Care Quality Commission

Deepdene Care Limited

Woodtown House

Inspection report

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Bideford
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

People said they felt safe, but some were expressing some levels of anxiety due to their mental health. There was a high proportion of agency being used to staff the service. This impacted on people because agency staff were not insured to drive the home's vehicle. It also meant that, at times, newer agency staff may not know people's needs well. Some agency staff had completed regular shifts at the service and two said "There is a good handover and we are always regarded as part of the team."

People's needs were at risk of not being fully met because of reduced staffing levels. We judged that with the reduction in staffing plus the high number of agency workers, there was an increased risk that people's needs were at risk of not being met. We fed this back to the provider who agreed that they would immediately re-instate the staffing numbers back to one senior or nurse plus three care staff.

People with nursing needs were at risk of having their needs unmet because the providers continued to struggle to get nurse cover, but their contingency plan was to have one nurse at least across one shift i.e. one 24-hour period. During other times they would have a senior support worker who was trained to give medicines. The provider said they have looked at ways to attract more nurses. To date they were still reliant on using agency senior support workers and sometimes this was for more than their own contingency of 24 hours. Some shifts had gone for two days without nurse input.

We raised some concerns around "as required medicine practices". This was addressed quickly by the provider to ensure these practices were improved. This should have been picked up by the provider's quality assurance systems and by having more nurses available.

We identified some issues with fire safety and have referred this on to Devon Fire and Rescue Services.

We were made aware that some people struggled to access the service's vehicle safely and were using the wheelchair ramp which was an unsafe practice.

Communication between the provider and the service appeared to be an issue and this had the potential to place people at risk.

The providers quality assurance system was not always effective or had led to enough improvements which placed people at risk of inappropriate care.

We have issued two requirements in relation to staffing and to good governance.

More information is in the full report

Rating at last inspection: Requires Improvement in all key questions except caring which was rated as good. Overall rating of requires improvement. Report published November 2018.

Why we inspected: We completed this focussed inspection because we had received some information of concern about staffing levels and people's safety. We looked at two key areas, Safe and well led during this inspection. At the last inspection these areas were rated requires improvement. At this inspection we have judged that well-led had deteriorated to inadequate. Safe remains requires improvement.

Enforcement: Action we told provider to take. We have told he provider to keep the staffing level under review and ensure nursing cover is consistent. We have issued two requirements notices in relation to regulation 18 - having sufficient and suitably qualified staff, and 17- good governance.

Follow up: We will continue to monitor the intelligence we receive about the service. We will continue to liaise with the local Authority safeguarding team, commissioners and the providers to ensure people's safety. We will complete a comprehensive inspection within the next six months. If any concerning information is received, we may inspect sooner.

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

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 well-led Details are in our Well-Led findings below.	**Inadequate**

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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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by some information of concern we received about the reduction in staffing and the quality support manager believing this placed people at risk.

Inspection team:
The inspection was completed by one adult social care inspector.

Service and service type:
The service is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at on this inspection.
Woodtown House is a home providing accommodation and personal care to a maximum of 28 people with enduring mental health conditions. It also provides nursing care. At the time of the inspection there were 11 people living at the service. Three people were in hospital but expected to return to the service.
The service is provided in one adapted building over three floors.
The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced; no notice was given.

What we did:
Before the inspection we used information, we had received about the service since the last inspection to help us identify any key areas we needed to focus on during the inspection. We looked at information we held about the service, including notifications they had been made to us about important events. We also reviewed all other information sent to us from other stakeholders, for example the local authority and

members of the public. There was also information of concern received in respect of reduced staffing levels.

During the inspection we spoke briefly with four people living at the service. We spoke with three care staff, the quality support manager, administrator, domestic staff and via phone with representatives of the provider. We reviewed two care plans, two electronic records in relation to medicines and one staff recruitment file.

Following the inspection, we attended a quality monitoring review meeting and heard feedback from two health professionals and the quality leads for the commissioning team.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Staffing and recruitment
• Prior to this inspection we had received some information of concern from a whistle blower which stated that the providers had reduced the core care staff by one and this placed
people at potential risk.
• We found for the weekdays of the inspection week, the providers had reduced the care staff by one. This meant there was one senior care worker or nurse and two other members of staff, plus an activities person. This had compromised people's safety. This was because there were two people who were risk of choking and required constant supervision whilst food and drinks were available. One person required two to one support for some of their personal care needs. They were also funded for large parts of their day to be given at least one to one support to keep them safe and occupied. The staffing rota did not show how this was being staffed. The quality support manager said she was not aware of the exact agreement of one to one hours. The provider did not comment on how many one to one funded hours this person was in receipt of.
• There was a high reliance on agency staffing for both care staff and nurse cover. This impacted on people because agency staff were not insured to drive the home's vehicle. It also meant that, at times, newer agency staff may not know people's needs well.
• Not all shifts had nurse cover despite the service being registered for nursing care and people needing nursing care. The providers said they had a constant struggle to find permanent and agency nurse cover. They had an emergency contingency plan for nurse cover to be at least one shift over a 24-hour period. This meant on most days there was either a nurse on day shifts or a nurse on night shifts. For the other shifts there was a senior care worker who was trained to administer medicines.
• We raised the concern that nurse cover was not simply to ensure medicines were administered correctly but also to monitor the ongoing well-being of people and their mental health conditions.
• We received information from one agency raising concerns that cover had been provided but there was no nurse cover and on one day over a weekend, every member of the team was agency. Some agency staff had completed regular shifts at the service for a period of time so knew people's needs well. However, this still meant there was no permanent staff or management covering the shift on one day.

The lack of appropriate staffing levels to meet people's needs is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following feedback to the provider, they agreed to increase the staffing levels back to three care staff plus one nurse for all shifts and said they were working hard to ensure that where possible nurse cover was in place for all shifts.
• Recruitment processes were being followed to ensure only staff who were suitable to work with vulnerable people were employed.

Assessing risk, safety monitoring and management
• Prior to the inspection the services' maintenance person had resigned and failed to hand over some aspects of the safety checks. Consequently, the fire safety checks had not been completed for the previous three weeks because no one understood how to check the fire panel. The quality support manager said she had made the providers aware two weeks previously and was awaiting them to organise for this training to be provided. The provider said they were only made aware of this fact one week ago.
• The quality support manager and administrator were unable to locate the safety checks completed to ensure the environment was safe and well maintained. This included checks on window restrictors, water temperatures and fire safety. We noted that one fire door guard was hanging off the door and therefore not fit for purpose. We have referred this to the Devon Fire and Rescue Service for follow up.
• Following the inspection, the area manager was able to locate the safety checks and to provide evidence that they were auditing these checks on a monthly basis.
• A staff member made us aware they had completed risk assessments in relation to people accessing the home's vehicle. Some people struggled to get in via the side door and so were using the wheelchair ramp which had no grab rails. They had sought quotes to have the correct modifications to ensure people's safety. They said this had been sent to the providers at least 18 months ago and despite repeated requests this had still not been addressed. The provider said in feedback they were unaware of this request and would action agreement for the modifications to be completed.
• Risks associated with people's care were assessed and recorded so staff could provide consistent and safe care to people. This included reviewing their mental well-being with other healthcare professionals.

Using medicines safely
• At the last inspection we found this area was robust. At this inspection we sampled two people's electronic records in relation to as needed (PRN) medicines. Protocols were in place, but these did not detail clearly how and when a PRN medicine should be administered. This was addressed quickly by the provider who audited these PRN medicines. They ensured protocols were written up in more detail. This was essential as some of these medicines were for calming people's moods and skill and judgment were required to understand when and how this should be used. As there was a large portion of shifts being covered by agency, clear details about how and when to consider PRN medicines was essential in order to ensure people were not being unduly restricted.
• Medicines were appropriately stored, and people came to the medicines room for their medicines. This appeared quite institutional in practice. One staff member said it worked well because it gave some responsibility to the person to come and get their medicines rather than having it brought to them.

Systems and processes to safeguard people from the risk of abuse
• Most shifts were being covered by agency staff. Those we spoke with had a good understanding of people's needs and who they should report any concern to.
• The service quality support manager had raised a safeguarding concern in relation to staffing levels and people being at potential risk. This was the catalysis for completing this inspection. We found their concerns were valid and the home is now in a whole home safeguarding process. This means the local authority safeguarding team will be working closely with the service to ensure people's safety.
• The provider said they were disappointed to be in a safeguarding process and "Wished to work with all concerned to ensure the wellbeing of everyone at the service."

Preventing and controlling infection
• The service employed domestic staff to keep the home clean and free from infection. They were down by one cleaner, and there was no cover over the weekends. The provider said this was being addressed.

- Some of the bathrooms and other areas were shabby and in needed of refurbishment. Worn surfaces increased the risk of infection because they were harder to ensure they could be wiped down effectively. We were told there was a programme of refurbishment.
- Staff were supplied with personal protective equipment for use to prevent the spread of infections. Not all staff had received training in infection control. We were informed this was being addressed.

Learning lessons when things go wrong

- The regional quality assurance manager and providers had oversight of incidents within the service. Shared learning was discussed.
- Any incident was recorded and discussed as part of the handover to the next shift.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
•□At the last inspection in September 2018 this key question was rated requires improvement and a requirement notice was issued around Good Governance. At this inspection we have not found enough improvements and the requirement notice is not met.
•□The service has been without a registered manager since March 2016. There have been a series of managers, but they did not stay for very long. The provider's governance arrangements had not led to effective actions to address this. We are taking actions in respect of this.
•□The current quality support manager who has a short-term contract felt they needed to raise a safeguarding concern in respect of the reduction in staffing. This was because they did not feel listened to by the provider and believed they had a duty of candour to protect people.
•□Some staff did not feel listened to and communication was poor between the home and the provider. For example, we have already highlighted the need for modifications for the home's vehicle. This had not been addressed for 18 months and the provider said they were not aware of any such request. The staff said this request had been repeatedly made when each new manager was recruited. This demonstrates the providers oversight and quality assurance had failed to identify the fact the vehicle needed improvements.
•□The providers had decided to reduce the staffing levels short term, based on the fact three people were in hospital. They failed to understand that those three people still required a level of service and visits from staff for their wellbeing and for effective transition back to the service when they were well enough to return. This showed a lack of understanding in their duty of care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•□The service's quality support manager said they had not been given autonomy to request agency cover. They were not confident that the provider had requested cover in a timely way or that they were requesting nurse cover across all shifts. The quality support manager had identified risks in reducing staffing levels, which she discussed with the providers at the time they implemented the reduction. they felt their views had been ignored.
•□The provider said they were asking three agencies for shift cover and where available were booking nurse cover. However, we saw some shifts two weeks in advance had already been covered by a senior support worker and not a nurse.
•□The quality support manager had made the provider aware via a phone call and email, that no one was able to complete the fire safety checks since the maintenance person left, but action to address this had

been slow. The provider said they were only made aware of it after two weeks of the maintenance person leaving and was addressing this. However, the providers quality assurance and improvement system had not been effective in addressing the issue.
•The activities person employed to ensure there were meaningful activities and or social engagement each day was spending most of their time driving people to appointments as they were the only staff member able and insured to drive the company vehicle. No one had thought to review roles and ensure activities were being covered by someone else. The provider had also failed to identify this as an issue as part of the quality monitoring processes.
•The area manager visited the service monthly to complete audits, speak with staff and people who use the service. However, these visits and audits had not been effective in identifying the areas we picked up during the inspection or in improving some services for people in the home. Given the lack of registered manager, high volume of agency cover and low staff morale, the local authority commissioning teams did not feel this was enough. They believed the providers needed to engage more meaningfully and more frequently with the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People were being asked their views and given choices in their daily lives albeit restricted by staffing levels.
•Surveys had been completed by both people and staff. The main issue identified was lack of meaningful activities. Although an activities person was employed their time had been diverted elsewhere so people remained with a lack of stimulation. For some people living with enduring mental health issues there was also a lack of motivation to take part in activities. However, without them being planned and initiated, this cycle of inertness continued.
•People's protected characteristics were considered.
•People were offered some opportunities to access the local community such as local coffee mornings and trips to the shops. Being in a very rural location means having drivers was key to ensuring this occurs on a more regular basis.
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The lack of appropriate assessing, monitoring and improvements to the quality and safety of the services provided for people demonstrates a repeated breach of Regulation17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
•There was evidence in people's care files of how the service worked in partnership with other healthcare professionals to monitor and review people's needs on a regular basis.
•Clear working with people's advocates and families ensured people's rights were protected and their freedom and rights considered and restricted in the least restrictive way. For example, most people smoked and there were clear agreements for ensuring staff kept their cigarettes and gave them out at regular intervals. People were then able to ensure they did not smoke everything in one go. This was agreed in line with people's best interests.

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 17 HSCA RA Regulations 2014 Good governance The quality of the service was not continually monitored and improved. There was a clear lack of leadership, oversight and scrutiny of the service. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient staff and staff with the right skills and qualification to ensure people's safety and well-being.