The Woodlands Care Home TWCH LLP

The Woodlands Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Woodlands Care Home is a care home providing accommodation and personal care to up to 16 people. At the time of the inspection there were 11 people living in the home.

People's experience of using this service and what we found
Risks to people had not been robustly assessed, monitored or mitigated. We could not be assured people received the care they required as their care records did not all accurately reflect their needs and risks to ensure staff knew how to support them safely. There were large gaps in the recording of care provided. There was no emergency evacuation equipment available to assist people out of the home in the event of an emergency and there was no hoist available to assist people who were supported in bed. There was no evidence that referrals were made to relevant professionals to ensure people's needs were met and risks were minimised.

The building was not safely maintained; we identified significant fire safety risks within the home, the lift was not in working order and chemicals that posed a risk to people were not stored securely. Appropriate Infection prevention control policies and procedures (IPC) were not all in place to help reduce the risk of infections, including COVID-19. Not all parts of the home were clean and well maintained and repairs required were not addressed in a timely way. Staff had access to adequate PPE, but there was no system to ensure they were completing COVID-19 testing in line with government guidance. People's family members were welcomed into the home safely, following current guidance regarding infection prevention and control risks.

The systems in place to monitor the quality and safety of the service were not effective and there was no evidence the provider had oversight of the service. The deputy manager was managing the day to day running of the service, with little support to ensure regulatory responsibilities were met. Ratings from the last inspection were not displayed on the provider's website as required. The Commission had not been informed of all incidents the provider is required to notify us of. Systems were not in place to gather regular feedback from people or their relatives regarding the service provided, to enable changes and improvements to be made as necessary.

Although medication administration records were completed, medicines were not stored securely and staff who administered medicines had not had their competency checked to ensure they could manage medicines safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Consent to care and treatment had not been sought and recorded and applications to deprive people of their liberty had not all been managed appropriately.

People and their relatives told us they felt The Woodlands was a safe place to be and that they were well cared for. However, we found that safeguarding incidents had not all been managed appropriately, safe recruitment practices had not been adhered to for all staff, and there was no evidence that staff had completed relevant training to ensure they could safely meet people's needs. Although staff felt well supported, there were no systems in place to ensure they received an induction, regular supervision and appraisal.

Relatives told us they were kept informed of any accidents or incidents regarding their family members and measures had been taken during the COVID -19 pandemic to facilitate people having contact with their relatives.

The provider has begun making improvements and addressing the risks identified during the inspection.

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 last rating for this service was good (published 1 September 2018).

Why we inspected
We received concerns in relation to risk management, the safety of the building, Deprivation of Liberty Safeguards, fire safety and the governance of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led.

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.

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 inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Woodlands Care Home on our website at 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 risk management, the management of medicines, staff recruitment, training and support, consent and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Woodlands Care 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
The inspection was undertaken by an inspector, an inspector manager and an Expert 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.

Service and service type
The Woodlands Care 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. The Woodlands is a care home 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 a registered manager employed, however they had resigned from the role and were not in the home at the time of the inspection.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and safeguarding teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with the provider and deputy manager who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with three other members of the staff team, three people who lived in the home, four relatives and a close friend to gather their feedback regarding the service. We reviewed a range of records. This included five people's care records, a sample of medication records, three staff employment files and records relating to the management and monitoring of 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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not robustly assessed or managed.
- People's individual risks had not all been considered and mitigated effectively, and risk assessments did not all reflect people's needs accurately. One person's moving and handling risk assessment stated they could get up and mobilise with support from two staff, but they were not mobile and were supported in bed. Another person's nutritional assessment showed they did not require a specialised diet, however they were receiving a soft diet due to swallowing difficulties which placed them at risk of choking.
- Personal emergency evacuation plans identified some people would require the use of a hoist to support their evacuation, however there was no hoist available. There was no equipment available to assist people down the stairs in the event of an emergency.
- Care plans did not reflect consistent or accurate information regarding people's needs, to ensure staff knew how best to support them.
- There were large gaps in the records of care provided, such as repositioning support. Air mattresses were in place for people at risk of developing pressure ulcers. However, they were incorrectly set. We could not be assured people received safe care.
- The building was not safely maintained. Significant fire safety concerns were evident. For instance, fire doors did not close adequately, doors were wedged open, door guards no longer worked to ensure doors would close automatically in the event of a fire, the fire alarm was not tested regularly and did not meet current standards for care homes and concerns identified in a recent fire risk assessment had not been addressed.
- There was no gas certificate available, the lift was not in working order and there was work required to improve the electrics within the home.

Failure to ensure risk was managed safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The provider has taken steps to begin addressing the concerns and risks identified.
- We shared our concerns regarding fire safety with Merseyside Fire Service, and risks regarding people's care and safety were shared with the local authority and safeguarding teams.

Staffing and recruitment

- Safe recruitment practices were not always adhered to.
- Not all staff files contained references from previous employers, no staff had photographic identification and risk assessments were not always in place for potential risks identified in the recruitment process.

Failure to ensure safe recruitment practices are followed is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Records showed that staff had undertaken a Disclosure and Barring Service (DBS) check, which provides information including details about convictions and cautions held on the Police National Computer and helps employers make safer recruitment decisions.
● Staff and people living in the home told us there were enough numbers of staff to support them. Comments included, "Yes, there's always staff floating around," "Every time I go staff are busy, but they've always got time" and "When I ask for something they come fairly quickly."

Using medicines safely
● Medicines were not always managed safely.
● Medicines were stored in a trolley within the office. There was no lock available on the office door and temperatures of the room were not monitored to ensure medicines were stored within recommended ranges. On the second day of inspection, the medicine trolley was left unsecured, with the keys in the lock and the cupboard containing controlled medicines had been left open.
● Staff who administered medicines had not undertaken a competency assessment to ensure they were able to manage medicines safely.

Failure to ensure medicines were manged safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The provider has taken steps to begin addressing the concerns identified.
● Medication administration records were completed robustly. They contained photographs of people and reflected any allergies they had.

Systems and processes to safeguard people from the risk of abuse
● A safeguarding policy was in place and information as to how to raise concerns was displayed within the home. However, records showed that not all incidents had been correctly identified as a safeguarding issue and so had not been reported appropriately.
● People told us they felt safe at The Woodlands. They said, "Yes it's secure and there are always people around" and "The people around me makes me feel safe." Relatives agreed and told us, "They give me total confidence in her safety" and "I know what's needed where safety is concerned. It's a safe environment and lots going on."

Preventing and controlling infection
● Appropriate Infection prevention control policies and procedures (IPC) were not all in place to help reduce the risk of infections, including COVID-19.
● Parts of the home were visibly dirty, and the home had not been well maintained. Audits reflected issues such as broken toilet seats and bathroom taps that had not been addressed.
● Staff had access to adequate amounts of PPE, and we observed this to be used appropriately.
● There was no clear oversight to ensure staff were completing COVID-19 tests in line with government guidance.

Visiting in care homes
● Safe visiting arrangements were in place in line with government guidance.

Learning lessons when things go wrong

● The provider did not ensure that incidents were reviewed in order to learn lessons and prevent recurrence.

● There was a high number of unwitnessed falls recorded and records showed that referrals had not been made to the falls team appropriately.
● Accidents and incidents had not been monitored and reviewed to look for trends and possible factors that may have contributed to the incidents.

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.

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

- People's consent to their care and treatment had not been sought and recorded appropriately.
- Where there were concerns about a person's capacity to consent to a particular decision, the MCA was not always followed. The capacity assessments completed were not clear; the outcome of the assessment had often been decided before the assessment had been completed and best interest decisions were not recorded with the involvement of relevant people.
- Records showed relatives had signed consent forms on people's behalf, with no evidence that they have the legal authority to do so.
- Applications to deprive people of their liberty had not all been made appropriately for all people who required this.

Failure to ensure people's consent was sought in line with the principles of the Mental Capacity Act is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff had not received the support and training necessary to ensure they could be effective in their roles.
- No evidence of staff training was available during the inspection. The deputy manager confirmed that staff had not had any recent moving and handling training, fire safety, practical first aid or fire evacuation training. This meant people were supported by staff who may not have the knowledge and skills to meet their needs safely.
- Although staff told us they felt well supported by the deputy manager, they had not received regular

supervisions or an appraisal to support them in their role.

Failure to ensure staff all staff have the necessary knowledge and skills to support people safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● We could not be assured that people's nutritional needs were fully met.
● Records regarding people's nutritional needs differed from information staff told us.
● When people required their food and fluid intake to be monitored, records were not completed robustly. For instance, one person's diet chart reflected they ate breakfast on one day and a packet of crisps; no other meals were recorded. The deputy manager assured us the person ate well and had both lunch and dinner that day.
● Feedback regarding the meals available was positive. Comments included, "My [relative] eats anything, there's a choice of food. He says he likes the food, they cut it up for him and then sit with him," "She always has a clean plate. They do ask her what she wants to eat, they give her a choice" and "The food is nice. They don't usually offer a choice but if you don't like it, they will offer you something else."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals to relevant health professionals for their expert advice and support were not always made in a timely way. For instance, there was no evidence of referrals to the falls prevention service for people who had multiple falls.
● Another person's care records showed they required a soft, bite sized diet as they were having difficulty swallowing and were holding food in their mouth. There was no evidence that advice had been sought from speech and language therapist (SALT) to address this risk.
● There was regular input from community nurses for those people who required it and a GP visited regularly.
● Relatives felt their family members health needs were met well. They described times when staff have contacted emergency services after their family members had accidents and a person living in the home said, "They would get me a doctor if I needed one; I haven't."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-admission assessments were completed before people moved into the home to help ensure staff could meet their needs.
● Records in relation to people's day to day care were poor. They did not evidence that planned care was provided.

Adapting service, design, decoration to meet people's needs
● The service was not always designed or maintained to meet people's needs effectively.
● The home provided accommodation to people over two floors. At the time of the inspection, the lift was not working. The dining room was temporarily being used as a bedroom to prevent a person who usually resided upstairs being isolated.
● Bathrooms appeared clean. There was a wet room available and a standard bath, but there was no adapted bath or lift to give access to the standard bath for those people with mobility needs, who may prefer a bath.

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.

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

- The systems in place to monitor the quality and safety of the service were not effective.
- When risks had been identified on audits, there was no evidence of actions taken to reduce the risks and the same issues were identified on consecutive audits. Some of the significant safety issues found during the inspection, had been highlighted months earlier on internal audits and external assessments, such as the fire risk assessment.
- Audits did not identify all the issues we highlighted during the inspection, such as those regarding recruitment, the management of medicines, staff training and support, inaccurate care plans and risk management, consent not assessed appropriately and DoLS not managed effectively.
- Systems in place did not ensure that referrals were made to health and care professionals in a timely way, in order to ensure people's needs could be safely met.
- There were no systems in place to ensure the provider could maintain effective oversight of the service.

Failure to operate effective systems to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider has begun making improvements to the quality monitoring systems in place since the inspection.

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

- Although people's health and care needs were not always fully met, people told us they received care that met their outcomes.
- People and their relatives told us they felt the home was managed well. Comments included, "It's run very well the manager is very nice" and "The management team are very good and approachable."
- Feedback regarding the care and support provided to people was positive. One relative told us, "[Relative] is quite capable now, far better than when she went in, she's come on an awful lot since being in The Woodlands. They give her privacy when she wants it, they respect that. She says, 'the staff are lovely with me'."
- Staff told us they had raised concerns with the registered manager, but they had not been acted upon. They told us however, they felt supported in their role and the deputy manager was now acting on concerns they raised.
- Measures had been taken during the COVID -19 pandemic to facilitate people having contact with their

relatives.

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

- Regulatory responsibilities were not always met by the provider.
- Relatives told us they were kept informed of any accidents or incidents regarding their family members.
- Ratings from the last inspection were displayed within the home. However, they were not displayed on the provider's website as required.
- The Commission had not been informed of all incidents the provider is required to notify us of.
- The deputy manager, who is also the nominated individual, was managing the day to day running of the service, with little support from the provider to ensure regulatory responsibilities were met.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Systems were not in place to gather regular feedback from people or their relatives regarding the service provided, to enable changes and improvements to be made as necessary.
- There had not been any recent meetings with people or their relatives to gather their feedback. A new survey had been created and sent to two relatives, but the responses had not been received.
- The GP and community nurses visited regularly, but referrals to other professionals such as the falls prevention team and SALT, were not always made in a timely way to get their specialist advice regarding people's needs.

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 Systems in place to seek people's consent did not follow the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure safe recruitment practices were adhered to.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people and the building were not managed and mitigated appropriately. Medicines were not always managed safely.

The enforcement action we took:

Urgent condition imposed to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Urgent condition imposed to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to operate effective systems to ensure all staff had the knowledge and skills to support people safely. Staff were not supported through regular supervisions and appraisal.

The enforcement action we took:

Urgent condition imposed to restrict admissions.