Orwell Housing Association Limited

William Wood House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
William Wood House provides personal care to people living in specialist 'extra care' housing. Personal care is help with tasks related to personal hygiene and eating, we also consider any wider social care provided. At the time of our inspection there were 26 people using the service. They lived in separate flats with shared areas including gardens and a large lounge and dining room. Not everyone who lived at William Wood House received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider's quality assurance system had not been effective in identifying the issues we found during the inspection. Audits had not always been completed. Risk assessments were not always in place for known risks to people. Accidents and incidents were not always analysed to see if action needed to be taken to prevent a reoccurrence.

Medicines were administered in a timely manner and in a way that respected people's preferences. Recruitment procedures had been followed to ensure new staff were suitable.

People told us they enjoyed living at William Wood House and that the registered manager and staff team were caring.

There was a new registered manager in post, they told us they had been concentrating on dealing with staffing issues since their appointment. Staff felt supported to carry out their roles effectively. People and staff were asked their opinions on the quality of the service.

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

Rating at last inspection
The last rating for this service was good(report published November 2017).

Why we inspected
We received concerns in relation to staffing and management. 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.

The registered manager implemented a monthly colour coded incident analyst form so that accidents and incidents could be easily analysed for trends and themes. The registered manager wrote to us after the inspection and told us that they had implemented a risk profile across the service to ensure all risks are assessed.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for William Wood house on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to keeping people safe and identifying when improvements are needed 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

William Wood House

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.

Inspection team
One inspector carried out this inspection.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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 in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before inspection
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. 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 used all this information to plan our inspection.

During the inspection
We spoke with 3 people who live at William Wood House. We also spoke with the registered manager, two team leaders and two care assistants.

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

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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.

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

- People had risk assessments in place. However, not all risk assessments contained the information staff needed to prevent harm occurring. Not all risk assessments had been updated to reflect changes. This put people at risk of receiving inappropriate support.
- For example, one person who was diabetic did not have a diabetes risk assessment, in place. Although the care plan stated that the person was diabetic it did not include any information about what support the person needed regarding their diabetes or what symptoms staff should be aware of. Not all staff who worked with the person were aware they were diabetic.
- District nurses had skin assessments and plans in place for people they were providing support to, however these were not kept in the care folders for staff to see. The service did not always have their own skin integrity risk assessments in place to prevent pressure areas developing or to remind staff about the need for monitoring the person's skin. One staff member told us about a red area on the person's body, this information was not in a risk assessment or care plan. This put them at risk of not receiving the care they needed to prevent further deterioration or treatment.
- There was an accident and/incident reporting procedure in place. However, this had not always been effective at recording all incidents on the providers electronic system which was used to analyse the trends and themes.
- Accidents and/incidents were not always analysed in a timely manner to see if any action needed to be taken to prevent a reoccurrence. Information in risk assessments and care plans were not always updated after an accident/incident. For example, one person had suffered a fall in April. However, their falls risk assessment was showing as them not having had a fall since November 2021. The accident form was incomplete.
- One person had fallen and hit their head. There was no apparent sign of injury and the person had refused any first aid or the need to refer to a healthcare professional. There was no process in place to ensure that the person was checked later during the day/evening at later care calls to enquire about their accident. There was no record in their daily notes that they had been asked about their head when they later received assistance with personal care.
- The folder containing the risk assessments and care plans for one person could not be found. This had not been reported to the management team so that it could be replaced to ensure staff had the information they needed to care for people safely.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where risk assessments were in place these contained the information needed to reduce risks to people when possible.

Using medicines safely

● Staff had completed training in the administration of medicines and been assessed as competent before administering medicines on their own.

● The medicines administration records were being regularly monitored to identify any missed medication so that appropriate action could be taken. However, action had not always been taken when medication was regularly refused. One person had refused some of their medication on a regular basis, but action had not been taken to follow this up with their GP.

● The records showed that one person had missed two tablets due to being out with family. There were no procedures in place for staff to follow if people were not at home when their medicines and personal care visit was scheduled. For example, ensuring that the person took their medicines with them, having it on their return or checking with a GP if missing the medication could lead had an adverse effect on the person's health.

● There was not always clear directions for staff to follow about where creams should be applied.

Preventing and controlling infection

● The regular testing regime for Covid -19 was being followed and staff were carrying out tests twice a week. However, the guidance for testing staff (to test for five days) had not been followed when a member of staff had tested positive for Covid-19.

● Staff were using PPE effectively and safely. The registered manager was making sure infection outbreaks can be effectively prevented or managed.

Staffing and recruitment

● Safe recruitment practices were being followed to ensure the right people were employed. Checks were completed to ensure that new staff were suitable to work with vulnerable people. Gaps in employment were explored during interviews however this was not always recorded.

●Staff had completed induction training to ensure that they had the knowledge and skills required to meet people's needs.

Systems and processes to safeguard people from the risk of abuse

● Staff had completed training about how to safeguard people from harm.

● People told us they felt safe living at William Wood House and if they had any concerns, they would raise them with the registered manager. One person told us, "I feel safe as houses."

●The majority of staff were clear about the process they would follow if they suspected anyone had been harmed. The registered manager stated that they would ensure all staff were aware of the correct procedures to follow.

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 our last inspection we rated this key question good. At this inspection the rating has remained good. 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 told us they liked living at William Wood House and liked the staff that supported them. One member of staff told us, "I want people to feel safe with me."
- Staff helped people to be independent and supported them when needed. One person told us, "It's nice here, the staff are alright. They do what I need them too but I like to be independent."
- One person told us, "It's lovely here, I wouldn't want to live anywhere else. If you've got a problem you always get the support you need."

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Staff told us how they respected people's dignity and promoted their independence. They told us they asked people how they would like to receive their care and support. People told us they had been involved in planning their care and support and reviewing it. One person told us that the best thing about living at William Wood House was that it meant they could still be independent.
- Another person told us, "Staff understand my needs, I would recommend living here."
- People told us that staff respected their privacy and dignity. One person explained that staff kept them covered up as much as possible when assisting them with personal care.
- People were encouraged to express their views about their individual care and the service offered.

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 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.

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

- The registered manager told us the service had been through a period of change which included some staffing issues. This had meant that they had focussed on dealing with the immediate issues so some other areas of their role had not been carried out as they normally would.
- The providers quality assurance systems had not always been carried out effectively to identify areas for improvement. It had not identified all the areas we found requiring improvement at this inspection. For example, not all of the registered managers audits had been completed each month. Audits that had been carried out were not always completed as expected.
- Audits did not always have clear action plans regarding comments made by people. For example, one person had said they were not sure if they had been involved in the reviewing of their care plan. However, there was no action to follow this up to see if there was evidence the person had been invited to be involved.
- Action was not always taken in the registered managers absence to ensure that processes were still followed. For example, whilst the registered manager had been on leave accident forms were not analysed or added to the providers system. This placed people at risk of harm as action was not taken in a timely manner to prevent a reoccurrence when possible. Government guidance for staff testing regarding Covid-19 had not been followed when the registered manager was on leave. This placed people at risk from the spread of infection.

The systems in place to monitor and improve the quality of the service were not always effective at identifying areas for improvement. This was a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager was passionate about creating a positive culture within the service and, since their appointment they had held meetings with staff and people to inform them about the plans for the service and to welcome feedback.
- People gave us positive feedback about the service and the registered manager. One person said, "If I wasn't happy with anything I would speak to [name of registered manager], they are approachable."
- Staff also spoke positively about the recent changes across the service and the registered manager. One staff member told us, "[Registered manager] is approachable."

● The registered manager understood their obligations in relation to the duty of candour.

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

● The registered manager welcomed our inspection and feedback. They showed their commitment to making the improvements needed and keeping people at the heart of these.

● The registered manager and staff worked well with other teams such as the district nurses and social workers to ensure people received the support and care they required.

● Meetings were held for staff and people to attend to discuss any concerns and suggest plans for the future. The registered manager said that feedback surveys had been sent to people to ask their views over a year ago so were due to be sent again.

● Equality and diversity support needs were well managed, and staff supported everyone to meet their specific 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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not always been mitigated where possible.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems were not always effective.