Woodfields Residential Carehome

Woodfields Residential Home

Inspection report

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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
Woodfields Residential Home is a residential care home providing personal care to up to 17 people. The service provides support to people living with dementia. At the time of our inspection there were 15 people using the service. The home accommodates people in one adapted building.

People's experience of using this service and what we found
People did not always receive support with their medicines from trained staff. However, systems used for the management of medicines were effective and people received their medicines as prescribed. Some aspects of the environment required improvement to reduce risks associated with cross infection.

Risks were assessed and managed by staff who knew people well. There were enough staff to meet people's needs and staff had been safely recruited. There were systems in place to ensure learning took place following incidents and events.

Improvements relating to quality audits and governance had been made since the last inspection. However, further action was required to ensure a proactive approach to identifying concerns and driving improvement. Action to address people's concerns or queries was not always timely.

People and relatives spoke positively about the home. Staff felt supported in their roles and had the opportunity to share their views in team meetings as well as through one-to-one meetings with the manager. The staff and management team worked alongside other professionals to ensure people's needs were met.

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 requires improvement (published 10 March 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. At this inspection we found the provider had complied with the Warning Notice and some improvements had been made. However, we identified a new breach of the regulations.

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 remained requires improvement. This is based on the findings at this inspection.

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 COVID-19 and other infection outbreaks effectively.

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

Enforcement
We have identified breaches in relation to the safe management of medicines at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Woodfields Residential 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.

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
The inspection was conducted by 1 inspector and 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
Woodfields Residential 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. Woodfields Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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 information gathered as part of monitoring activity that took place on 30 January 2023 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 4 relatives about their experience of the care provided. We also spoke with 4 staff, the deputy manager, the manager and the registered manager who was also the provider. We reviewed a range of records, these included 5 people's care records, medicines administration records, as well as governance and quality assurance records. We also looked at 2 staff recruitment files.

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 focused inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and in some areas there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Where people required support with their medicines at night, or early in the morning, these were not always administered by staff who were trained or assessed as competent in medicines administration. This placed people at risk of harm.

● We discussed our concerns with the manager and registered manager who advised there were currently no medicines trained staff who worked between 10pm and 8am. However, records confirmed one person was regularly receiving their medicines during these times.

We found no evidence people had been harmed, however systems were not in place to ensure staff responsible for the administration of medicines were suitably trained and competent. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and manager took immediate action in response to our concerns. They arranged for the timing of people's medicines to be reviewed to ensure they were only administered by a person who was trained and competent to do so. They also offered assurances about plans to ensure staff working at night were trained to support people safely with medicines.

● At our last inspection we identified concerns relating to the safe management of medicines. Where people required topical medicines applied to their skin, or used pain relieving patches, the administration of these had not been recorded. At this inspection we found improvements had been made to the recording of medicines administration. Improvements had also been made to the use of 'as required' medicines.

● Systems used for the recording and storage of medicines were effective. Where people were prescribed controlled drugs, which have special regulations on ordering, storage, administration and recording; we found records we checked relating to the administration and storage of these medicines were accurate.

Preventing and controlling infection

● We identified some concerns with the home environment which may contribute toward poor infection control. These concerns included odorous, or torn flooring in some areas which could not be cleaned in accordance with infection control guidance. The registered manager was aware of these concerns and was working towards an action plan following a visit from the local infection control team. They told us they were in the process of replacing flooring in several areas of the home.

● 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 using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● 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.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● The registered manager was aware of their responsibilities in relation to supporting people's rights to have visitors at the home. Visitors could access the home freely.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person said, "I feel safe here…I'm not worried about anything. Staff are kind, always someone about." Relatives we spoke with told us they felt their family members were cared for safely.
● Staff had received training in safeguarding and were able to tell what action they would take if they were concerned for a person's safety.
● The registered manager understood their responsibilities in relation to keeping people safe. Where safeguarding incidents had occurred, they had made appropriate referrals to local authority safeguarding teams, and had notified us, as required by law.

Assessing risk, safety monitoring and management
● Risks to people's health, safety and wellbeing had been assessed and guidance was available for staff to follow to reduce the risk of avoidable harm.
● Staff knew people well and were able to identify any concerns for people's health or well-being. Where staff observed a change in a person's presentation concerns were shared with the staff team to ensure any additional support, or healthcare advice could be provided. For example, where people appeared quieter than usual, staff were prompted to increase observations and escalate if there were concerns for people's health.
● People's known risks were monitored by staff and regularly reviewed. For example, where people's risk of sore skin had escalated, we saw staff were supporting them to reposition more frequently to protect their skin.

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

● People told us staff were available when they needed them. One person said, "The carers come quickly when I press the bell." Relatives confirmed staff were available when they visited and checked regularly on people who spent time in their bedrooms.

● We observed staffing levels throughout the day and saw staff were available to respond to people's needs, as well as carry out required care tasks. Staff also had time to spend time chatting with people and relatives and appeared unhurried when supporting people.

● Staff had been safely recruited. The provider had carried out pre-employment checks, including DBS checks, to ensure staff were safe to work with people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

● There were systems in place to record and follow up on incidents.

● Where incidents had occurred, learning had been shared with staff using communication logs and concerns had been escalated appropriately with visiting professionals.

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 focused inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection we found governance systems for the management of medicines were not effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection, we served a Warning Notice in relation to the concerns we found.

At this inspection we found the provider had complied with the warning notice and was no longer in breach of the regulation.

● Since the last inspection systems relating to the management of medicines had been developed and improved. Records were now in place relating to the administration of all medicines and other aspects of people's health were also being monitored. This enabled staff to review people's care needs and escalate any areas of concern to healthcare professionals.
● The manager and staff team were responsive to any identified risks, but systems needed to be developed and embedded to ensure their effectiveness. For example, individual aspects of health and safety were audited for safety, however there was a lack of clear planning about how identified issues would be addressed.
● The registered manager and manager were already aware of some of the concerns identified during the inspection. While they had taken some action to address those concerns, they had not always clearly identified who was responsible for each action. This meant improvements were not always made in a timely way.
● The registered manager was aware of their regulatory responsibilities and they and the manager were responsive to the findings of the inspection. They took immediate action to address the concerns with staff training and following the inspection shared with us further improvements they planned to make.
● People and relatives spoke positively about the staff and management team. One relative shared, "Staff are fantastic. They act on the side of caution every time. This is good."
● The rating from the previous inspection was displayed in the entrance of the home, as required by law.

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

● Although feedback from people and relatives was generally positive, we were made aware of some concerns that had previously been raised with the staff team but were not yet resolved. One person shared with us how they had asked for some specific support relating to a deteriorating health condition. Although the manager had made some enquiries about this, the person's experience had not changed, and further action was required to ensure the person received support that met their individual needs. Following the inspection the manager contacted relevant external agencies for advice about how best to support the person.
● Relatives shared examples with us of how the staff team responded positively to feedback they had given. For example, one relative told us how their family member's night time routine had been changed on their request, to better support the person's preferences.
● Staff spoke positively about the manager and registered manager. They told us they were able to share their views in team meetings and one to one meetings. One staff member said, "I think the home is well managed. I'd be happy going to the manager with any concerns. They would do something about it. I can say what I think."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of their responsibilities under duty of candour. Where incidents occurred, they were aware of the need to be open and honest and ensure relevant people were informed.

Continuous learning and improving care; Working in partnership with others
● Although the management team were responsive when they identified concerns, further actions were needed to ensure an approach of on-going improvement.
● The manager and registered manager recognised they would benefit from support from other organisations and told us they planned to actively seek out opportunities to learn from other professionals.
● The staff team worked in partnership with external agencies, including district nurses and GPs to ensure people's needs were met.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure staff responsible for the administration of medicines were suitably trained and competent.