Four Seasons 2000 Limited

Woodview

Inspection report

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Date of inspection visit:
04 July 2023
06 July 2023

Date of publication:
19 September 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodview is a residential care home providing personal and nursing care to 48 older people, younger adults and people living with a dementia type illness. The service can support up to 60 people. The service is divided into two units. 'Woodview' provides care to older people or people living with a dementia type illness and 'Greenwood' provides care for younger adults with physical disabilities and longer-term medical conditions.

People's experience of using this service and what we found
Governance systems and processes were in place. However, these were not always operated effectively. This meant risks and shortfalls were not always identified and addressed.

Risk management was poor. Risks were not identified, assessed or managed well. Meaning people experienced poor outcomes and increased risk of harm.

Care plans did not always contain person centred information. Some care plans contained conflicting information about how to support the person to ensure their assessed needs could be met. We found when reviews took place, any changes to people needs could not be easily located and the care plan was not updated.

Accidents and incidents were recorded by staff. However, reviews and action taken as a result of accident and incidents was not always effective. This meant people were experiencing recurrent accidents and incidents of the same nature.

Medicines management was not always operated effectively. People did not always receive their medicines as prescribed; 'As and when' medicines did not always have information for staff about when these should be administered.

There was not always enough staff to meet the needs of people. There was a high dependency on agency staff, increasing the risk of inconsistent care. Safe recruitment systems were in place to ensure staff were suitable to work with people.

Infection control measures were in place and a housekeeping team completed daily cleaning tasks. However, malodours were present, and some areas of the home required repairs and refurbishment. This meant whilst cleaning was completed, the effectiveness of cleaning could not be maintained.

Activities were in place; however further work was need from the provider to ensure these were meaningful and the electronic system for recording activities was reflective of people engagement and involvement of activities.

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 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 3 April 2020)

Why we inspected
We received concerns in relation to the management of medicine, risk management, leadership and governance. As a result, we undertook a focused inspection to review the key questions of safe, responsive 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 based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to risk management, medicines management, learning lessons, person centred care, leadership and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Woodview

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 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 2 inspectors 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
Woodview 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. Woodview is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection the manager was registered with us.

Notice of inspection
This inspection was unannounced.

What we did before 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 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 this information to plan our inspection.

During the inspection
During the inspection we spoke with 6 people who lived at the service and 19 relatives, 6 care staff, 1 nurse, the registered manager, unit manager and the regional support manager. We looked at 9 people's care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance.

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.

Assessing risk, safety monitoring and management

● People's risks were not managed. We found historical information in care plans and risk assessments which were not relevant to peoples current and ongoing needs. We also found some care plans and risk assessments in place for a person who had been admitted to the service 8 days prior had not been completed. This meant peoples risks were not assessed, monitored or managed effectively, leading to poor care for people.

● People were at risk of choking, due to their nutritional needs not being met. For example, two people who have their nutritional need met by a Percutaneous Endoscopic Gastrostomy [PEG], are required to remain sat up when the feed is in process. PEG is a tube placed into a person's stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate. However, during the inspection both people were observed multiple times to be laid down in their beds. This significantly increased the risk of aspiration.

● Further choking risks were found and care plans we reviewed had conflicting information. For example, one care plan stated a person required level 2 thickened fluids, however, their 'Personal Food Passport' stated they required Level 0 Thin fluids. Another person had 3 different levels of modified food described in their care file. Inconsistent and inaccurate information significantly increased the risk of choking.

● People were not protected from the risks associated with smoking. We were informed 3 people smoked, we found no individual risk assessments in place for smoking and no consideration for further risks associated with smoking including flammable creams, use of oxygen, and vapes. We were also informed as an organisation you do not do individual risk assessment, despite this being detailed in the providers own policy.

● People were at risk of skin breakdown due to poor management of skin integrity. Records we reviewed demonstrated repositioning was not taking place as frequently as it should. The person at times was not repositioned for a period of 6.5 hours. A further risk in the person care file was conflicting information of the frequency of repositioning. The care plan stated 3 hourly, the skin integrity sheet stated 4 hourly and the review sheet stated 2 hourly. Conflicting and inaccurate information significantly increased the risk of skin breakdown.

Systems and processes to safeguard people from the risk of abuse

● Staff had training on safeguarding, however, staff did not know how to recognise and report abuse. We found an incident of a safeguarding nature on the provider's incident log had not reported to the relevant professional bodies, meaning it could not be investigated fully. When we spoke with the registered manager, they had failed to recognise this was their responsibility to report.

● Following the incident action was taken to address and mitigate risk. However, the care plan produced

was handwritten and unreadable. This meant staff did not have the information to support the person and ensure their safety meaning they remained at risk of harm.

Using medicines safely

● People did not always receive their prescribed medicines. We found 3 people did not receive their prescribed medicines for prolonged periods of time. For example, a person did not have 2 of their prescribed medicines for 19 days. Another person did not have their prescribed pain relief for 5 days.

● 'As and when' [PRN] protocols were not always in place meaning staff did not have any guidance of when to administer medicines. We found a person had been prescribed antipsychotics need to explain or simplify, however, there was no evidence to indicate why this was prescribed and how it should be used, meaning this had not been assessed and managed appropriately.

● Out of date controlled drugs were found during the inspection. Records showed the controlled drugs had not been checked since May. Audit records showed these should be checked weekly.

● The failure to recognise and resolve issues with medicines administration put people at increased risk of not receiving their medicines as prescribed or being administered with reduced effectiveness. This meant people's health needs were not effectively managed which placed them at increased risk of health deterioration.

Learning lessons when things go wrong

● We found evidence of organisational learning did not always take place. At the time of the inspection, we found 3 significant incidents involving medicines management. The provider responded to the concerns raised, however, further incidents of the same nature occurred and during the inspection we found further risks with medicines management. This demonstrated that the provider did not always learn lessons when things went wrong.

Staffing and recruitment

● The service did not have enough staff. Agency staff were heavily relied upon. We reviewed rota's and found 16 different nurses had completed shifts over a 6-week period, with 10 only completing 1 shift, meaning lack of consistent care. Furthermore, at times night shifts consisted entirely of agency staff meaning understanding people's needs could not always be achieved.

● Staff told us there was not enough staff to meet people's needs and the dependency tool did not reflect people's actual needs. One staff member told us, "The staffing is based on numbers, not needs". A relative told us, "[Person] had to wait 3 hours to be cleaned and changed".

Preventing and controlling infection

● Some areas of the environment were worn and damaged which increased the risk of harbouring bacteria and compromised the effectiveness of cleaning. Some areas of the care home had malodours.

● The bath/shower rooms had mould, broken silicone and plastic coving coming away from the walls, these all contributed to areas that could not be cleaned effectively, and increased risk of harbouring bacteria.

● The carpet outside a bedroom in Greenwood was ripped and torn. An attempt had been made to put hazard tape over this, but this had twisted and moved, revealing a hole. The carpet in Greenwood was old, dirty and stained quite significantly in some areas. These areas were frequently used by service users. This posed a risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.

The provider's failure to assess and manage a wide range of risks placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

● Records showed the provider had recruited staff and a number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff did not have criminal convictions.
● 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 responding effectively to risks and signs of infection.
● 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 service facilitated visiting in line with national guidelines.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Since the last inspection the approach to activities had deteriorated. We observed activities taking place during the inspection; however, they did not appear to be meaningful. For example, an activities employee was playing a games console with his back to the person who was in the room sat behind him looking at his back. It was observed no attempts were made to engage the person in the activity.
- We also observed a person in an environment where the only source of stimulation was a television. They had no means to reposition themselves and we also observed the service user to be left in this environment and in the same position for an extended period of time without supervision from staff.
- The provider's 'Magic Moments' electronic recording system for activities was generalised for group activities and did not specify or reflect if people interacted or were involved in the activity.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Records showed care plans did not always contain the information to ensure people's needs and preferences could be met. For example, as detailed in safe section of this report multiple people's care plans did not contain sufficient guidance for staff about how to support them to ensure theirs and others safety.
- Reviews of care plans did take place regularly. However, when a person had a significant change in their needs, this was not reflected in their main care plan. For example, a person's care plan stated they required the support of 1 carer for personal care needs, a review of which was located further back in the care file stated the, 'level of need is now high as requires now full assistance from care staff and appropriate supervision whilst undertaking personal care: unable to assist'.
- This failure to update and clearly document changes to people's needs, significantly increased the risk to their welfare and safety.

End of life care and support

- We reviewed documents regarding end of life wishes in place for people and found incomplete information or no information. Care plans we reviewed stated to ensure the person's rights and wishes were met. However, there was no further information of what these wishes were. Lack of information could lead to confusion and inappropriate care being given at the end of a person life.
- Some care plans were not completed, this meant people's wishes were at risk of not being met and a dignified death may not being supported. Systems were either not in place or robust enough to ensure people's preferences and wishes for end of life could be met.

The provider had failed to ensure that the care provided reflected people's individual needs, risks and

preferences. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had a system in place to record complaints when they were received, and the action taken to resolve them. There were a policies and procedures in place for handling complaints. The manager informed us they did not get complaints. This is because they dealt with any issues when they were highlighted, however these are not recorded.

● This inconsistent approach to dealing with complaints means improving care quality cannot always be recognised, monitored or sustained. The provider acknowledged the shortfalls in the system and provided assurance that they would take action to improve.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Records showed the provider had assessed people's communication needs and set out how to meet those needs in their care plan. Care plans clearly set out their preferred communication method and the level of support needed and any equipment, for example hearing aids.

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.

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; Continuous learning and improving care

- Systems were in place to monitor the quality of the service. However, effective analysis of incidents was not in place. The manager had failed to put in place effective measures to prevent people not receiving medicines. Consequently, for 3 months in a row, significant medicines errors reoccurred.
- The provider had failed to be open and honest. We found regulatory requirements had not been met by the provider, we had not been notified regarding an incident, due to the manager misunderstanding their responsibilities to report incidents of a safeguarding nature. Consequently, the provider had failed to notify the relevant professional bodies when appropriate and failed to investigate incidents effectively.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We found a range of audits in place to monitor the quality and safety of the home. However, some of the audits systems in place had failed to identify the concerns we found as detailed in the safe section of this report. This meant the manager had not always been able to implement and embed the improvements needed. For example, ensuring people who smoke had appropriate safety measures in place.
- Audits and governance processes in regard to risk management were not always effective. This was evidenced by the failure to identify issues raised at this inspection. Where the manager had identified errors, insufficient action had been put into place to prevent reoccurrence.
- Audit checks had failed to identify controlled drugs had not been checked, and there was no clear plan to ensure this was completed. Further work was needed to develop and embed systems and processes for quality monitoring. During the inspection, the manager and provider were responsive to feedback and told us about the actions they have planned to resolve the issues identified.

The provider's failure to develop and sustain systems to monitor and mitigate risks, placed people at risk of avoidable harm and 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were positive about their experience of using the service. For example, one person told us, "I have nothing to complain about." Another person told us, "I have met the new manager

and they appear friendly. There was a 'meet and greet' arranged for families."

● Feedback from staff was varied, some staff told us they felt supported in their roles and were complimentary of the manager. One staff member told us, "The manager is approachable, and she supports me". More negatively another staff member told us, "I don't feel listened to, I can't approach the manager to talk about things."

Working in partnership with others

● The registered manager and provider worked collaboratively with health and social care professionals to ensure people were safe and received care which met their needs. However, as detailed above in the safe section of this report, the provider did not always ensure care plans were accurate and reflective of professionals advise or the person's needs.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care provided reflected people's individual needs, risks and preferences.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider's failure to assess and manage a wide range of risks placed people at risk of avoidable harm .

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's failure to develop and sustain systems to monitor and mitigate risks, placed people at risk of avoidable harm.

The enforcement action we took:

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