

Woodbridge Lodge Limited

# Woodbridge Lodge Residential Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Woodbridge Lodge Residential Home is a residential care home providing personal care to up to 32 people. The service provides support to older people, some living with dementia. The service is provided in one adapted building over three floors. At the time of our inspection there were 28 people using the service.

### People's experience of using this service and what we found

The registered manager had retired 11 days before our inspection visit. The provider had advertised for a new manager and the service was being managed by the provider's operations manager and other members of the provider's operations management team.

The service was working with stakeholders, were in the process of improving the service and had an action plan in place. However, not all of these improvements were fully implemented and embedded in practice.

The governance systems were not robust enough to support the provider and management team to independently identify shortfalls and address them. Improvements were being made in this area.

The systems in place to assess and mitigate risk were not always robust enough to keep people safe from abuse and avoidable harm. People were not always receiving their medicines as prescribed. We found bed linen was not always clean and hygienic. We were assured by the operations team these shortfalls were being addressed.

Staff had been recruited safely and the provider had a system in place to calculate the numbers of staff needed to meet people's needs. We received mixed views from staff and relatives relating to the staffing numbers in the service. Improvements were being made in the deployment of staff around the service to be present to support and make checks on people on all floors.

The provider had risk assessments and policies relating to the COVID-19 pandemic. People were supported to have visitors. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was good (published 12 December 2019).

### Why we inspected

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.

The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a criminal investigation. 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 skin care and diabetes. This inspection examined those risks.

We received concerns in relation to pressure ulcer management, staffing, records, safe care and treatment and the overall governance of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodbridge Lodge Residential Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and good governance at this inspection. 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# Woodbridge Lodge Residential Home

## **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 Health and Social Care Act 2008.

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 undertaken by one inspector.

#### Service and service type

Woodbridge Lodge Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. [Care home name] is a care home [with/without] nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was manager registered at the service, but they had recently left on 16 April 2022 due to retirement. The provider's operations manager was overseeing the management of the

service until a permanent manager could be recruited. We have referred to them as the operations manager throughout the report.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. 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. We used all this information to plan our inspection.

#### During the inspection

During our inspection visit on 27 April 2022 we spoke with five people who used the service and two relatives about their experiences. We also observed staff interactions during lunch. We spoke with five staff members including two operations managers, head of care, senior care staff and activities staff, we also briefly spoke with the maintenance staff member. We reviewed medicines management and records relating to staff recruitment, health and safety and governance.

Following our visit, we received feedback on the telephone or electronically from 10 relatives and 11 staff members, including senior care staff, support workers, catering and domestic staff. We reviewed the care records of six people, including their care plans, risk assessments and medicine administration records. We also reviewed records relating to the governance and management of the service including audits.

On 12 May 2022 we fed back our findings, via a video call, to three of the provider's operations managers.

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Systems and processes to safeguard people from the risk of abuse

- We noted an incident in a person's daily records, which had not been reported to the local authority safeguarding team, who are responsible for investigating concerns of abuse. Once we pointed this out to the operations manager, they raised a safeguarding referral. Staff told us that there had been instances where they had reported concerns, but these were not always listened to.

The systems in place were not robust enough to identify concerns of risks and mitigate them. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The operations manager told us the incident had not been flagged due to the electronic system not being used to identify an incident. Staff had been advised of this and records would be reviewed to identify if any other incidents had not been reported. Training was planned for the week following our feedback on the use of the electronic system to prevent future concerns.
- All of the staff we received feedback from confirmed they had received training in safeguarding and understood how they should report concerns. However, some staff told us they did not feel the online training was sufficient.

Assessing risk, safety monitoring and management

- We had received concerns regarding the prevention and identification of wounds and pressure ulcers. People's care plans included information for care staff to ensure people's bedding was not creased and audits had identified creased bedding. However, we looked at six beds which had creased and crumpled sheets on them. Creases in bed linen increase the risk of people developing pressure wounds.
- Records of supporting people to reposition to reduce the risks of pressure ulcers developing did not evidence that people were supported in line with their care plans. These were in the process of being improved, but these were not yet fully implemented to show people were receiving this support safely and consistently.
- People's daily notes did not always show that people were supported to wash when they received continence support. One person's daily notes showed a red area had been identified, a later note showed they had seen a district nurse for a different issue, there was no record of the staff making the nurse aware of the redness and this was not further explored in following notes or mentioned again.
- We found a radio lead between the bed and the bedside table in a person's bedroom which was a trip hazard. The operations manager told us, at our feedback, that this had been addressed.
- We found that there were areas in care plans which required improvement in how risks were assessed, and guidance provided to staff in how any risks were being mitigated. For example, one person's behaviours had

recently changed in how they expressed their anxiety and distress. Their care plans had not been updated to show the risks in this area and actions in place to safeguard this person and others.

- Prior to our inspection we had received concerns about two people who were found to be dehydrated. The operations manager told us people who were at risk of dehydration were being monitored and supported and there were targets for the amounts of drinks to be taken each day. We saw records which had shown some improvement over March to April 2022, however, there were still times people were being offered less than the target amount of fluid.
- We saw people had access to drinks during our inspection visit. However, one relative told us, "I feel that the resident's hydration needs should be addressed better. I see the drinks trolley come around during the morning and the afternoon, however cold drinks should be offered throughout the day. My [family member] is often thirsty and devours a glass of squash when I get it for [family member]."

The systems in place were not robust enough to identify shortfalls and assess risks and mitigate them. This was a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During our feedback on 12 May 2022, the operations manager told us new bedding had been ordered following audits but had not been used. They assured us the new bedding was now being used and storage of the bedding was reviewed to reduce the risks of creases.
- Records showed that the environment and equipment used was checked and serviced, where required, to reduce risks to people. This included electrical appliances, fire safety and equipment used to support people to mobilise, such as hoists.
- During our inspection visit, we observed staff supporting a person to transfer from a chair to a wheelchair safely. We also saw a staff member act when they noted a person's shoes needed adjusting to reduce the risk of a fall.
- People's care records included the warning signs staff should be aware of in people's wellbeing relating to diabetes.

#### Using medicines safely

- We were not assured people were receiving their medicines as prescribed.
- Medicine administration records reviewed showed there were times when people were asleep and did not receive their medicines due to being asleep, too ill, out of stock or waiting for stock. There was not a consistent use of codes to show why medicines had not been administered and no record of actions taken if people had not received their medicines for a period of time.
- The service had identified shortfalls in the recording of creams, and this was in the process of being improved. This included the administration of creams used to reduce the risks of pressure ulcers developing.

The systems in place were not robust enough to ensure people received their medicines as prescribed. This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The operations manager told us they would undertake risk assessments to ensure any risks were mitigated in relation to people having their topical medicines such as creams and lotions in their bedrooms.
- We reviewed the room where medicines were stored, we found temperature checks were made of the room and medicines fridge, the date of medicines being open were recorded on the packaging and medicines which required specific storage and recording were managed safely. A sample of medicines in stock were taken and these tallied with the controlled drugs register.

- One person's relative told us how the service had worked closely with health professionals to find suitable medicines which their family member could take. Another relative told us the staff had noted their family member may be in pain and they had discussed their concerns with the doctor and pain relief was prescribed.
- Staff received training and had their competency checked where they were responsible for administering medicines.

#### Preventing and controlling infection

- We looked at six beds during our visit to ensure they were clean. Five of the beds looked at had bedding which were unclean and stained, this included the bottom sheet and duvet cover. One bed which had been made had a wet bottom sheet and duvet and cover. The cover on one mattress was stained on the flap which covered the zip.
- The toilet lid in the first-floor bathroom was cracked and the covering was peeling. This provided a place for bacteria to develop. The trollies used to store and administer medicines from were not clean, these were cleaned as soon as we pointed it out.

The infection control systems in place were not robust enough to identify shortfalls. This was a breach of regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We fed back our concerns to the operations manager on the day of our visit. The operations manager told us during our feedback on 12 April 2022 they had now had systems in place for the changing of bedding and the toilet seat had been replaced.
- We had received some feedback that staff were not always wearing their masks appropriately. We were assured this had been addressed and during our inspection visit we saw staff were wearing PPE as required.
- We found the shared spaces such as the lounge and dining room were clean and hygienic. Domestic staff told us how touch points were routinely cleaned.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

- We received feedback from relatives that they were able to visit their family members in the service.
- This was confirmed in our observations when people were enjoying visits with their relatives.

#### Staffing and recruitment

- We had received some concerns prior to and during our inspection about the deployment of staff in the service. To address this staff were being advised to make regular checks on the people on the first floor, who were in their bedrooms. The electronic system used for care planning and recording care provided now had an alert to remind staff when they should make checks.
- We received mixed feedback about if there were sufficient staff to meet people's needs. One relative said, "We feel that the home is often understaffed which puts pressure on the working staff therefore residents not having the help they need when they need it." Another relative told us, "I have found on several occasions there has been no staff around the downstairs rooms, and I have had to intervene with other residents who were upset or needing reassurance."

- We received feedback from some relatives that they had noted there were recently improvements in the visibility of staff in the service. One relative stated, "There does seem to be more staff around recently as they may have recruited more." Another relative said, "Only in the last couple of weeks I have felt there has been enough staff."
- We received mixed views from staff if there was enough of them on shift to meet people's needs. Several staff did raise that at weekends there were sometimes less staff than on weekdays.
- The provider used a tool to assist them to calculate the numbers of staff they needed to meet people's needs. Records showed, on some days the calculated number of staff was below the planned numbers. However, the operations manager told us where there was short notice absence of staff, these were filled by existing staff or agency.
- We reviewed the recruitment records of three staff members and found checks had been made to reduce the risks of employing a staff member who was not of good character and unsuitable to work in the service. The checks included previous employment and Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

#### Learning lessons when things go wrong

- Following concerns raised by stakeholders; the provider had introduced systems to reduce future concerns. Not all of the improvements were fully implemented and embedded in practice.
- To reduce risks, head of departments attended daily meetings where any emerging risks were discussed, and actions agreed in how these would be mitigated.
- During handover meetings from one shift to another, a walk around had been introduced. This enabled the next shift to identify if there were any outstanding actions required and that people had received the care reported on at handover.
- Analysis of incidents such as falls were not always identifying potential trends and measures in place to reduce future incidents. The operations manager assured us improvements were being made in this area.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

# 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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- There was a programme of audits in place which were designed to assist the provider and management team to identify shortfalls and address them. However, we saw audits which had not picked up all of the shortfalls identified by stakeholders and us, and where some shortfalls had been identified in the audits they had not been addressed promptly. For example, a pressure care audit completed in March 2022 had been rated 100% and outstanding. This was despite concerns being identified in pressure care management. Another audit was undertaken in April 2022 which was rated 70% and identified improvements required.
- Following concerns raised about the care being provided to people, the local authority had taken the decision to suspend their contract with the service until improvements were made.
- The service was in the process of updating and reviewing people's care plans. However, we found shortfalls in the care plans, which did not fully explore risks and for example, people's conditions, to provide staff with clear guidance on how their needs were to be met.
- One person's records identified they had a soft diet, there was no further information in the records as to why this was, nor the texture of the diet required. The record of food intake showed they were provided with meals which were prepared at usual, soft and pureed consistencies, as well as biscuits which were not soft. The operations manager told us the person had not been assessed as needing a soft diet, but this was due to what they found manageable to eat, this was not recorded in their care records.
- An operations manager told us there had been a recording issue, which they were in the process of improving, however, these were not yet fully implemented. The records did not always provide clear detail on the care provided to people, including in repositioning charts, fluid charts, personal care provided and how people had spent their day.

The governance systems in place were not robust enough to identify shortfalls and address them. This was a breach of regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The operations manager told us they were in the process of improving audits and the way the service was assessed and monitored, this was confirmed in records. These improvements needed to be fully implemented and sustained to show the systems were robust enough to independently identify and address shortfalls.
- We received positive feedback from relatives and people using the service about how caring the staff team were. This was confirmed in our observations. One relative told us that their family member received,

"Incredible compassion and care." Another relative said, "The staff are extremely kind and respectful to my [family member]."

- The service was operating a 'resident of the day' system which meant their care needs and provision and records would be reviewed at least once a month.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager had retired 11 days before our inspection visit. The provider had advertised for a new manager and the service was being managed by an operations manager and the provider's operations management team.
- The operations team were in the process of driving improvement in the service, in line with shortfalls they had identified and those identified by stakeholders. An action plan was in place which identified the timescales for improvement.
- The changes being made in the service also included the change from having two head of care staff members into one deputy manager to support the running of the service. The service was recruiting to the role of deputy manager.
- We received mixed comments from staff regarding if they felt supported and if the service was well-led. Some staff told us they had recently seen improvements in the service. Some staff told us they had reported concerns to senior colleagues, but these had not always been acted on.

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

- People using the service, relatives and staff had been asked for their views about the service in satisfaction questionnaires, which we reviewed at the inspection. An operations manager had found that although previous questionnaires had been sent out and received, there was no record of analysis or actions taken as a result of comments received.
- To address this, comments were being reviewed for previous questionnaires and new questionnaires had recently been sent out to gain people's views. The operations manager told us they had asked people and relatives to raise any concerns at any time to enable them to address them.
- Records showed people, relatives and staff were given the opportunity to discuss the service and make suggestions in meetings. Recent staff and senior staff meetings included guidance on the improvements being made and the expectations of their role.
- We received mixed feedback about if the service kept relatives updated about any issues in their family member's wellbeing. Relatives told us they had been invited to participate in their family member's care reviews and care plans. We received mixed comments from relatives relating if they felt their comments were acted on. One relative said, "We have been asked, but this has not necessarily been consistently acted on." Another relative said they were, "Kept updated feel I am listened to."
- There was a duty of candour policy in place which was understood.

Continuous learning and improving care

- The provider was in the process of making improvements in the service to reduce risks of people not receiving good quality safe care. However, these were not fully implemented or embedded in practice.
- We saw records which showed staff had received training in subjects which were referred to as mandatory. This included safeguarding and moving and handling. We were not provided with records which showed other training was delivered to staff to evidence staff received training in meeting people's specific needs, such as dementia and diabetes.
- The operations manager assured us recent workshops had been delivered by stakeholders including skin

care and catheter care, further training was planned in for example, recording. Further training was planned relating to behaviours which may challenge others, which had previously been planned but not gone ahead due to the pandemic.

- The majority of staff told us they would like more training to meet people's needs and did not always feel the online training they received was sufficient. Several staff commented on needing more training in supporting people living with dementia.

#### Working in partnership with others

- We attended meetings with both the service's representatives and stakeholders and identified the service was working with other professionals to drive improvement.

- We had been made aware of how relationships could be improved with health professionals, this included acting on feedback provided. Improvements were being made, including how visits to the service were being managed to ensure any concerns about people's wellbeing were shared and guidance was being implemented.

- One person's relative told us how the service had worked well with health care professionals to ensure their family member received the care they needed, which had resulted in an improvement in their family member's wellbeing.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The systems in place were not robust enough to reduce the risks of people receiving unsafe care.</p> <p>Regulation 12 (1) (2) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The governance systems in place were not robust enough to identify shortfalls and address them.</p> <p>Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>