Woodchurch House Limited

Woodchurch House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on Saturday 5 and Sunday 6 November 2016 and was unannounced. Woodchurch House provides accommodation, nursing and personal care in purpose built premises. It also provides a personal care service to people who rent or buy their accommodation within Woodchurch House. There were 65 people using the service during our inspection; of which 47 were receiving nursing care. The service is divided into two floors with the ground floor dedicated to nursing care and the first floor to people living with dementia; some of whom also require nursing.

It is a requirement of this service's registration with the Care Quality Commission, that there is a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was no registered manager in place when we inspected and there had only been a registered manager for around a month during the last year. A new manager had started their induction into the service on 4 November 2016 and commenced work as the manager on 8 November 2016.

Woodchurch House was last inspected on 31 August and 1 and 2 September 2016.They were rated as requiring improvement overall but rated inadequate for safety. As the service had already been placed into special measures following an inspection in January 2016; (when it was rated as inadequate in every domain) it remained in special measures following the last inspection. We took enforcement action and asked the provider to submit an action plan to demonstrate how they would make the necessary improvements. The provider had assured the Commission that it had taken action to reduce risks to people which were identified at our previous inspection in August and September 2016. However, we found that risks to people had not been mitigated, and people had experienced harm and were at risk of continued harm. We took steps to mitigate harm to people which included alerting the local authority to the risk. The local authority and the clinical commissioning group, along with the CQC are supporting the service to make immediate improvements to ensure people's health, safety and welfare.

On 4 November 2016 we received information of concern about Woodchurch House; which suggested that people living there might be at risk of harm. We responded to this by carrying out a focused inspection over the weekend of 5 and 6 November 2016.

As this was a focused inspection, we looked to see whether the service was safe, effective and well-led.

The service was not safe. Known risks to people had not been reduced; even though these had had been specifically highlighted in our last inspection report.

A medicine prescribed for heart problems had not been managed properly; creating a risk that people might be given it when they should not have it.

People had not been protected from abuse or neglect because staff did not always react promptly or appropriately to people's calls for help. People's private space and personal possessions were not protected by staff who allowed one person to enter rooms uninvited and take other people's property away.

The service was not effective and there were not enough trained, experienced or competent staff deployed to meet people's needs appropriately. Nurses that worked at the service had not had their competency assessed, and did not have the necessary skills or competence to support people safely or to recognise when people needed support.

Professional advice about people's diet had not been followed and records about people's intake were inadequately completed. This made it difficult to monitor people's health and well-being. The management of people's urinary catheters did not include analysis of their fluid intake and output.

The leadership of the service was poor and this placed people at risk of harm. There had been a lack of provider and management oversight to ensure the safety and quality of the service.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

Risks had not been appropriately mitigated to ensure people's health and safety.

People were not protected from the risks of neglect or abuse.

There were not enough staff deployed to meet people's needs.

Medicines had not always been managed safely.

Is the service effective?

Inadequate

The service was not effective.

People's risks of poor nutrition and hydration had not been properly assessed and managed.

Health care needs and catheter management had not been carried out effectively.

Staff on duty were inexperienced and lacked training and competency.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in place. There had only been a registered manager in post for around one month in over a year.

None of the issues highlighted in our last inspection had been properly addressed.

There had been no effective management or provider oversight of the service.

Quality assurance systems operated were inadequate. The provider had not taken action to identify shortfalls in quality and safety and mitigate known risks to people.

Woodchurch House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out in response to information of concern which suggested that people might be at risk of harm. We checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

This inspection took place on 5 and 6 November 2016 and was unannounced. The inspection was carried out by one inspection manager and two inspectors and included an evening shift until 11:30pm.Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. On the first day of the inspection we were joined by a representative from the local authority.

We met eighteen people who lived at Woodchurch House. Not everyone was able to verbally share with us their experiences of life at the service. This was because of their dementia. We inspected the environment, including communal areas and some people's bedrooms. We spoke with five care workers; including three registered nurses, the provider and the provider's representatives.

We pathway tracked eight of the people living at the home. This is when we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included medicines records, risk assessments, care plans, catheter records, wound charts and food and fluid documentation.

Inadequate

Is the service safe?

Our findings

At our last inspection, we reported that a range of risks to people had not been properly assessed and minimised. We specifically highlighted that two people were at risk of choking because they had been given toast to eat; which was difficult for them.

At this inspection we found that the situation had not improved and some people remained at risk despite our report and detailed feedback given to the provider and manager after the last inspection. One person whose care plan stated they needed a soft diet was found to have eaten toast, bran flakes, bacon and other foods which could not be described as soft. A referral to a speech and language therapist (SaLT) had been made during the last inspection after we highlighted the issue; and an appointment had been made for 11 November 2016. In the meantime, however there had been no assessment of the risks of choking until we brought this to the provider's attention again; and this person had continued to be given an unsuitable diet.

Another person had been assessed in October 2016 by SaLT as needing a soft diet because they had difficulty with swallowing. Guidance sheets provided by SaLT clearly stated in bold type that this meant no bread should be given, without express approval from SaLT. We looked at food charts for this person and saw that they had been given bread, rolls and sandwiches on many occasions. This went against the professional advice received for this person. There was no assessment in place about the risks, no guidance to staff about how to prevent choking from happening and no instructions about actions to take in the event of choking. People had been placed at risk because known risks to them had not been reduced.

Other known risks had not been managed properly. For example; one person's care plan recorded that staff should know their whereabouts at all times to keep them safe. We asked staff where this person was when we arrived, but one staff member told us they did not know who this person was because it was their first ever shift working in the service. A second staff member said they did not know where they were and made no attempt to look for the person. The nurse on duty told us that they thought it was care staff responsibility to monitor this person, but admitted that they really did not know who had this duty. Staff were supposed to complete a check-sheet every 15 minutes when the person was awake; to record where they were and what they were doing. At 8:05pm we observed this person going in and out of others' bedrooms, picking up their property and removing it from their rooms. We alerted staff to this who led the person away. When we looked at the check sheet, we found that this person's whereabouts had not been recorded since 7:15pm. Later in the evening we saw that the check-list had not been completed for over an hour. The check sheet for the previous day showed that there had been a gap of three and a half hours when no record had been made to show where this person was and what they had been doing. Risks to this person's personal safety had not been minimised by the use of 15 minute monitoring in line with their care plan.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection we reported that medicines had not consistently been managed safely. At this inspection we found that care staff had been administering a specific heart medicine in an unsafe way.

People's pulse rate must be accurately taken before this drug is given. If the pulse rate is too low, then it should not be administered. Staff had been using a special probe to assess people's pulse rates, but clinical guidance states that this should be done manually; as probes can sometimes give false readings. Staff we spoke with did not know that they had been taking pulses incorrectly, and there was a risk that people may be given heart medication when their pulse rate did not support that they should take it.

Concerns were raised about how another person's diabetes had been managed. A safeguarding alert was raised after they were admitted to hospital from the service with low blood sugar levels.

We have referred our concerns about the safety of medicines to the local safeguarding authority.

The failure to ensure correct actions were taken before medicines were administered is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection staff had not responded to a person who was calling out for their help; and we reported that staff appeared to be desensitised to people's shouts for assistance. At this inspection there was further evidence of this; and that people's needs were being neglected at times. One person was found by inspectors alone in a dark room, undressed from the waist and with no bed covers over them. They had been calling out repeatedly and they were highly agitated and distressed. Staff told us that this person was unable to use a call bell. The only way this person could attract attention was to shout out; but staff had not responded to them until we asked them to.

Another person was heard shouting loudly from their room; as they too were unable to use a call bell. Staff told us that this person's door was meant to be left ajar so that staff could hear them but it had been shut during the inspection. We found a staff member and asked them to offer support to the person but they said they would have to find other staff as they were going off duty. They offered no comfort or assistance to the person but we asked them to stay with them until we could locate other staff to attend the person. We read charts which had been used to record regular checks on this person throughout the days and nights. There were many consecutive entries which documented that the person had been shouting or calling out over several hours. There was no information however to show what had been done to support or comfort them.

Staff told us that this person's bedroom door must have been shut by another person who was observed constantly walking the corridors and going in and out of other people's rooms. There was not adequate monitoring in place to prevent this from happening. The person was seen rifling through people's possessions and picking up some of these and carrying them around the service. This person's care plan recorded that they could be aggressive towards others, but staff did not act to protect people or their personal belongings.

The failure to protect people from the risk of neglect or abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Equipment had not always been properly used or maintained. One person had a special air flow mattress to help prevent pressure areas from developing. The mattress is inflated by a pump and we saw that this showed a reading of 'Fault- low pressure' when we checked it at 8:05pm. The mattress felt very soft to the touch and had clearly deflated; which could have been uncomfortable for the person sleeping on it; and would not be effective in preventing pressure areas. We told the nurse in charge about this immediately and reminded them later in the inspection. However, at 11pm the pump had still not been attended to and the mattress remained deflated. At 11:20pm the mattress was checked by the management team who said they

would re-inflate it.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection, staff had not been deployed effectively to meet people's needs. We particularly highlighted that people's call bells were not being answered promptly and that those who were unable to use call bells were sometimes overlooked by staff. At this inspection people continued to tell us that they often waited for unacceptably long periods for staff to attend their needs. For example; one person told us that they sometimes waited for up to two hours to receive pain relief and had been left lying in their own faeces when staff did not respond promptly to their requests for support with toileting. Another person said that there were never enough staff around when they needed them; and that they felt "Humiliated" by being left on the toilet waiting for staff to return to assist them.

During the inspection we struggled to find staff to help people who were making us aware of discomfort. For example; one person living with dementia was walking around looking for staff and was clearly troubled. We were able to engage them and they showed us that their catheter leg bag had slipped down their leg so that the valve was showing beneath their trouser bottoms. This could have caused discomfort for them if the position of the bag was pulling on the catheter tube. We had to bring this to staff attention. Staff did not hear or attend to two people who were calling out until we told them about it. There were not enough staff to prevent a further person from shutting bedroom doors; which meant that people in those rooms could not easily be heard shouting for assistance. There were not enough staff to monitor the whereabouts of a person who required 15 minute monitoring; which left this person and others at risk. Staff told us that there were not enough of them on duty to meet people's needs promptly and that they were permanently rushed.

This was a failure to ensure sufficient staff were deployed; which is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection we reported that food recording charts had been completed with insufficient information for staff to effectively monitor people's well-being. At this inspection there had been no improvement, and food charts remained inadequate. There were still no records on many occasions of portion sizes offered to people, so that an accurate picture of their intake could be seen. For example, one person's charts showed 'Fish and mash' and 'Fruit pudding' with no indication of the size of the meal and staff comments such as 'Ate all'. This was unhelpful when it was unclear how much had been offered. There continued to be a lack of detail about the nutritional make up of foods, such as 'Soft meal' or 'Pureed supper', with no information about what this included.

One person had been assessed by SaLT as needing to have a soft diet. There was clear guidance from SaLT which described this; stating: soft, tender and moist foods which still need some chewing. However, this person's food charts showed that they had sometimes been given pureed meals. These were not of the correct texture and this conflicted with professional advice about this person's needs. This person had been given biscuits on a number of occasions; which did not meet the soft diet criteria; and could create a choking risk.

Some people were at risk of dehydration and needed support to drink, and their fluid intake closely monitored. At our last inspection we identified that records about people's fluid intake were not always accurate or reliable. At this inspection we continued to find a confusing picture. For example; one person had four beakers of drinks on their over-bed table when we visited them. Each of these had different amounts in them and a beaker of tea was cold. Records shown on fluid charts did not correspond with the drinks seen and it would have been difficult for staff to accurately see how much had been drunk.
Another person had been identified as unwell during the inspection and staff told us that their fluid intake was poor. When we checked fluid charts we saw that staff had only recorded those drinks that were offered to this person and not how much had actually been drunk. No details had been recorded about urinary output, by noting whether continence pads were wet or dry when changed. This meant that staff could not effectively monitor this person's well-being because they had inadequate information about fluid intake and output.

Risks to people around their nutrition and hydration had not been adequately mitigated; which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we highlighted concerns about the management of some people's catheters. At this inspection we found that there were still unresolved issues in this area. For example; one person's catheter had blocked twice in recent months. Blocked catheters can sometimes happen if people do not drink enough so we looked at records about this person's fluid intake and urinary output. However, there were no fluid charts to show input or output for the week leading up to either of the blockages. Staff were unable to tell us why there were no charts for these periods; when there were input and output charts for other dates. Without these charts, it would be difficult for staff to assess whether this person had been drinking enough

or to check that they were passing enough urine. These actions could help to prevent uncomfortable blockages. This person told us they had recently been fitted with an incorrect catheter for their needs. This had been replaced with a short-term catheter, but a replacement for this had yet to be ordered. There was a risk that another incorrect catheter might have to be used if the correct one was not ordered in time.

At this inspection we had other concerns about people's how people's health care needs were being met. For example; one person's care plan showed that they were at risk of skin breakdowns and needed to be repositioned every three hours. However, repositioning charts showed that this did not always happen. On one day of the inspection, this person had been in the same position for 14 hours. This had not protected the person from potential skin breakdowns and went against care plan directions for this person's care and treatment.

We looked at records of people who had skin wounds and found that these had not always been managed appropriately. For example; one person's wound was due to be reviewed by nursing staff on 4 November 2016 but this had not happened by 6 November 2016. It was important that wounds were regularly reviewed to ensure they had not deteriorated or required further or different treatment. During a handover between day and night staff, a nurse said that another person's wound dressing should have been changed that day, but that they had not had time to do so.

People's health risks had not been appropriately assessed and minimised which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we highlighted shortfalls in staff training and knowledge; which had had a negative impact on people's care and treatment. We specifically reported that staff understanding about catheters and nutrition and hydration was poor. At this inspection we found continuing issues in both of these areas; that had not been addressed by the provider. We also discovered that care staff had not been taking people's pulses correctly before administering heart medicines. This was unsafe practice which had not been identified until it we brought it to staff attention.

In addition we established that staff on duty during the inspection were neither sufficiently experienced nor competent to keep people safe and well. People using the service had a range of complex needs including dementia, diabetes, stroke, breathing difficulties, arthritis and cancer. New care staff did not know anything about the people they were caring for and said they had not read care plans. They told us that they had not been given any information or instructions about individual people's needs. One nurse said that they had qualified in their home country but had never worked as a nurse until they were employed by the provider. They told us that they had no experience whatsoever of delivering nursing care; other than a few months working in the service. They said that this was very concerning to them as they had only received training about medicines from the provider and had shadowed staff for one shift before being placed in charge overnight. This nurse was the only qualified staff working on one floor during the inspection. The nurse working on the other floor overnight was also new to the service. English was not their first language and we found it very difficult to communicate effectively with them. We observed that people and other staff struggled to understand what this nurse said to them and the nurse did not always appear to comprehend their responses. This situation was unsafe and meant that people's needs may not be properly understood or appropriately met.

The failure to ensure staff received adequate training and support is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well-led and the lack of leadership and management within it had placed people at risk of harm.

Following our last inspection at the beginning of September 2016, the registered manager had left the service. Since then, the provider had employed a number of different consultants who had worked in various roles over the two months between the last inspection and this one. At this inspection staff told us that there had been no clear leadership or direction in this time; which had left them confused and frustrated. They said that the consultants had all offered differing advice and guidance so that "We don't know what we're doing from one day to the next. It gets confusing between this advice and that and it's a safety issue".

A new manager had been employed and had started work the day before this inspection, but there had been a complete lack of effective management oversight in the service for at least two months; which had negatively impacted on the safety and quality of the care delivered. During the inspection the provider brought in a team of consultants to manage the service; and the local authority and other stakeholders have provided support and guidance since.

At our last inspection, the service had been rated as inadequate for safety; and because of this had remained in special measures. Despite this, safety had not improved and people remained at risk of harm. Although we had specifically reported about the poor management of a range of risks, these had not been addressed and we could not see any positive changes at this inspection.

We continued to find that choking risks had not been adequately mitigated, that known risks to one person had not been managed through regular monitoring, that effective systems were not in place to protect people who could not use call bells and that equipment designed to reduce the risk of pressure areas developing, had not been checked or maintained.

In addition, there had been no monitoring to ensure that professional advice had been followed about people's eating or that food and fluid charts were properly completed. Risks to people's health; including the management of their catheters had not improved and had not been overseen by the provider or their representatives. Staffing levels, training and competency had not been effectively reviewed or managed; leaving people exposed to the risk of receiving care and treatment from inexperienced staff.

The failure to operate robust quality assurance processes is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We spoke with the provider about the failings within the service but they were unable to provide us with assurances that they had taken appropriate action following our last inspection to reduce risks to people and ensure that effective care and support were delivered.

During the inspection we found that some records had been completed in retrospect and with information

that we knew from our own recorded observations to be incorrect. When we asked staff about this, none wanted to take responsibility and there was a lack of accountability amongst staff.

The failure to maintain accurate and contemporaneous records is a breach or Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.