Charing Way Limited

Woodside Residential Care 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
Woodside Residential Care Home is a residential care home providing personal care to up to 40 people. The service provides support to older people, some of who live with dementia. At the time of our inspection there were 32 people using the service.

People's experience of using this service and what we found
People and their relatives had positive feedback about the service, staff and the management. However, we found that care plans did not provide detailed guidance for staff on how to support people with health and other risks. Medicines were not always managed safely; staff did not always follow processes in place to store medicines safely. Staff were not consistently wearing face masks in line with guidance.

Although checks and audits were completed on most aspects of the service, they did not identify issues highlighted in this report.

Staff we spoke with understood their responsibilities to keep people safe. There were enough staff to meet people's needs and keep them safe.

Relatives told us they were kept up to date with their loved one's care and support. People were engaged in activities which they clearly enjoyed. There was a positive culture within the service, people were happy and relaxed. Staff worked with healthcare professionals to provide joined up care to people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 30 October 2021).

Why we inspected
We received concerns in relation to staffing, and the management of behaviours of distress. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
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 changed from Good to Requires Improvement. This is based on the

findings at this inspection. 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodside Residential Care Home on our website at www.cqc.org.uk

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.

Enforcement
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 have found breaches in relation to managing risks to people and checks and auditing at this inspection. Please see the action we have told the provider to take at the end of the full version 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.

Woodside Residential Care Home

Detailed findings

Background to this inspection

Inspection team
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 carried out by one inspector.

Service and service type
Woodside Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. The previous registered manager had de-registered in July 2021. Shortly following our inspection, the manager successfully registered for this service.

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. We used all this information to plan our inspection. 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 all of this information to plan our inspection.

During the inspection
We spoke with five people and one relative about their experiences of the service. We spoke with six staff including the director of care and operations, manager, deputy manager, and three care staff. We reviewed a range of records. This included five people's care records, multiple medication records and two staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits were reviewed.

After the inspection
After the inspection we spoke to six relatives of people who lived at the service about their experience of the care and support provided to their loved ones.

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 we have rated this key question 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.

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

● Risks to people's health were not consistently managed. Detailed guidance had not been provided to staff to inform them of how best to support people with catheters. A catheter is a tube that is inserted into your bladder, allowing your urine to drain freely. One person's care plan referenced them having a catheter in place, however this was no longer in situ. Staff could not demonstrate that they monitored the person's fluid input/output as requested by healthcare professionals.

● Some people lived with diabetes. There was no diabetic care plan for two people, to inform staff about any modifications to the person's diet or action to take if the person became unwell. One person could become distressed and display physical aggression when their blood sugar levels were high. Although their blood sugar levels were taken regularly, there was no evidence of action taken when their blood sugar levels were outside of their normal range.

● Some people could display behaviours of distress, including verbal or physical aggression. Care plans did not detail potential triggers or risks to those people or others. Following incidents between people, care plans had not been reviewed and updated.

● During our inspection, we observed the call bells constantly ringing. Staff told us every room had two alarm mats, which staff constantly triggered, for example when they cleaned the room and failed to turn the alarm off. Staff told us the constant noise had a detrimental effect on them, and people. A professional told us, "The sound of the call bell is enough to drive you bonkers. It makes me wonder what effect it has on the residents." A relative told us, "It's very strange that the bells go all day non-stop. I think people get conditioned to it which is sad. There's not one moment where there is peace." When we highlighted this to the manager and director of care and operations action was taken to address some of the call bells.

● Staff informed us they had observed one person dragging or pulling another person on several occasions. However, documentation reviewed showed only one incident had been documented by staff. The provider could not be assured that all incidents were being documented in order to review and look for patterns and trends.

● One person had a body map that showed they had two large skin tears. Although staff had initially documented this, there was no later review to inform if the skin had healed or needed further input.

● Some incidents had been completed on incorrect forms, which did not allow for a review of the incident and document any learning. We discussed this with the manager and director of care and operations who ensured all old forms were replaced.

Using medicines safely

● Medicines administration and management was not always safe. Some medicines require two staff to be

present and sign the medicine administration record (MAR). We found the MAR had not always been double signed by staff.
● Medicated creams were not always stored according to best practice. The manager had requested that all creams were stored in the medicines cabinet, however we found creams stored in people's rooms. There was a risk that people who could become confused with their surroundings may be at risk of consuming the cream. This was not risk assessed.
● Medicine administration for creams was not robust. There were no medicine administration records kept to detail when creams were applied. Creams were not always dated when opened in line with best practice.

The provider failed to accurately assess and mitigate risks to service users. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met. We found that staff were seeking consent before supporting people with any tasks, and mental capacity assessments had been completed when people lacked capacity to make decisions.

Preventing and controlling infection
● We observed staff not to be wearing personal protective equipment (PPE) or to be wearing PPE incorrectly, for example face masks under their nose. We discussed this with the manager, who spoke with staff.
● 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 accessing testing for people using the service and staff.
● 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.
● Visits to people were encouraged and welcomed by staff. We observed a number of visitors at the service, who were given space to spend time with their loved ones.

Systems and processes to safeguard people from the risk from abuse
● People and their relatives told us they felt safe at the service. One relative told us, "Without a doubt he is safe. He wanders around but there always a member of staff close by so I know he's ok."
● Staff we spoke with understood their responsibilities relating to safeguarding, however we identified staff had not always documented concerns accordingly. We discussed this with the manager and director of care and operations, who ensured the correct forms were available to staff.

● When safeguarding incidents were raised, the manager worked with the local authority safeguarding team to resolve any concerns raised in a timely manner.

Staffing and recruitment

● There were sufficient staff to meet people's needs. There was a range of staff including domestic, catering and an activities staff member who supported care staff. We observed staff had time to spend with people. One relative told us, "There's always staff around,' and another, "Yes there certainly seems to be more staff than before."

● Staffing numbers were decided by head office and agreed with the manager. Staffing was based on the dependencies of the people living at the service and reviewed as new people moved into the service.

● The activities coordinator spent time with people, engaging in activities people clearly enjoyed, and organised for external entertainment such as singers to visit the home.

● The provider completed checks to ensure staff were of good character, before working with people living at Woodside Residential Home. Disclosure and Barring Service (DBS) checks were completed on staff, along with checking work histories. The DBS provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 we have rated this key question 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; Continuous learning and improving care

- The manager and providers representatives completed a series of checks and audits on the service. However, these did not identify the issues raised during our inspection.
- Care plans we reviewed were not always accurate and complete. For example, one person's care plan detailed they needed slightly thickened fluid, one teaspoon of thickener to every 200ml of fluid. However, other parts of their care plan stated they needed two teaspoons of thickener. Staff we spoke with gave us inconsistent information relating to which guidance was correct. Following the inspection, the manager updated this guidance, and shared it with staff.
- Checks and audits had failed to identify that a care plan to inform staff how to support someone who could display behaviours of concern was only implemented two months after they moved into the service, despite this risk being documented in the person's pre-assessment.
- Although the manager was completing regular checks on medicines, they did not identify that staff were not following processes implemented. For example, MAR were not being completed in line with guidance when applying medicated creams. The manager had put a new process in place relating to the storage of creams, but this was not being used by staff, and no checks had been completed to ensure the new system was working. Following the inspection, the manager told us they have revised the process, informed staff and checked it was now working.
- Following our inspection, the provider sent us an action plan to inform us how they planned to address the shortfalls identified within this report.

The provider failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People received person centred care specific to them. Some people had been supported to go out for day trips and outings with the support of staff. A professional told us, "There's always nice activities on. They used to take photos of people doing activities and you could look through the photos which is really nice.

It's important. I think that's really positive, not all dementia homes do that."

● There was an activities coordinator who organised activities for those who did not leave the service, including crafts and entertainers. On the day of our inspection, people were crafting whilst singing and dancing to music they enjoyed. They were smiling and told us how happy music made them.

● People told us they were happy living at Woodside Residential Care Home. One person told us, "They are all nice people we have here, we all like it, that's the main thing," another person told us, "Oh I love it. The staff are great."

● Feedback from relatives was that staff were caring and kind towards their loved ones. A relative told us, "Mum is really happy here and the care is really good and that's all that's important to me."

● A professional had positive feedback about the service, they told us, "I have always found them really good. Really helpful really caring."

● The duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The provider was open and honest when things went wrong.

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

● Residents meetings had been held, but due to people's varying needs they were not always successful. People were asked on an individual basis what activities they wanted to take part in, and as a group fed back on singers or entertainers.

● Relatives had been asked to give feedback on the service provided. One family member had fed back that there were no refreshments available for visitors. The manager introduced a hydration station in the visiting room and reminded staff to ask people and their visitors if they would like refreshments.

● A healthcare professional told us their opinion was sought and used to improve the service. They told us, "I found they acted on what I said, they had been very attentive," and, "I have always found them really good. Really helpful really caring."

Working in partnership with others

● Staff and the manager worked in partnership with other professionals including healthcare professionals. For example, when people lost weight, referrals to the dietician had been made.

● The manager had liaised with a local GP surgery to move most people to be supported by the local practice. They told us this made huge difference in the ordering of medicines and had enabled them to commence a weekly visit from the GP surgery to support with people's on-going health.

● A professional told us, "When I suggest a referral such as to the dietician it is always done. They seem very efficient."

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 The provider failed to accurately assess and mitigate risks to service users. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.