

Woodfalls Care Limited

Woodfalls Care Home

Inspection report

Vale Road
Woodfalls
Salisbury
Wiltshire
SP5 2LT

Tel: 01725511226

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

About the service

Woodfalls Care Home is a care home providing accommodation and personal care for up to 24 people aged 65 and over. At the time of the inspection 22 people were living in the service.

People's experience of using this service and what we found

We made a recommendation that the provider reviews the medicines management practice, to ensure their procedures are followed consistently.

People told us they were supported to take the medicines they were prescribed on time. People said they could get additional support if needed, for example additional pain relief. Staff had kept clear records of the support they provided for people to take tablet and liquid medicines. However, the records for people prescribed emollient creams were inconsistent, with some days when there was no record of people being supported to use the cream.

The home had good infection prevention and control procedures in place. Procedures had been reviewed and updated to reflect the COVID-19 pandemic. Systems were in place to prevent visitors catching and spreading infections.

There were enough staff to meet people's needs. The registered manager had strengthened the home's staffing contingency measures following an emergency situation. This meant there were more bank staff to call on to cover unexpected staff absence if needed.

The registered manager had taken action to keep people safe and manage the risks they faced. Staff had a good understanding of the action they needed to take to keep people safe.

Staff demonstrated a good understanding of people's individual needs and a commitment to provide person-centred care.

The registered manager worked well with people to meet their needs. They had developed good relationships with health and social care professionals.

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 19 October 2019) and there were breaches of regulations. Targeted inspections were completed in January and October 2020, following which we served warning notices due to continued breaches of regulations. A further targeted inspection was completed in November 2020, when we found the provider had complied with the warning notices.

Why we inspected

We received concerns in relation to staffing. 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.

The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.

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

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Good ●

The service was well-led.

Details are in our well-led findings below.

Woodfalls Care 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 Care Act 2014.

Inspection team

The inspection team consisted of two inspectors.

Service and service type

Woodfalls Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Before the inspection we reviewed the information we held about the service and the service provider. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

During the inspection

We spoke with six people to gather their views about the care they received.

We looked at five people's care records. We checked recruitment, training and supervision records for staff and looked at a range of records about how the service was managed. We also spoke with the registered manager and four staff.

After the inspection

We spoke with a further three care staff by phone. We received feedback from three relatives and two health professionals by email.

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 requires improvement. At this inspection this key question has remained the same. 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.

Preventing and controlling infection

At a targeted inspection in October 2020 we found the provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of infection control procedures. We served a warning notice because the registered manager at the time was not following infection prevention and control guidance. We completed a further targeted inspection in November 2020 and found the provider had met the warning notice.

At this inspection the provider had maintained good infection prevention and control practice.

- We were 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 accessing testing for people using the service and staff.
- 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 were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely

At the last comprehensive inspection in September 2019 we found the provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of medicines management. We served a warning notice because people were not always supported to take their prescribed medicine. We completed a targeted inspection in January 2020 and found the provider had met the warning notice.

At this inspection the provider was meeting the requirements of regulation 12 in relation to medicines management, but we have made a recommendation to address minor recording shortfalls.

- Medicines administration records had been completed for tablets and liquid medicines people were prescribed. These gave details of the medicines people had been supported to take. However, the records for people prescribed emollient creams were inconsistent, with some days when there was no record of people being supported to use the cream.
- People told us staff provided good support for them to take their medicines. People said staff brought them their medicines on time and additional pain relief if needed.
- Where people were prescribed 'as required' medicines there were clear protocols in place. These stated

the circumstances in which the person should be supported to take the medicine.

We recommend the provider reviews the medicine management practices to ensure their recording procedures are followed consistently.

Staffing and recruitment

- The provider had experienced staffing shortages due to sickness absence. An incident occurred in which they needed to use a member of staff in an emergency who had not been thoroughly checked. Before making this decision, the registered manager had tried all other sources of staff, including temporary staffing agencies. The registered manager put measures in place to ensure the unchecked person was supervised throughout the one shift they completed.
- Following this incident, the provider had strengthened their staffing contingency plans. They had recruited additional permanent and bank staff. Staff had been thoroughly checked, including a disclosure and barring check and references from previous employment in social care services. This helped to ensure staff had suitable skills and experience and were not barred from working in social care.
- People said there were enough staff available, with comments including "Staff come in good time when I ring the bell" and "Staff come when I want them."
- Staff told us staffing levels were sufficient to provide the care people needed. Comments included, "There are some issues with sickness, but management will always provide care when needed" and "I feel staffing levels are safe."

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

- Care records contained assessments of the risks people faced and plans to manage those risks. The plans set out the support people needed to stay safe, including any equipment they needed. Examples included support for people to reduce the risk of falls and to prevent pressure ulcers.
- Staff demonstrated a good understanding of risk management plans and the actions they needed to take to keep people safe.
- The registered manager reviewed incident reports and recorded any actions that were necessary following them. This ensured lessons were learnt following incidents and reduced the risk of an incident re-occurring.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt safe in the home. Comments included, "I've never not felt safe here."
- The service had effective safeguarding systems in place. Staff had a good understanding of what to do to make sure people were protected from harm. Staff had received training in safeguarding issues.
- Staff were confident the registered manager would take action to keep people safe if they raised any concerns. Staff were also aware how to raise concerns directly with external agencies if they needed to.

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 comprehensive inspection this key question was rated as requires improvement. At this inspection this key question has improved to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted 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

At the last comprehensive inspection in September 2019 the provider did not have effective quality assurance and management oversight systems. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

- The provider had effective quality assurance systems in place. These included, reviews of care records, medicine records, support plans, staff records and quality satisfaction surveys. In addition to checking records the management team completed observations of staff practice. This was to assess whether staff were putting the training and guidance they had received into practice.
- Incidents were reviewed by the registered manager and were discussed as part of staff meetings. This helped to ensure lessons were learnt and practice changed where necessary.
- The provider had employed a consultant to provide regular audits of the service and support to the registered manager. The results of the various quality assurance checks were used to plan improvements to the service.
- The manager was aware of the need to notify CQC of certain important events. Records demonstrated these notifications had been submitted when necessary.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 had promoted a person-centred approach in the service. This was evidenced through the feedback from people who use the service, the training staff received, and the way records were completed. Staff reported the registered manager worked to ensure people received individual support to meet their needs.
- Staff we spoke with praised the management and told us the service was well run. Comments included, "[The registered manager] is driving the service in the right direction and making improvements."
- The registered manager understood their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service involved people and others effectively in a meaningful way. The registered manager

responded to issues raised in regular feedback meetings and let people know what action they had taken.

- The registered manager worked well with the local health and social care professionals. They had established good links and working relationships. Comments from visiting professionals included, "They flag up concerns about residents in a quick and effective manner and provide individualised care" and "The home is well run, and residents appear happy."
- Staff told us they felt listened to, valued and able to contribute to the running of the service.
- The registered manager kept up to date with best practice and changes to guidance in respect of the COVID-19 pandemic.