Larchwood Care Homes (North) Limited

Alwoodleigh

Inspection report

4 Bryan Road
Edgerton
Huddersfield
West Yorkshire
HD2 2AH

Tel: 01484453333

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16 December 2020
07 January 2021
26 January 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Alwoodleigh is a nursing home providing personal and nursing care to 33 people aged 65 and over at the time of the inspection. The service can support up to 40 people.

People's experience of using this service and what we found
People did not always receive safe care. Risks were not always identified and responded to appropriately following accidents and incidents. Care records did not always take account of risks and include guidance for staff to support people safely. We found concerns relating to the safety of the environment. Remedial action to ensure compliance with fire safety of the premises had not all been completed within set timescales.

Quality assurance systems were not always effective and did not drive improvement within the service. We found concerns relating to the management of risk and the safety of the premises. Learning was not always shared when things went wrong.

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.

Recruitment procedures were in place, but we made a recommendation to strengthen these.

Medicines were managed safely, and staff were knowledgeable about recognising and reporting abuse.

There were sufficient staff who were appropriately trained to support people safely. People were supported to access healthcare and maintain a nutritious diet.

Staff told us the registered manager was approachable, they felt supported and communication amongst the team was good.

For more details, please see the full report which is 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 24 April 2018).

Why we inspected
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 coronavirus and other infection outbreaks effectively.

The inspection was prompted in part by notification of some specific incidents. Following one of these a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of accidents and incidents including falls and missing persons. This inspection examined those risks.

Some of these incidents are subject to or have the potential to be subject to a criminal investigation. As a result, this inspection did not examine the circumstances of these incidents.

The information CQC received about the incident along with other concerns we received indicated concerns about the management of risks, staff skills, communication within the service and recording. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

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

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safety and governance at this inspection.

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

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

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Alwoodleigh

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.

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
This inspection was carried out by three inspectors and a specialist advisor specialising in nursing care.

Alwoodleigh is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 announced on the day of the visit. We did this to discuss the safety of people, staff and inspectors with reference to Covid-19.

Inspection activity started on 16 December 2020 and ended on 26 January 2021. We visited the care home on 16 December 2020 and 7 January 2021.

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, professionals who work with the service and Healthwatch. Healthwatch is an

independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with eight members of staff including the registered manager, regional manager, nurse, senior care workers, care workers and the chef. We spoke with one relative about their experience of the care provided.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who visited the service.

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 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.

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

- Risks to people's safety following accidents and incidents were not appropriately managed. The provider had not identified risks in one person's environment and ensured these were removed.
- We highlighted these risks to the registered manager during our inspection, who confirmed action would be taken. Following this, we became aware of this happening again. The provider assured us and the local safeguarding team that items presenting a risk would be stored safely.
- The environment and systems in relation to fire safety had not been rectified by the provider following a fire risk assessment completed in November 2020. Some of these issues had been identified as high risk requiring action within one month. During our inspection, we found a number of these outstanding. The provider responded during and after the inspection. They confirmed all the actions from the fire risk assessment were either completed or in progress.
- Care plans contained minimal information of the control measures for staff to follow to keep people safe. This meant not all staff would have access to the information needed to keep people safe.
- Risks were not always appropriately identified, monitored and mitigated. For example, some people were identified as being at high risk of falls. However, risk assessments lacked information about the contributing factors and what steps needed to be taken to reduce the risk.
- There were gaps in care records. For example, one person's record indicated the level of continence care they received was insufficient. Although they were not harmed, there was a risk this person's needs had not been met appropriately.

We found no evidence that people had been harmed however, insufficient action had been taken to effectively manage people's safety and placed them at risk. Systems did not support this. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider did not always operate a safe recruitment process. The provider could not assure us checks to ensure some agency nurses were registered with their regulatory body were carried out before they provided support to people.
- Following our inspection, the provider confirmed all nurses working at the services were registered with their regulatory body. This meant the provider could be assured they were safe to work in the role.
- Other recruitment checks were completed to ensure people were suitable to work at the service.

We recommend the provider strengthen their recruitment procedures to ensure all checks are completed before staff commence work.

● There were sufficient staff to meet people's needs and people received care in a timely way.

Preventing and controlling infection
● We were not assured that the provider's infection prevention and control policy was up to date. This was provided after the inspection.
● 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 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.

Using medicines safely
● Medicines were received, stored, administered and disposed of safely.

Systems and processes to safeguard people from the risk of abuse
● Staff knew how to recognise abuse and protect people from harm. They were aware of how to report concerns and felt confident to do so.
● Staff were familiar with whistleblowing and felt confident to raise any concerns should these arise.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
- Information about people's capacity was unclear in their care records.
- Staff had awareness of the MCA and the importance of involving people in decisions about their care.
- Decisions were made in people's best interests where required.
- Applications for DoLS authorisations had been made where required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
- People had care plans outlining how their needs and preferences should be met. These were regularly reviewed, but lacked the information needed to ensure they reflected people's current needs.
- People were able to personalise their bedrooms as they wished. Areas of the home had been considered for people's needs and accessibility. The home's decor was well maintained.

Staff support: induction, training, skills and experience
- Staff had the skills and knowledge to appropriately support people. Staff completed an induction when new to their roles and regular training to ensure they were able to meet people's needs.

● Staff were supported in their roles. The management team provided staff with regular support through a variety of means including supervision sessions and appraisals.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to meet their nutritional needs. People's dietary requirements were met, and nutritional needs monitored.
● A varied and balanced menu was on offer with choices available.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's health and wellbeing was monitored. Staff supported them to access healthcare services when required.
● Staff liaised with health and social care professionals to achieve good outcomes for people.

Inadequate

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 inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Opportunities to learn from accidents and incidents were missed. Information and learning was not always shared with staff in a timely manner which placed people at risk of similar incidents occurring. The monthly analysis of accidents and incidents was not always completed, which meant patterns and trends were not identified.
- Systems to monitor the quality and safety of the service were not effective. This meant they had failed to identify the issues we found during our inspection. These related to risk management, staff recruitment and accurate records relating to people's care. As a result, the provider was unable to effectively identify and address quality shortfalls.
- Internal investigations and quality monitoring reports had identified a number of shortfalls within the service. An action plan was developed but was not followed up and embedded into practice, therefore they continued to occur.
- The registered manager did not follow up on and ensure actions were completed in relation to aspects of safety within the service. For example, checking items were stored safely and making sure agency staff were aware of risks before providing care.

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

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

- People were not regularly involved in decisions about the running and development of the service. We saw evidence of only two resident meetings taking place during the last year and no other means of gaining people's feedback. A relative told us they were invited to provide feedback online. The provider did not provide any analysis of feedback or action taken from it.
- Daily meetings and handovers took place to ensure effective communication between staff. Staff told us they felt this was informative.
- Links had been made with other professionals and services; staff worked in partnership with them to achieve outcomes for people.

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;

● Staff felt supported by the registered manager. They felt the management team and staff were approachable and team morale was good. A member of staff told us, "There is a lot of support from the manager and team leader." Another said, "This is a home that I love. It is a warm place."

● The registered manager was aware of their responsibilities in relation to the duty of candour; they were open and honest.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12: Safe care and treatment Care and treatment must be provided in a safe way for service users. (a) Assessing risks to the health and safety of service users of receiving the care or treatment. (b) Doing all that is reasonably practicable to mitigate any such risks. (c) Ensuring that the premises used by the service provider are safe for their intended purpose and are used in a safe way.