Langdale Lodge Limited

Woodlands Care and Nursing Home

Inspection report

Wardgate Way
Holme Hall
Chesterfield
Derbyshire
S40 4SL

Tel: 01246231191

Date of inspection visit:
12 July 2022

Date of publication:
10 October 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodlands Care and Nursing Home is a care home providing personal and nursing care for up to 50 people. The service provides support to both older people and younger adults, including people living with dementia, mental health, physical, and sensory needs. At the time of our inspection 43 people were using the service. The care home is purpose built, accommodating people over two floors.

Peoples' experience of using this service and what we found
The location was taken over by the current provider earlier this year and was inspected 1 February 2022. The number of residents had increased from 14 in February 2022 to 43 at the time of this inspection. The provider had endeavoured to develop a stable management team and implemented an action plan to improve the service.

People's risk assessments and care plans were not always fully completed or kept up to date which meant staff did not always have information to help to keep people safe. People were at risk of being supported by unsuitable staff as safe recruitment procedures were not always followed.

Improvements to administering people's medicines safely were identified at this inspection. The manager identified the implementation of a more frequent medicine audit would further improve safe medicine administration for people.

People and their relatives described varying experiences when communicating with the provider. Not everyone was confident to raise concerns with the managers at the service or thought their concerns would be dealt with. Some people were happy with their interactions with the provider staff team.

Mental Capacity Act
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 (published 15 February 2022).

Why we inspected
We received concerns in relation to the deployment of suitable and sufficient staff and peoples' care needs not being met. 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.

Follow up
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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Woodlands Care and Nursing 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.

Inspection team
The inspection team included two inspectors, a nurse specialist advisor and a 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
Woodlands Care and Nursing 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. Woodlands Care and Nursing Home is a care home with 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 in post. The registered manager was not at the location on the day of the inspection. On the day of inspection the inspectors spoke to the clinical home manager of the service, referred to throughout the report as "the manager".

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 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 three people who used the service and ten relatives about their experience of care provided. We spoke with ten staff, including housekeeping and care staff, managers and the registered manager. We reviewed a range of records. This included nine people's care records and numerous medicine records. We looked at seven 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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Information about people's known risks was not always comprehensive. For example, a person's completed risk assessment identified them as being at a high risk of falls. There was no guidance available for staff on how to observe or support the person to reduce their risk of falls and maintain a safe environment. This meant the person remained at a high risk of harm from falls. For another person it was identified they required full support to meet their personal hygiene needs. There was no guidance in place for staff to follow to achieve this. A relative told us they did not think their family member's hygiene needs were always met.

● Information about people's risks was not always up to date. Risk assessments and care plans were not always reviewed and updated following incidents. For example, care notes identified an incident of physical aggression, however, the person's risk assessment and care plan had not been reviewed to identify guidance to support the person when they became distressed to keep them and others safe. Another example is where staff recorded incidences of a person refusing their meals; there was no risk assessment or care plan developed in response to this to mitigate the risk of malnutrition.

Using medicines safely

● Staff did not always have guidance to administer medicines correctly. People were prescribed medicines which needed to be taken a certain amount of time before food or drink to reduce the risk of indigestion and heartburn. Not all medicine administration records (MAR) included this information. This meant people were at risk of pain and discomfort if medicines were not administered at the correct time before their meals.

● People were at risk of their health conditions not being managed safely. We identified where completed record sheets used for monitoring peoples' diabetes were not completed correctly to record blood glucose levels and the times of testing. This meant people were exposed to the risk of harm and deterioration of their condition.

● Information was not always in place for staff to ensure medicines were administered safely. We identified two people who had recently been admitted to the service did not have a medicine profile sheet in place. This meant staff did not have instant access to essential information about people. People were at risk of staff not being able to use a photograph to identify them, of staff not knowing their allergies and not knowing how they preferred to be supported to take their medicines.

● MAR did not always identify a reason for a medicine not being administered. This meant people were at risk of their needs not being reviewed accurately and medical attention not being sought when needed.

The provider had not always assessed people's known risks or done all that was reasonably practicable to mitigate these risks. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records we reviewed identified staff implemented safe management of medicines in relation to checking and rotating stocks of medicines, recording disposal of medicines and daily recording of medicine room and fridge temperatures.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● The provider did not always implement safe recruitment processes. We reviewed seven staff files and found some information and pre-employment checks were not in place. For example, staff's full employment history and reasons for leaving previous jobs were not recorded. We also identified not all required documentation had been completed. For example, risk assessments had not been completed as required for staff prior to employment. This meant people were at risk of being supported by unsuitable staff.

The provider did not follow safe recruitment guidelines to ensure suitable staff were deployed in the service. This placed people at risk of harm. This was a breach of regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014 which requires providers to make available to CQC the information set out in Schedule 3.

Following inspection feedback, we signposted the registered manager to information for meeting CQC requirements of employment for Regulation 19.

● The provider had an ongoing recruitment campaign in order to increase the number of staff deployed in the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People or their relatives described to us varying experiences when asked if people were safe in the home. Some people or their relatives felt people's needs had not been met safely; alerts had been made to the local authority safeguarding team to investigate where concerns had been raised. Some people were happy and felt safe in the home.
● Some people or their relatives told us they understood how to raise any concerns they had but had not had reason to do so. One relative told us, "I think (family member) are quite safe, the staff seem attentive, so far so good". Where issues had been raised people or their relatives were not always confident the concerns had been listened to. For example, concerns of missing personal items had not been addressed by managers at the service.
● Systems were in place to help keep people safe. The provider had an up to date safeguarding policy and procedure in place which was reviewed annually. Staff attended safeguarding training and were confident to

be able to identify signs of abuse.
● The provider engaged with partner organisations when something went wrong. For example, investigations and reviews were completed in response to safeguarding alerts. The provider shared outcomes and learning with staff through regular meetings.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The provider was undertaking necessary risk assessments and activities to ensure safe zoning and cohorting in response to an outbreak confirmed on the day prior to inspection.
● It was identified during inspection not all staff were wearing masks appropriately. This was raised by the inspectors to the manager who responded immediately. Following this staff were seen to be using masks and other PPE appropriately.

Visiting in care homes
● The provider had a visitor policy in place which was kept up to date in line with government guidance.

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 provider failed to have contingency plans in place to manage risk safely. For example, intermittent internet access at the home meant there were gaps in peoples' care records. The provider had identified this risk but did not take action to ensure accurate care records were made in a different way. This meant people were at risk of their health needs such as fluid intake, bowel monitoring and repositioning not being met due to accurate monitoring information not being available.
- The registered manager failed to effectively use the auditing systems in place. For example, during the inspection, the electronic care system identified seven care plans as being overdue for review. The registered manager had not carried out checks of the system or taken action to ensure care plans were kept up to date. This meant people were at risk of their needs not being met as staff did not always have the most up to date guidance to follow to implement safe care.
- The registered manager failed to ensure effective systems and processes were in place to assess new residents and ensure necessary information was in place quickly. For example, no assessments had been recorded on the electronic care record system for a person who was admitted on 5 July 2022. This meant people were at risk of not having their needs known or met as there was a lack of information available to support people safely. The registered manager confirmed this information should be recorded within 48 hours of admission.
- The provider did not implement effective governance systems to manage risk. For example, the provider's systems had failed to monitor, and audit had failed to identify, where recruitment records had not been completed in line with legal requirements or where documents for safe medicine administration were not completed.

The provider did not implement effective systems to monitor and mitigate known risks in order to keep people safe. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the management team took action to develop and introduce a paper form to ensure accurate care records were in place.
During the inspection the manager identified the completion of more frequent medicines audits would help to improve safe management of medicines.

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

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

● Stakeholders told us they were not always confident the issues they raised with the management team would be addressed appropriately. For example, family members did not always consider the concerns they had raised were responded to. This meant there was no opportunity for issues to be resolved satisfactorily and lessons were not able to be learned to improve service delivery.

● Not all staff and relatives were happy to raise concerns as they felt there may be a negative impact for themselves or others. Some concerns were raised anonymously outside the organisation rather than directly with the management team.

● Staff described mixed experiences of receiving support in their roles from senior staff at the service. Some staff felt they received good support from their managers whilst others felt differently and described staff morale as not being good due to the lack of support for staff.

● Family members and professionals identified difficulties in contacting the service via telephone. The provider had identified this as an area for improvement and updated the communication network at the location and introduced direct dial lines to each area of the home.

● The provider had identified working with and engaging with stakeholders, including people, their relatives or representatives, staff and professionals, as an area for action in the service improvement plan. The plan identified actions to collaborate with external partners to deliver safe care; to gather people's views and experiences to improve the service and culture and to ensure staff were actively engaged in the planning and delivery of services. The feedback from stakeholders indicated there was improvement still required for stakeholders to feel confident in engaging with the provider.

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; Working in partnership with others

● The registered manager understood their responsibility to be open and honest and acted in a transparent way when things went wrong.

● Statutory notifications were submitted to the CQC as required. A statutory notification is a form used by the providers when they need to notify CQC about certain changes, events and incidents that affect the service or the people who use it.

● The provider engaged with the local authority safeguarding team and responded to information requested in response to safeguarding alerts that had been made. This showed the provider was interested in developing good working relationships with stakeholders.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always assessed people's known risks or done all that was reasonably practicable to mitigate these risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not implement effective systems to monitor and mitigate known risks in order to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not follow safe recruitment guidelines to ensure suitable staff were deployed in the service.