Parkcare Homes (No.2) Limited

Woodthorpe Lodge

Inspection report

7 Norbriggs Road
Chesterfield
Derbyshire
S43 3BW

Tel: 07590713928
Website: www.craegmoor.co.uk

Date of inspection visit:
07 July 2020

Date of publication:
07 October 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodthorpe Lodge is a care home registered to provide personal care for up to eight people who may have a learning disability or a mental health condition. There were seven people living in the home at the time of our inspection. However, one person was on extended home leave.

Woodthorpe Lodge is purpose built and the accommodation is all on the ground floor. The service did not fully apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

People's experience of using this service and what we found
People were not always protected from the risk of avoidable harm or abuse because the systems and processes in place to safeguard people were not effective. The provider's incident management policies and procedures were not routinely followed. Opportunities to learn from incidents were missed. There was a closed culture where staff were reluctant to use the provider's whistle blowing procedure.

Risks associated with people's individual needs lacked detailed guidance for staff to effectively manage and reduce risks. Support plans and risk assessments had not been reviewed at the frequency the provider expected.

Staff lacked specific training in some areas and refresher training had not been kept up to date. The environment had not always effectively met people's needs and ensured their safety. Staff had not received opportunities to discuss their work, development and training needs.

There was not a registered manager. There was a delay in the covering management team having access to key documents to effectively monitor the service and review incidents that had occurred.

The provider's initial response to concerns raised about increased risk, closed culture and governance was limited. However, following our inspection the provider took immediate action and made improvements to our greatest concerns about safety.

Infection prevention and control procedures reflected Covid-19 pandemic. However, individual support plans and risk assessments in relation to Covid-19 had not been completed. This meant people were put at increased risk during the Covid-19 pandemic.

Staff deployment was based on the numbers of people living at the service and not their individual assessed needs. It was unclear how people's additional care and support needs were being met.

Medicines prescribed to be administered when required, had protocols but lacked specific guidance for

staff. Medicine reviews and oversight and management was ineffective due to poor record keeping and follow up.

Staff morale was low, and the staff team did not feel valued and involved in the development of the service.

Systems and processes to assess and monitor quality including health and safety had not been kept up to date.

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

Rating at last inspection and update
The last rating for this service was Good (Published 17 January 2019). The rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Before our inspection we received concerns in relation to their being a closed culture, financial and verbal abuse from staff, poor management of incidents and governance. We raised these concerns pre-inspection with the provider but were not sufficiently assured. As a result, we undertook a focused inspection to review the key questions of safe 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.

Why we inspected
The inspection was prompted due to concerns received about failure to protect people from avoidable harm or abuse, staff culture and governance. A decision was made for us to inspect and examine those risks.

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 report.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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, 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 of 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Woodthorpe Lodge

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.

Inspection team
The inspection was carried out by two inspectors and one assistant inspector. Two inspectors carried out a site visit, whilst the assistant inspector made telephone calls with relatives and staff.

Service and service type
Woodthorpe Lodge 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 service did not have a manager registered with the Care Quality Commission. At the time of the inspection, an acting manager was managing the service and recruitment for a registered manager was underway. A registered manager and provider mean they are 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. Prior to entering the location we assessed risks associated with Covid-19.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. This included any

notifications we had received from the service (events which happened in the service that the provider is required to tell us about). We reviewed the last inspection report. We also sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection we spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with ten members of staff and the acting manager.

We reviewed a range of records. This included in part, five people's care records. We looked at three staff files. We reviewed a variety of records relating to the management of the service, including accidents and incidents, three people's medicine records, audits, and checks on health and safety.

After the inspection we continued to seek clarification from the provider to validate evidence found. This included, but was not limited to additional audits, training data, policies and procedures.

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.

Systems and processes to safeguard people from the risk of abuse
- Oversight of, and lessons learnt from, safeguarding incidents, including episodes of challenging and self injurious behaviour was ineffective.
- People told us they did not always feel safe living at Woodthorpe Lodge, this was due to a person's behaviour towards them. Incident records reviewed and staff confirmed, people had experienced verbal threats, physical abuse and damage had occurred to the property. Furthermore, there was no evidence to show emotional support staff had provided to people following distressing incidents.
- People were not always protected from abuse and improper treatment. Six staff raised concerns about the behaviour and attitude of other staff towards people living at the service. Some people who used the service also told us how staff sometimes shouted at people.
- Whilst the provider had a whistle blowing policy and procedure on display, some staff told us they were not confident in using it. A whistle blower is an employee who reports concerns about any wrong doing confidentially.

Poor systems and processes to record, manage and learn from safeguarding issues placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had taken action to report and investigate allegations of abuse which were known to them, including taking staff disciplinary action. We shared feedback received during the inspection with the acting manager. Following our inspection, the provider told us of the action they were taking to investigate these concerns and also made us aware that a person who posed a risk to others was no longer living at the service.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- The provider's incident management, reporting and investigation policy and procedure was not followed. Debrief meetings and opportunities to review lessons learnt to reduce further risks did not happen. Staff told us and incident records confirmed this. The lack of staff reflection and formal review meant opportunities to reduce risks had been missed.
- Risks to people's health and wellbeing had not been effectively assessed, monitored and managed, and this impacted on people's safety.
- The risk of people harming themselves was not managed effectively. Three people had self injured and or, threated to harm themselves within the last six months. Risk assessments did not provide staff with sufficiently detailed guidance on how to reduce the likelihood of behaviours happening and the action required if behaviours occurred.

● Action had been taken to update the business continuity plan to reflect risks associated with Covid-19 and other contingency plan. Individual support plans and risk assessments in relation to the risk of Covid-19 to people had not been completed. We were aware of a person who was not following social distancing guidance and was frequently accessing the community. Two people were more vulnerable to Covid-19 than others and therefore at greater risk.
● A person who smoked was at risk of avoidable harm. The smoking shelter had been removed and not replaced, despite a request made by the acting manager on 26 June 2020. We observed this person sitting outside in the rain smoking. Due to them not being protected from the weather, we were concerned for their health and safety.
● Fire risks were not effectively overseen. The fire officer's visit action plan (dated January 2019) was not signed off as completed until July 2020. This prolonged period for completion of the improvement's required put people at increased risk of harm. One person's risk assessment showed they were a known fire risk and there was insufficient guidance in place for staff to manage this risk. A person's personal emergency evacuation plan lacked sufficient guidance of the support required in the event of a fire.
● Risks associated with the environment had not been assessed or monitored to reduce risks. For example, a cupboard that stored cleaning and hazardous products was left unlocked. One person had previously said they wanted to use hazardous products to harm themselves. This placed them at risk of harm.

Using medicines safely
● Medicines prescribed to be administered as required (PRN) had protocols to guide staff of when and how, to administer these medicines. However, these lacked specific guidance for staff. For example; 'To be given for anxiety or agitation,' but not detailed how the person may present during these times. This meant there was a risk people may not receive their medicines when needed. This risk was increased by the use of agency staff who may not have been familiar with people's individual needs.
● One person was prescribed PRN pain relief. Their medicine administration records showed these were routinely administered the maximum dose daily. There was no evidence this had been reviewed by a GP. This shows a lack of record keeping, follow up and oversight of people's medicines.

Staffing and recruitment
● Staff were not suitably trained in managing behaviours such as self-harm, and substance misuse. Staff confirmed they had not received this training and would find it supportive. The staff training matrix also showed gaps in diabetes, epilepsy, emergency first aid training and mental health refresher training. We were therefore not sufficiently assured people were supported by trained and competent staff.

Poor risk assessment of people's needs and health and safety, and a lack of mitigating actions placed people at risk of harm. This was a Breach of Regulation 12 (Safe Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Following our inspection, we sent the provider a letter about urgent risks and the provider informed us of actions they were planning to reduce risk in relation to self-harm, the environment and medicines.
● The provider was following safe protocols for the receipt, storage and disposal of medicines.

● Concerns were identified with staff deployment. The acting manager told us staffing levels were based on the number of people living at the service and not their dependency needs. The provider received additional funding for four people to meet their individual needs. It was not clear from the staff rota how these additional hours were provided. This meant there was a potential risk people were not receiving the support they had been assessed as required.
● The covering manager said, " [Name] has 81 hours of one to one support a week, Over two weeks I think

[Name] had about six hours."
● Safe recruitment processes were used to ensure only staff suitable for their role were employed at the service.

Preventing and controlling infection
● Staff were aware of the infection prevention and control measures to reduce the risk of cross contamination. This included guidance on the current Covid-19 pandemic. Information was available for staff and people who used the service, and this was also available in easy read.
● People confirmed staff had spoken to them about Covid-19 and they were aware of the requirements of wearing personal protective equipment (PPE) and washing hands and the signs and symptoms of an infection. Good stocks of PPE were observed.
● Staff told us the frequency of cleaning had increased as a result of the Covid-19 pandemic. Cleaning schedules confirmed cleaning was being completed and we saw staff completing cleaning tasks and wearing PPE.
● The service on the whole was clean and hygienic. However, concerns were identified with a person's shower room that had mould growing due to the shower being broken. The acting manager had arranged for this shower to be repaired.

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 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

- The registered manager left the service in May 2020 and the service had been managed by other managers within the organisation on a temporary basis. Following our inspection, the provider confirmed the interim management until a permanent registered manager was appointed. We will continue to monitor this.
- Before the inspection, we had received concerns about staff culture, incident management and overall governance at the service. We raised this with the provider in June 2020.
- We reviewed incident forms over the last seven months, which repeatedly showed these had not been effectively reviewed. We were concerned that incident management had been raised as a concern, yet ineffective action had been taken to mitigate this risk. This meant learning still did not occur from incidents that happened.
- The management team did not have access to essential records to ensure the safe and effective running of the service. Two acting managers were put in place between 22 June and 5 July, followed by one acting manager thereafter. However, they did not have electronic access to review incident records until 3 July 2020. This lack of governance had impacted the safety of incident management. There has been missed opportunities to learn from mistakes and this has impacted on quality and safety.
- Staff were not sufficiently supervised, and their competency assessed. Staff told us they had not received regular supervision. Staff raised concerns about the quality of supervision they had experienced from the previous registered manager that they described as a 'Tick box exercise.' Staff however, did say they felt more supported and supervisions had started to happen with the acting manager, and records confirmed this. The acting manager advised that current supervisions were lengthy as staff were unhappy with the service and wanted to discuss it.
- People's care records had not been kept up to date. People's care records did not always clearly record when health appointments had occurred and what the outcome was. This put people at increased risk of not having their health needs met. The acting manager told us they considered guidance for staff about how to meet people's individual needs lacked detail and how support plans were overdue a review.
- Training associated with people's individual support needs had not been provided and some refresher training was out of date. The provider's contract with the local authority was to provide specific learning disability training but this had not happened. This poor governance meant we were not assured that staff were supported in their role and this could impact on the quality of care and support people received.
- Timely action had not been taken to address environmental concerns. This included the replacement of a smoking shelter, the repair of a person's shower and the replacement of a cracked communal television

screen. his delay had put people at increased risk of harm.

Continuous learning and improving care; 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

● There had been previous concerns raised about financial abuse at the service. The provider had investigated this. The acting manager told us that whilst internal audits and action had been taken, no changes had been made to the onsite systems and process of managing people's money.

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

● A closed staff culture had developed at the service. Before our inspection we expressed concerns with the provider about a poor staff culture. The provider had developed an action plan. However, this had not led to improvements at the service. The action was to have listening groups with staff. We were not provided with evidence that this had started.

● During our inspection, both people who used the service and staff, told us about how some staff had a poor attitude and behaviour. Staff were reluctant to use the provider's whistle blowing procedure to report concerns, some had limited confidence in the provider listening to them or taking action.

● Staff did not always work together as a cohesive team. Staff morale was low, and they did not always feel listened to. Staff acknowledged that the acting manager was working hard and had achieved some improvements.

Failure to ensure that systems and processes operated effectively to ensure compliance with regulation 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 received opportunities to share their views about the service via monthly 'Your Voice' meetings and 'keyworker' meetings for people to share their concerns or wishes.

● The acting manager told us they had sent a survey to people the week before our inspection inviting them to share their experience. These are completed six monthly, and at the time of the inspection feedback received had not yet been analysed.

● Relatives told us feedback from staff and information sharing was limited and tended to be, "When there's a problem."

● Staff told us staff meetings had occurred, but these had been infrequent. Staff told us they had not felt listened to, engaged or involved in service development.

Working in partnership with others

● People told us how they were supported to attend health appointments.

● Staff told us they worked with external health and social care professionals such as social workers, advocates, community psychiatric nurses and psychiatrists. Visits to the service were limited due to Covid-19 but reviews were continuing via telephone.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were poor systems to assess and mitigate the risk of harm in relation to individual needs and the environment. PRN protocols lacked detail. Staff had not received specific training to meet people's individual needs. Regulation 12 (1)

The enforcement action we took:

We have added an additional condition to the providers registration.

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 Systems and processes to manage and learn from safeguarding issues which placed people at risk of harm were not robust. This placed people at risk of harm. Regulation 13 (1)

The enforcement action we took:

We have added an additional condition to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service. This placed people at risk of harm.

Regulation 17 (1)

The enforcement action we took:

We have added an additional condition to the providers registration.