identified instances where this guidance wasn't followed. Where people used specific methods to communicate these were recorded and staff were aware of these. Care plans recorded if people required glasses or hearing aids to read or hear staff.

● As reported, in the Eliza Palmer Hub there was not yet decoration or signage, which meant we could not see that people's needs with regards to accessible information had been met in this area. There was signage and information about how to complain or raise concerns in an accessible format in a communal area.

● In other parts of the service, information was presented to people and care was planned in a way that was considerate of their communication needs.

The shortfalls in relation to activities, care planning and accessible information are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People told us they knew how to complain and felt able to raise concerns. We saw recent issues had been fed back to management by people and relatives and work was underway to respond to them.

● The provider kept a record of individual complaints and these showed they had been investigated and responded to appropriately. Where a complaint was made about a staff members attitude this had prompted work with the staff member and a response to the person who raised the complaint.

● There was analysis of complaints and records showed these included verbal complaints, to ensure all forms of concern were analysed. An annual analysis was drawn up and complaints were also discussed at regular governance meetings.

Requires Improvement

# 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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The governance framework did not always proactively identify and address issues at the service and people did not always feel involved in changes.
- People and relatives said they had not been involved in recent improvements, particularly the development of the Eliza Palmer Hub. One person said, "I don't think [we are involved] at times. 'Why didn't you tell us?' You often hear." A relative said, "Some of us feel there has been a shift towards grand designs, without asking us about the basics."
- People and relatives did not feel they were always consulted on changes at the service. The provider shared their plans about the new building with CQC and we also saw that there were meetings to involve people and relatives. However, the feedback on this was mixed.
- However, we heard examples from people of issues, such as the way rooms were laid out and how the service was decorated, which they would have liked input into. They gave examples of how these areas affected their wellbeing, such as not being able to access some communal spaces and changes to the way people received drinks during the day. After the inspection, the provider told us they were working with relatives to address these issues, including arranging works to improve access to some areas of the service.
- The provider was aware of these issues and meetings of people and relatives had been carried out in the days before our visit, we received positive feedback on these meetings but more work would be required to implement changes in a way that involved people.
- There were a variety of checks and audits at the service, however these had not identified and addressed shortfalls in daily notes and charts that we found. The provider's systems of surveys and quality assurance had not ensured a response to people's negative feedback about staffing. However, we did note a recent increase in staffing levels in the two residential buildings which had not yet impacted positively on people's experiences. Medicines audits had taken place but had not ensured the shortfalls we found were addressed proactively.
- Documentation was not always accurate and up to date. As reported, parts of the service had care plans that lacked important information about risks to people or their needs. The management team were aware of this issue and we saw evidence that they had started work to improve these before our visit. However, our findings showed more work was required to ensure people's care records were accurate and up to date.

The shortfalls in involving people in improvements and shortfalls in record keeping and governance were a

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

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

● People gave us positive feedback on the management team. One person said, "[Registered Manager] comes around to see people." Another person said, "The manager seems to be on top of things. Something brought to their attention is received well."

● There were two managers registered with CQC and one registering at the time of our visit, ensuring there was a registered manager for both residential buildings and the homecare service. There was also a director of care and head of care who oversaw the service, as well as managers taking the lead on areas such as safeguarding and wellbeing.

● People and staff said management was visible and they knew who to contact, despite a large portion of the team being new in post. We observed people interacting with the director of care and head of care in a way that showed familiarity, despite them having only been in post for a short time. In each area of the service, people knew who the managers were and felt they could raise day to day concerns with them.

● People and relatives had regular meetings and we saw evidence of the provider gathering views through surveys. There was a regular magazine, 'The Whiteley Villager' which provided updates and information to all people in the village about activities and news in the community.

● Staff in each part of the service told us they felt supported by their managers. One staff member said, "She's very nice, she's approachable, accommodating and friendly. We always see her in meetings."

● Staff had regular meetings within each service and there were systems to communicate important messages to them. Each service had daily handover meetings and there were meetings for staff on a weekly and monthly basis. Records showed these were used to pass on messages and also gave staff opportunities to make suggestions or raise issues.

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; Continuous learning and improving care

● Records showed that the provider had notified CQC where they were required by law to do so. Where there had been important events such as deaths, injuries or allegations of abuse the provider had notified CQC and provided detail of the actions taken.

● The governance framework for all incidents meant they were reviewed by both managers at the service and the safeguarding manager who checked all relevant agencies had been informed and any actions had been followed up. For example, a recent safeguarding concern had been escalated by staff and reported to the local authority and CQC. This prompted reviews of the person's care and referral to healthcare professionals, which were signed off by management.

● Incidents were routinely analysed each month and actions were checked by management, these considered the need to report to CQC and the local authority and also checked relatives had been informed in a way that promoted transparency.

● There was also a quarterly report of any incidents issues complaints or compliments which looked at patterns and trends and was discussed by the management team to identify learning.

Working in partnership with others

● People benefitted from community links. The village had a church which was attended by people who used this service and people spoke positively about this and their visits to the residential units.

● Volunteers from the local community supported activities, as well as support coming from schools, and events in the community being attended by people that used the service. Some of these community events benefited the people that used the service by raising money for the trust.

● In care plans we saw evidence of staff working alongside professionals with people's care. The governance

framework at the service showed consideration was routinely given to referrals to healthcare professionals or agencies involved in people's care.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always have access to meaningful activities and care was not always planned in a personalised way. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people were not always safely managed and people's medicines were not always managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider governance systems had not involved people in improvements. Checks and audits had not identified and addressed the shortfalls found at this inspection. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not always enough staff deployed to safely meet people's needs. |