Barchester Healthcare Homes Limited

Woodhorn Park

Inspection report

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Date of inspection visit:
13 January 2022
19 January 2022
25 January 2022

Date of publication:
28 March 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodhorn Park is a residential care home providing accommodation and personal care for up to 61 people. At the time of our inspection 58 people were resident at the home. Accommodation is available across two floors which have adapted facilities to meet people's needs. The first floor of the home provides specialist support for people living with a dementia related condition.

People's experience of using this service and what we found
The service was not always well-led. Systems had not always been effective in identifying issues to help drive improvements within the service. There were gaps in the records to evidence government guidance was followed in relation to testing for COVID-19.

The providers visiting policy was not in line with government guidance and placed additional restrictions on people. This had negatively impacted upon the well-being of some people. People, or where appropriate, their representative had not been involved in the decision-making process for visiting restrictions. Staff demonstrated kind and caring values and treated people with respect.

Systems were in place to safeguard people from abuse and staff understood how to escalate any concerns they had. Analysis of accidents and incidents were taking place to assess if any learning from incidents could be made. During the inspection the home manager introduced a new system for reviewing safeguarding records which included communicating outcomes to the staff team. Medicine records were not always accurately maintained.

There were enough staff deployed to meet people's needs and systems were in place to recruit staff safely. There were some gaps in records to show candidates suitability had been robustly assessed. We have made a recommendation about this.

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 5 December 2019).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns we had received about the service. The inspection was prompted in part due to concerns received about visiting restrictions at the home which were not in line with government guidance. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the visiting arrangements, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, caring and well-led.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We identified breaches in relation to person centred care, dignity and respect and good governance 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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Woodhorn Park

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 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
Woodhorn Park 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. Woodhorn Park is a care home without nursing care. 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. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service, including the statutory notifications we had received from the provider. Statutory notifications are reports about changes, events or incidents the

provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams and the local NHS infection prevention and control [IPC] team to request feedback.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and 11 relatives about their experience of the care provided. We spoke with eight members of staff including the home manager, commercial manager and regional director. We reviewed a range of records. This included care records for six people and multiple medicines records. We looked at recruitment records for three staff and a variety of records relating to the management of the service, including policies and procedures. We communicated with the nominated individual to share our initial inspection feedback. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We requested additional information by email and continued to seek clarification from the provider to validate the evidence we found.

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.

Using medicines safely

- Medicines were not always managed safely due to issues with record keeping.
- Protocols were in place to guide staff in the administration of 'as required' medicines. These records varied in the amount of detail they contained and required improvement to ensure they contained person specific information.
- Systems were in place to monitor the temperature of the medicines fridge. However, records showed occasions where the fridge temperature had exceeded its maximum range. Records did not demonstrate what action had been taken to rectify this. This is important to ensure medicines which require refrigeration are stored at the correct temperature. The home manager told us no medicines required refrigeration at the time of our inspection.
- Medicine administration records [MAR] were completed for people. MAR's did not document the exact time for the administration of time specific medicines. This is required to ensure people consistently receive their medicines at the prescribed time and with the correct interval between doses.

While we identified no impact to people, the providers failure to maintain appropriate and complete records is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- PPE was not always stored safely. Large quantities of PPE supplies were stored in one of the home's stairwells. This area was also a fire exit and this practice had not been risk assessed. We shared this information with the fire service who advised combustible materials should not be stored in fire escapes. The home manager responded immediately to this feedback and removed the PPE supplies from this area.
- There were gaps in records to evidence COVID-19 testing for staff, Essential Care Givers [ECG], relatives and visiting professionals had always been completed in line with government guidance. This had not been identified in audits carried out at the home.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were somewhat assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- 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 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.

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

Visiting in care homes
● The providers visiting policy was not in line with government guidance. Additional visiting restrictions had been imposed on people which had not always been assessed on an individual basis. We have reported on this in more detail in the 'caring' section of this report.
● At the start of the inspection people were able to have indoor visits from one identified ECG. During the inspection the provider updated their policy initially to allow one identified ECG plus one named visitor. This was not in line with the government guidance at that time. The provider then updated their visiting policy, so it was reflective of the current government guidance.
● An appointment system was in place for other visitors to see people in a 'visiting pod'. People were separated in the visiting pod by Perspex screening and were able to communicate with each other by using an intercom system.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.
● A system was in place to check the vaccination status of staff and visiting professionals. However, records did not always evidence staff had always followed the procedure in place.

The providers failure to ensure records were well maintained was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Accidents and incidents were recorded. A review to assess if there were any trends or if actions could be taken to reduce the risk of repeated incidents was completed.
● Systems were in place to safeguard people from the risk of abuse. Staff understood their responsibilities in relation to safeguarding. One staff member told us, "I would be confident to raise a whistle blowing concern if I had to. Staff are asked on a daily basis if they have any concerns.

Staffing and recruitment
● There were enough staff deployed to meet people's needs. During the inspection we observed staff to respond quickly when people required support.
● Systems were in place to recruit staff safely. However, information collected about candidates during the recruitment process had not always been robustly assessed. For example, some information on the reference for one member of staff did not correspond with the information on their application form. Some employment gaps had not been considered during the recruitment process. We brought this to the attention of the home manager and commercial manager who took immediate action to address this and update records.

We recommend the provider ensures best practice guidelines in relation to the recruitment of staff are

always followed.

Assessing risk, safety monitoring and management

● A range of risk assessments were completed to ensure the safety of the building and the environment.

● Known risks people were exposed to had been assessed. Risk assessments had been reviewed at the frequency identified by the provider. However people hadn't always been involved in this process.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● People had not been consulted about the visiting restrictions the provider had imposed. Some people told us they had been negatively impacted by the providers visiting policy. When asked about visiting one person told us, "There is a very big impact on me, it feels worse than being in prison."
● Some individual assessments had been completed for people in relation to visiting. These records did not evidence people or (where appropriate) their representative had been involved in their development.

The providers failure to involve people in decisions about their care was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some relatives told us they were supportive of the providers visiting policy and agreed with a cautious approach to visiting.

Respecting and promoting people's privacy, dignity and independence
● People had not always been supported to maintain important relationships with family or friends due to the impact of the providers visiting policy. At the start of the inspection most people were only able to have one indoor visitor from one ECG. This was not in line with government guidance.
● People were not supported to access their local community if this was something they wanted to do. The self-isolation procedure in place for people who left the care home was not in line with the current government guidance. One person said, "I was told I would have to stay in my room for three days if I visited family at Christmas. I decided not to go for Christmas Day because I didn't want to have to stay in my room. You miss the company and having the exercise."

The providers failure to support and promote the autonomy and independence of people was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We shared this feedback with the home manager and regional director who told us the provider had updated their visiting policy to bring it in line with government guidance.
● Staff demonstrated kind and caring attitudes in their work. The home manager had organised for key rings to be made for staff with attached prompt cards. The prompts included information of the values staff were expected to display.
● Staff described respectful ways of working and promoted the independence of people.

Ensuring people are well treated and supported; respecting equality and diversity

● People and their relatives spoke positively about the caring nature of staff. One relative told us, "Staff are so wonderful and very, very helpful. They do their best to make sure that people are safe at all times."

● Staff had established links with some organisations in the community to benefit the experience for people. For example, a local shop had donated gardening equipment people could use to engage in activities and a therapy dog had visited the home where people had the opportunity to interact with a pet.

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; 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 provider had not ensured the 'Statement of Purpose' for the location was up to date. A statement of purpose is a legally required document that includes a standard set of information about a service.
- A range of audits were completed to monitor quality at the service. These audits had not identified the issues we found during the inspection.

Robust systems and processes were not in place to demonstrate the provider had effective oversight of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service did not have a manager registered with the Commission. The home manager told us they had submitted their application to register with CQC and were waiting for this to be processed.
- Managers and staff worked in an open and transparent way.

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; Working in partnership with others

- The provider had introduced a visiting policy which was more restrictive than the current government guidance. This policy was not person-centred and did not consider the impact to individual people and their relatives.
- The provider's policy insisted that relatives visiting the care home were vaccinated against COVID-19. This was not in line with legal requirements. We brought this to the attention of the home manager who told us no people had been declined a visit with their relative as a result of their vaccination status.
- One relative told us they had contacted the provider to raise their concerns in relation to the impact to both them and their loved one of not being able to have face to face contact with each other. The response received from the provider did not address the individual concerns which had been raised.
- Individual risk assessment documentation did not evidence people or their representatives had been involved in assessments or contributed to the process.

The failure to have an effective engagement system in place was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to communicate any changes with relevant people such as relatives and visiting professionals. One relative said, "We are kept informed. I think that this is one of the strong points of the home, the communication is very good."

Continuous learning and improving care

● Action was taken in response to the inspection feedback to improve recording at the home. For example, the home manager introduced a new system for monitoring safeguarding records which included a review of the incident, identifying if any lessons could be learned and how information would be communicated to people, their relatives and staff.

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 The registered provider had failed to ensure people received personalised care or that people were fully involved in the decision making process regarding their care and support. Regulation 9 (1)(3)(a)(b)(c)(d)(f)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure people were supported to maintain relationships which were important to them or support people to be involved in their local community as often as they wanted. Regulation 10 (2)(b)

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. Regulation 17 (1)(2)(a)(c)(f)