Hemunjit Ramparsad

Woodlands

Inspection report

33-35 Fox Lane
London
N13 4AB

Tel: 02088868725

Date of inspection visit:
23 October 2020
26 October 2020
02 November 2020

Date of publication:
22 January 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodlands is a residential care home providing accommodation and personal care to people aged 65 and over, some of whom were living with dementia. The service is registered to support up to 20 people. At the time of the inspection there were 11 people living at the home. The home is a large adapted residential house.

People's experience of using this service and what we found
We observed people to be happy and content living at Woodlands. People and relatives did not express any significant concerns with their care experiences. However, we found significant concerns around how the home was managed, documentation relating to care, health and safety and ensuring people were not placed at risk of harm.

Risk to people were not identified or assessed. Where risks were assessed, risk assessment documents were not always comprehensive and were generic. Guidance and direction to staff on how to minimise was not clear and detailed, placing people at risk of harm.

People were not always receiving their medicines safely and as prescribed. Systems and processes in place to manage medicines safely were ineffective.

Health and safety and infection control were not always well managed. We found the environment and furniture to be either unsafe or in a poor state of repair. Staff had not received any recent infection control training especially considering the current COVID-19 pandemic. Whilst the provider took remedial action when this was pointed out, there were not adequate systems in place to identify this prior to the inspection.

People did not always have a choice of what they wanted to eat and were not involved in menu planning.

People may not have always been supported to maintain healthy lives. There were no personal hygiene products available and people were not being supported with their oral hygiene.

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 did not support this practice. Capacity assessments had been incorrectly complete and best interest decisions had not been considered.

There was a lack of managerial oversight of the home. There were no effective audits of any aspect of care delivery. Written records were ineligible or were not a true account of the care people received.

Staff understood safeguarding and how to keep people safe from abuse. Staff told us that they received training to support them in their role.

Relatives feedback about the provider and the deputy manager was positive stating that they were kind, caring and approachable.

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 (published 24 January 2019).

Why we inspected
We received concerns in relation to staff not accessing emergency health and medical support where a person was found unresponsive. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

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 coronavirus and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified six breaches of regulation around person centred care, premises and equipment, safe care and treatment, safeguarding people from abuse, consent to care and good governance. The failings found are detailed in the main body of the report.

In response to the breach identified regarding good governance, regulation 17, we will be writing to the provider asking them to provide an action plan in response to the issues identified and to provider time specific updates on the progress of actions taken.

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.

With regards to the breaches found regarding person centred care, premises and equipment, safe care and treatment, safeguarding people from abuse and need for consent, please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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?

Requires Improvement

The service was not always 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.

Woodlands

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 carried out by one inspector. The inspection was also supported by 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. The Expert by Experience contacted people's relatives and friends by telephone to request their feedback.

Service and service type
Woodlands is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home is operated by an individual who is registered as the provider and the nominated individual. They also manage the home. 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 announced. We gave a short period notice of the inspection as we were mindful of the impact and added pressures of Covid-19 pandemic on the service. This meant we took account of the exceptional circumstances and requirements arising as a result of the COVID-19 pandemic.

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 professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service. We spoke with the provider and four members of staff including the deputy manager, two care staff and the activity co-ordinator.

We reviewed a range of records. This included five people's care records and seven people's medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance, training records and health and safety were also reviewed.

After the inspection
We spoke with five relatives and one friend of people living at the home and two night care staff. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risks associated with people's health, medical and care needs had not always been assessed so that staff were aware on how to minimise known risks to people.
- Risk assessments that had been completed for people were not always comprehensive and were generic, only assessing specific risks associated with skin integrity, elimination, falls, breathing and certain health conditions such as diabetes. This meant that people may not be receiving care that was appropriate to their needs.
- One person was noted to refuse attending essential hospital treatment which could impact their health. This had not been risk assessed. The same person was also known to remove medical interventions implanted beneath the skin. This again had not been risk assessed.
- Three other people had been prescribed blood thinning medicines which had not been risk assessed as a 'high risk' medicine.
- Another person was identified as bruising easily and at risk of scratching themselves. This had not been risk assessed.
- In light of the current pandemic and the risks presented to vulnerable people with specific health conditions, the provider had not assessed the impact of COVID-19 on people. One person had been classified as 'extremely' vulnerable in their care plan and had been placed under the shielding category. This had not been risk assessed.
- Accidents and incidents were now always documented, appropriately acted upon, investigated and follow up actions recorded where required.
- One person had sustained a significant injury. The service was unaware of how and then when this person may have sustained this injury. This incident had not been recognised, documented and reported to the relevant authorities so that learning could take place when things may have gone wrong.
- The provider completed a monthly analysis and review of all accidents and incidents. However, the analysis was not always accurate when compared to actual accident and incident records. There was no recorded detail of review, analysis and identification of trends and patters so that learning, development and improvement could be implemented.

We found systems were either not in place or 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.

Using medicines safely

- People were not always receiving their medicines safely and as prescribed.

● There were no records in place of medicine stock kept at the home. There was no system in place to monitor and check medicine stocks held in the home were correct.
● Where people's medicines were administered from the original packaging including eye drops and topical creams, there was no date of opening recorded on the box, which meant we could not be sure that the medicine had only been in use for 28 days as per guidance.
● For two people, where a specific medicine was administered from the original packaging, we found excess tablets remaining in the box when checked against the Medicine Administration Record (MAR) of tablets actually administered. This suggested that people had not received the medicine even though the Medicine Administration Records (MAR) had been signed to confirm the medicine had been administered.
● Medicines that came into the home, not as part of the regular medicine system, had handwritten MARs completed by staff. However, these did not follow recognised guidance and were not signed by two staff. There were insufficient checks to ensure that the medicine coming into the home was correct.
● Care staff responsible for managing and administering medicines had received appropriate training. However, competency assessments had not been reviewed and care staff had not had their competency reassessed since 2018 to ensure they were appropriately skilled and knowledgeable when administering medicines. Following the inspection, updated competency assessments were sent to us.
● Monthly medicines audit had failed to pick up medicines issues that were found at this inspection. This is discussed further in the well-led section of this report.

We found systems were either not in place or robust enough to ensure safe medicine management and administration. This meant that people may not have been receiving their medicines safely and as prescribed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People may not have always been protected and kept safe from the possible spread of infection.
● We found the home to be clean and there were no malodours noted during both days of the inspection.
● However, there were no additional cleaning schedules implemented as a direct result of the COVID-19 pandemic. On day one of the inspection we did not observe any cleaning taking place around the home.
● The provider explained that he did not have designated staff to carry out the cleaning around the home but had employed someone who was due to start.
● Care staff had not received any formal training since September 2019 on infection control, the use of PPE or on COVID-19. The provider stated that staff had been provided with guidance and information in these areas.
● All care staff that we spoke with were unable to tell us the correct order in which Personal Protective Equipment (PPE) should be put on and taken off.
● The provider had not given any consideration to the impact of COVID-19 on people and the risks upon their health and medical conditions.

We found that there was a lack of systems and processes in place to prevent the spread of infection. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, we found the home was in a general state of disrepair and required modernisation. This meant that people may not have always been kept safe and could be placed at risk because of health and safety issues around the home.
● Some armchairs, bedside cabinets, chests of drawers, wardrobes, dining lap tables were old, in a general state of disrepair, ripped and chipped.

● We identified several radiator covers that were not securely affixed to the wall, placing people at the risk of harm.
● In two communal toilets, used by people, there were no hand washing facilities.
● People's rooms did not have en-suite bathrooms but did have washing facilities. Where this was the case, we identified issues with the taps and water temperatures.
● For one room we were unable to turn the tap off. For another four rooms we checked hot water temperatures which measured at above 43 degrees which meant that people were placed at risk of scalding.
● At the last food standards agency inspection in 2018, broken tiles in the kitchen had been identified as requiring replacing and had been included on the report for the provider to action. This had not been done.
● The provider had walked around with us and was shown the issues we identified.

The poor condition of parts of the home and the failure to identify and address these issues was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider sent through risk assessments that had been compiled in response to identified risks associated with blood thinning medicines and the refusal of attending important health and medical appointments.
● The provider also confirmed actions that had been taken to address the issues we identified with health and safety and the environment.
● Health and safety checks completed to ensure people's safety included checks and tests of equipment and systems such as fire alarms, fire evacuation plans, emergency lighting, gas and electrical safety.
● All staff had access to a full range of Personal Protective Equipment (PPE). This included masks, gloves and disposable aprons. Staff always wore PPE to protect people from risk of infection.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes in place were not always appropriately followed by the provider and deputy manager to ensure people were safeguarded from the risk of abuse.
● The provider and deputy manager demonstrated an understanding of their responsibilities to report incidents and events which placed people at the risk of abuse to relevant authorities including the CQC and the local authority. However, we identified two such recent incidents which had not been reported or investigated by the provider.
● One incident was identified prior to this inspection and prompted this inspection to take place. The second incident was identified during the inspection process.
● The provider and the deputy manager could not provide any explanation as to why these incidents had not been reported to the relevant authorities and agreed that these should have been reported.
● This meant that due to the lack of recognition, reporting and investigating of an accident or incident people continued to be placed at risk of abuse or harm as learning and improvements would not be implemented to prevent future re-occurrence.

The lack of systems and processes in place and the failure to report and investigate immediately an allegation or incident of abuse means that the service was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection we observed people interacting with staff positively and with confidence. Relatives also confirmed that they believed their relative to be safe living at Woodlands. Feedback included, "She is safe because there were staff around all the time and they would notice if anything happens" and "My relative is safe here because they are surrounded by members of staff and has the equipment."
● Staff understood the provider's policies and procedures on how to identify and report concerns or signs of

possible abuse. Staff told us they had received safeguarding training which was refreshed regularly.

Staffing and recruitment

- People were supported by care staff that had been assessed as safe to work with vulnerable people.
- Required recruitment checks and assurances had been obtained which included criminal record checks, evidence of conduct in previous employment and identity verification.
- Throughout the inspection we saw that there were enough staff available ensuring people's safety.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We were not concerned that people were being unlawfully deprived of their liberty and appropriate applications for DoLS authorisations had been made where required. However, we found that the application of the MCA was not always understood and documented appropriately.
- Where people required a DoLS authorisation to ensure their own safety, we saw that this was in place with information on when these needed to be reviewed.
- However, we found that capacity assessments had not been correctly completed. Answers to questions around whether people had an impairment of the brain had not been answered correctly, despite people being assessed as lacking capacity.
- Where best interest decisions were required to be made, because the person had been assessed as lacking capacity, these had not been given any further consideration and discussions with involved relatives and health professionals had not taken place or documented.
- One person, who had been assessed as lacking capacity, regularly refused to attend medical treatment required due to a specific health condition. The provider had not considered whether the person's refusal was in their best interest and had not discussed this with their relative and involved healthcare professionals. This meant that people may not have been receiving effective care and support which upheld their rights.

The poor understanding of the application of the MCA and the failure to recognise, assess and document

decisions that need to be made in people's best interest means that the service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans recorded people's consent and where required a relative's involvement in the planning and delivery of care.
● We observed that care staff respectfully spoke to people and asked for their consent before supporting them. Care staff also explained to people what they were doing and how they were going to support them. One care worker stated, "We talk to people, make sure they have everything need, give them choice, ask them what they want to wear."
● Relatives confirmed care staff did explain what they were doing when supporting people and sought consent. One relative stated, "The staff ask her for permission before they help her."

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always given choice around the meals that they ate. On the first day of the inspection we observed people were given cereal, jam or marmalade sandwiches with a drink. People were not asked what they wanted and no alternatives such as a cooked breakfast, fruit or yoghurt was offered as listed on the menu.
● Daily records documented that everyone living at Woodlands ate the same breakfast every day, seven days a week.
● During lunchtime, food was served on the plate in the kitchen and then transported to people in the lounge. We did not see anyone being asked what they wanted. The chef stated that people's choices were taken in the morning and meals served accordingly. However, most people were living with dementia and may not remember what they had chosen in the morning. No visual choice or reminder was offered.
● We discussed our observations with the provider who agreed to implement change so that people's choices and preferences were obtained. However, we were not assured that the provider and staff had fully understood the concept of offering choice.
● On the second day of the inspection, following the weekend, we observed and daily records documented that every single person had eaten a cooked breakfast over the last three days. There was no evidence that people had been asked whether they wanted a cooked breakfast or not.
People did not receive care and support that was person centred. People were not always provided with a choice of food that they wanted to eat. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not always supported in a way which promoted their health and physical well-being.
● Daily records documented that people were supported with personal care and oral hygiene daily. However, when we visited people's bedrooms, we found that there were no personal hygiene products available to support people with personal care. There was no soap, shower gels or shampoo visible.
● We visited 11 bedrooms and found that in five of the bedrooms there was no toothbrushes or toothpaste available and for the remaining rooms we found that there was either a toothbrush or toothpaste available which were dry and had not been used.
● The provider was present when we identified these issues but could not offer any explanation as to why people did not have these products available to them in their room and what staff were using when supporting people with their hygiene.

People did not receive care and support that was person centred and took account of their needs and preferences. People were not always effectively supported to maintain a healthy life. This was a breach of

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The home had not been adapted, designed or decorated in a way which met people's needs especially those people living with dementia.
● There was no appropriate signage, decoration and availability of dementia friendly equipment to promote people's independence, way-finding and well-being.
● People's rooms had not been decorated or personalised with items, photos or pictures that meant something to them.
● The provider had not given any consideration to how safe visits could be facilitated during the current COVID-19 pandemic to enable relatives to visit their loved ones safely and effectively.

People did not receive care and support that was person centred and took account of their needs and preferences. The home and people's bedrooms had not been adapted and decorated to meet people's needs. This means that the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were seen to eat well and enjoyed their meal. One person told us, "The food is lovely." One relative said, "The food is very, very good and my relative loves it. I have seen them eat and they polish the plate."
● Where people had specific dietary or cultural requirements, these had been clearly documented with their care plan. The care staff and chef were observed to have an awareness of people's likes and dislikes.
● People were supported to have enough to drink. We saw regular tea rounds serving people hot drinks. People were regularly offered cold drinks to maintain hydration.
● Following the inspection, the provider sent us evidence confirming that he had purchased a variety of personal hygiene products for people to use.
● People were supported to access health care and were referred to healthcare services where required.
● People's care records showed when they had healthcare appointments, the outcome and any follow up actions to be taken.
● Relatives told us they were confident care staff recognised ill health promptly and accessed appropriate healthcare support when required. One relative told us, "My relatives' diabetes is better controlled and they [staff] are on the ball with the GP and managing pain."
● Following a recent incident where one person was found unresponsive and care staff did not promptly call for help, we asked care staff to explain the actions they would take if placed in a situation where emergency support was required. Care staff demonstrated a clear understanding of the actions they would take in an emergent situation which was to immediately call the emergency services for assistance.
● People were able to access all areas of the home which included garden and outdoor areas with the support of a staff member.

Staff support: induction, training, skills and experience
● Relatives told us that care staff appeared to be appropriately skilled and trained to support people safely and effectively. One relative told us, "I think the staff are skilled and knowledgeable and they are very kind and caring."
● Care staff also confirmed they had received an induction, regular training and support to carry out their role. However, records showed that care staff had last received training in September 2019 with some refresher courses on medicines management and food hygiene delivered one week before this inspection.
● Care staff had not received any refresher training on mandatory topics such as safeguarding, MCA 2005 and moving and handling.
● Care staff had also not received any refresher training on infection control, PPE especially considering the

current COVID-19 pandemic.
Following the inspection, the provider confirmed that they had scheduled infection control and PPE training for all staff.

● One care staff, who had been recently recruited in July 2020, had only received in-house induction and had not received any training on mandatory topics required. The provider had accepted training certificates from a previous employment completed in 2018. We have reported further on this under the well-led section of this report.

● Staff received regular supervision, annual appraisals and told us that they felt supported by the provider and deputy manager.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs and choices were assessed in line with current standards, guidance and the law to ensure the home was able to meet people's needs safely and effectively.

● Prior to admission to the home, a pre-admission assessment was completed which looked at the person's care needs as well as their well-being, preferences and specific equipment that may be required to meet their neds.

● Following the assessment care plans were created using the information from the pre-assessment. We saw that where possible, relatives were involved in the care planning process.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

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

- The provider did not have effective systems and processes in place to monitor and oversee the quality of care people received.
- Audits in place for medicines, health and safety of the home and the kitchen were ineffective and a tick box exercise which had not identified any of the issues that we highlighted as part of this inspection.
- Accidents and incidents overview and analysis were ineffective and did not accurately record the actual number of accidents and incidents that had occurred. There was no detailed analysis or identification of trends and patterns so that improvements and learning could be implemented.
- The deputy manager reviewed care plans on a monthly basis but did not update and consider that people's risks had changed or that people were at additional risk due to changes in their health or circumstance such as COVID-19.
- There were no infection control audits in place or oversight of infection control procedures.
- There were no other management audits or checks in place, such as to check care plans, to ensure people were in receipt of good quality care and to ensure good managerial oversight.
- Issues identified at a Food Standards Agency inspection in 2018 had not been addressed.
- Recruitment checks were complete. However, the provider had not followed best practice and had not reviewed or updated staff members criminal record checks since the start of their employment, which for some staff was in excess of three years.
- Care staff rotas, medicines administration and daily record evidenced that certain staff members including the deputy manager and night care staff were working at the home seven days a week without any scheduled days off. This may place people at risk of harm due to care staff possibly being over worked and fatigued.
- Two staff members working at Woodlands, were both identified as working at other care homes, which increases the risk of COVID-19 infection transferring between services. The provider had not considered this risk and had not taken action to address this.
- One care staff, who had been recently recruited in July 2020, had only received in-house induction and had not received any training on mandatory topics required. The provider had accepted training certificates from a previous employment completed in 2018 and had not refreshed any of their training upon employment.
- There was a lack of oversight by the provider of the management of the home. The provider confirmed that whilst he was present at the home daily and that he believed oversight to be good, he stated that he

relied on the information provided by the deputy manager which gave him assurance that there were no issues with the quality of care people received.

Whilst we found there was no evidence that people had been directly harmed by the issues as identified above, systems were either not in place or robust enough to demonstrate that there was adequate oversight of the home. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and 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

● The provider did not plan and promote good outcomes for people through person centred care. Risks had either not been assessed or lacked individualised detail on how the risk specifically impacted people and how care staff were to support the person to minimise risk.

● Daily recording of the care people received was hard to read due to ineligible handwriting or was not a true record of people's care experience. Where documents recorded people had received oral hygiene, this was not the case as there was no oral care equipment available in their rooms or it was unused.

● People were not always given choices around meals they were offered. The provider and staff lacked understanding around offering choice and recognising people's preferences.

● Whilst we found that people were physically taken care of, we found significant failings throughout the inspection as detailed within this report that impeded the delivery of person-centred care.

People did not receive care that was person centred, open, inclusive and empowering. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We were not assured that the provider understood and acted on the duty of candour and their legal responsibility to be open and honest when something goes wrong.

● We had identified two incidents that required safeguarding alerts to be raised. Both incidents had not been raised as safeguarding concerns and had not been reported to the local authority or CQC.

● For both incidents we had to ask the provider to report the concerns to the local authority and CQC.

● When we highlighted these issues to the provider and deputy manager, both demonstrated that they understood their responsibilities around being open and transparent and reporting concerns but on these two occasions had failed to do so.

The provider failed to act on the duty of candour and did not fulfil their legal obligation to be open and honest with something had gone wrong. This placed people at the risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People using the service, relatives, the public and other stakeholders were not always engaged and involved in the delivery of care and the overall management of the service.

● There was no evidence of any resident or relatives meetings taking place to obtain people's feedback about their experiences.

● People and relatives had not been asked to complete satisfaction surveys since 2018 so that they could

give their feedback on the quality of care they received or make suggestions for further improvements.
● The provider stated that they were regularly in contact with relatives by telephone providing them with updates and information about their family member. However, this was not documented.
● We received mixed feedback from relatives. Some stated that they received regular updates and other relatives stated that communication between them and the home needed to improve and that they only received updates when they called the home themselves.
● Some relatives also told us that even though they had asked for video calls to be organised, so that they could speak with their family member especially during the COVID-19 pandemic, this had not happened and there was no clear communication about visiting or available alternatives such as video calls.
● Feedback included, "The deputy manager is a good manager and is approachable. I don't have any complaints or concerns. I would speak to them if I did", "To make things better they should involve friends and relatives more and improve communication" and "They [provider] said they would be doing video calls, but this hasn't been sorted out yet. They said they were going to use Skype and then didn't. I'm not sure if we can use the garden. I don't say much because they might take it out on my relative. There aren't any relatives' meetings and no surveys/questionnaires."
● The provider told us, and staff confirmed, that regular staff meetings did take place. However, there were no minutes or written record of these meetings to evidence the topics discussed. There was no evidence that accidents and incidents were discussed to implement learning, development and improvement where required.

The provider had failed to engage and involve people on the quality of care they received and give feedback on improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider sent us immediate actions that had been taken to address some of the issues we identified. This included the purchasing of new chairs, and personal hygiene items, actions taken to address health and safety issues, as well as quotes obtained to address issues identified in the kitchen. Infection control training had also been scheduled for all staff.
● People were observed to be content and happy living at Woodlands. Relatives also commented that people received good care and had no concerns. One person's representative told us, "My friend seems happy and there are no problems."
● Throughout the inspection, we observed that the provider, deputy manager and all care staff knew people well and engaged and interacted with them positively with care and kindness.
● Relatives spoke positively about the provider and the deputy manager stating that they were kind, caring and approachable.
● Care staff stated that they felt supported by the provider and the deputy manager and were kept abreast of relevant information daily. Staff also felt able to give their ideas and suggestions for change and improvement.

Working in partnership with others
● The home worked in partnership with other agencies to support people's physical health.
● Records seen confirmed that referrals had been made to varying healthcare practitioners and these were followed up appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care. People were not involved in choosing what they wanted to eat. The home had not been decorated or adapted in ways which supported people living with dementia. People's bedrooms were not person centred. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The poor understanding of the application of the MCA 2005 and the failure to recognise, assess and document decisions that need to be made in people's best interest meant that people were at risk of receiving ineffective care and support. Regulation 11 (1)(2)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments failed to document people's known risks. Where risks were documented these often failed to provide staff with adequate guidance to minimise the risk. The environment overall and some furniture were in a state of disrepair. There were ineffective systems in place to manage medicines.

Regulation 12 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The lack of systems and processes in place and the failure to report and investigate immediately an allegation or incident of abuse meant that people were not always protected from the risk of abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment and some furniture were not always in a good state of repair. There were no effective systems in place to identify and address issues found during the inspection. Regulation 15 (1)

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 17 HSCA RA Regulations 2014 Good governance The lack of robust management oversight systems and processed demonstrated that there was inadequate oversight of the home and that people were not always in receipt of care that was person centred, open, inclusive and empowering. This placed people at risk of harm.

The enforcement action we took:

We have imposed conditions on the providers registration.