Woodlands Retirement Residence Limited

Woodlands Retirement Residence

Inspection report

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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

About the service
Woodlands Retirement Residence is a residential care home providing personal care to 17 people aged 65 and over who may also be living with dementia. The service can support up to 19 people. The care home accommodates people in one adapted building which is set out over two floors. There is access to the second floor via a lift.

People's experience of using this service and what we found
People had not received a service that was well-led. We found significant shortfalls in the systems in place to monitor the quality of the service.
Since our last inspection, the service had made improvements to how people's risks were assessed and in ensuring there was guidance available for staff to evacuate people safely in the event of a fire.

People received support from staff who understood how to recognise and escalate safeguarding concerns. Whilst staff had received training around the administration of medicines, we found some systems around the administration of medicines required improvement.

We identified that further improvement was needed around the monitoring of staff recruitment and in the monitoring of staffing levels at the home.

Whilst we found many instances where people had been supported to have maximum choice and control of their lives, we also identified areas which required further improvement. Staff did not always support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We have made a recommendation about accessing information and resources to support people living with dementia.

Staff supported people to access healthcare appointments. People were offered a choice of meals that met their needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement overall and inadequate in well led (published 22 February 2020) and there were two breaches of regulation in relation to the safety of peoples care and in the monitoring of the service. We carried out enforcement activity to place conditions on the provider's registration to support them to improve in this area. These conditions remain in place.
At this inspection sufficient improvement had not been made in the governance of the service and the provider was still in breach of regulation 17 (Good Governance).

The last rating for this service was requires improvement (published 22 February 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last six consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about medicine management, restrictive practices and people being involved in choices in their care. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection

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.

We have found evidence that the provider needs to make improvements. Please see the well led sections of this full report. 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 Woodlands Retirement Residence on our website at www.cqc.org.uk.

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.

This inspection has identified a continued breach in relation to monitoring systems at the service. We will continue to monitor the improvement within the service through existing conditions we have placed on the providers registration. This includes sending us monthly reports of action the provider has taken to monitor and make improvements within the service.

Special Measures
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up
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 request reports to be sent to us on a monthly basis to monitor the planned improvements. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Woodlands Retirement Residence

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
The inspection was carried out by two inspectors. Two inspectors carried out the site visit on the 06 October 2020. On the 08 October 2020 one inspector made phone calls to staff. We continued analysis of the evidence sent to us and the inspection concluded on the 13 October 2020.

Service and service type
Woodlands Retirement Residence 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 who was also the provider of the service. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We informed the service of the inspection shortly before entering the

building because of the risks associated with COVID19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

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 who commission services with the provider. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We met a number of people and spoke with two people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager who is also the registered provider, and the care administrator, senior staff and care workers.
We reviewed a range of records. This included two people's care records and three medication records. We looked at two 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 looked at care plans, training data and quality assurance records. We spoke with one relative and two members of staff.

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.

Staffing and recruitment

- We saw there were sufficient staff available to support people at the service. Most of the staff we spoke with told us that there were sufficient staffing levels to support people safely.
- A review of the staffing rotas showed us that required staffing levels had not always been met. We discussed this with the registered manager who assured us that this was a recording error and that she would be aware of lower staffing levels at the service. The registered manager informed us she had been working hard to recruit staff to ensure optimum staffing levels were available.
- The provider had a dependency tool to determine safe staffing levels based on people's changing needs. Whilst the provider was able to tell us how many staff should be on each shift, the dependency tool was not fully understood by the provider.
- We saw that recruitment checks were completed prior to a staff member starting work at the service. These included obtaining a Disclosure and Barring Service (DBS) check to assess whether staff were suitable to work with people. We identified some systems around the recruitment of staff were not fully robust. For example, the provider had failed to ensure their own risk assessments were followed and had not consistently ensured that records had been maintained.

Using medicines safely

- Whilst the practice of administering medicines overall was safe we identified concerns with one person's medication. This person had not received one of their medications for three days. In addition, staff had not been following prescribing instructions for two of the person's medicines. This was followed up on the day of the inspection.
- Where people received medicines 'as required' there were protocols in place that stated the signs of a person needing their medicine. This ensured consistency in administration of these type of medicines.
- Staff told us they had received training in medication administration and that their practice was checked.

Preventing and controlling infection

We looked at the infection prevention and control measures in the home. These were our findings.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were somewhat 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 not 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.
● We were somewhat 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.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who understood the signs of abuse and appropriate action to take should they have concerns. One staff member told us, "I would report [any concerns] to the registered manager."
● Staff had received safeguarding training and were able to describe action to take to keep people safe.

Learning lessons when things go wrong
● There were systems in place to monitor any accidents or incidents within the home. This had often helped to analyse individual accidents enabling external healthcare professionals to be consulted in order to reduce the risk to peoples care although these systems were not always effective.
● Whilst there were systems in place to analyse individual accidents and incidents to determine any trends or patterns which could mitigate further risk, we found these could be improved further. For example, one month had identified that four falls had occurred at the same time frame. There was no clear audit trail that showed this trend had been explored.

At our last inspection the provider had failed to reduce the risks to people's care because risks to people had not been clearly recorded and personal evacuation plans (PEEPS) were not up to date. This constituted a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (2008) Regulated Activities (2014).

At this inspection we found improvements had been made and the provider was no longer in breach of this regulation.

Assessing risk, safety monitoring and management
● People that we spoke with felt safe living at the service. One person described how staff made sure they had an aid available which helped them feel safe when mobilising.
● We noted improvements with the detail available around personal evacuation plans. This meant instructions were available for staff to follow to keep people safe in the event of a fire at the home.
● People had the individual risks identified with their care assessed and minimised. We saw there were care plans available that detailed these risks and steps to take to minimise the risk occurring.
● The provider had consulted with other healthcare professionals where it had been determined that a person had a certain risk associated with their care to seek advice and guidance on action to take to minimise the risk.
● Staff were aware of the risks associated with people's care and how to support people safely.

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

- From records we viewed we saw that some people had been supported to get out of bed very early in the morning. We discussed this with the registered manager who advised us this was people's choice and that it helped to reduce the risk to people from falls out of bed for example. Care plans and capacity assessments we viewed showed us that this choice was not documented in people's care plans nor was the consideration of a best interest meeting where the person lacked the capacity to make this decision. The registered manager had not had full consideration of whether this practice was in people's best interests or the least restrictive option.
- Where it had been determined that a person lacked the capacity to consent to living at the home the registered manager had applied for a DoLS appropriately. There were systems in place to ensure that DoLS were renewed where needed.
- The registered manager had carried out assessments of people's capacity to make specific decisions about their care. Improvements were needed to ensure these assessments considered all the decisions associated with people's care.
- The registered manager had sought confirmation from relatives of their legal authority to make certain decisions for their relative in most cases. We saw one example where the service had sought consent for care from a relative who did not have the legal authority in place.
- Whilst people told us they had choices in their care, we also found evidence that choices had not been consistently considered due to the evidence of people getting up early in the morning.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to them living at the service to ensure that their needs could be met safely. We saw that people's care plans were reviewed and updated as and when people's needs changed.
● The initial assessments and care planning also took people's cultural needs into account such as their religious needs.

Staff support: induction, training, skills and experience
● The provider had systems in place to monitor the training that staff received. There had been a number of new staff at the service. We saw that these staff had an induction completed.
● Most of the staff we spoke with were happy with the training they had received.
● Many of the people at the service were living with dementia. The registered manager could not demonstrate all staff had received recent training and guidance to help understand the needs of people living with dementia. This meant staff may not have had up to date knowledge about how to support people living with dementia effectively.
We recommend that the provider finds out information about current best practice in relation to the specialist needs of people living with dementia and share this information with the staff team.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat meals of their choosing. We saw people enjoying their meals and that specialist aids were available to support people with their independence.
● Where people were at risk of poor nutrition or hydration we saw there were monitoring tools in place and care plans indicated action staff needed to take to reduce this risk.

Staff working with other agencies to provide consistent, effective, timely care
● The registered manager informed us that they worked with a number of healthcare professionals to support people's healthcare needs. This included physiotherapists and nurses.

Adapting service, design, decoration to meet people's needs
● The premises was accessible to those with differing mobility needs and there was a lift and stair lift to enable people to access the different floors of the service.
● The home was decorated to a high standard and checks were carried out on the environment to ensure it was well maintained.

Supporting people to live healthier lives, access healthcare services and support
● People were supported to access the healthcare they needed to remain healthy. Whilst healthcare professionals hadn't always visited the home, due to Covid 19 restrictions, they had been consulted about people's changing needs.
● People were supported to maintain good oral healthcare and assessments had been introduced in line with best practice.

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 Inadequate. At this inspection this key question has remained the same. 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.

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

At our last inspection we found that systems had not been established or operated effectively to monitor and mitigate the risks to people's health and safety. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Whilst we found some improvements, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- The last five inspections have rated this key question no better than requires improvement. This demonstrated that the registered manager, who is also the registered provider, has been unable to sustain improvement over a period of time or instil a culture of continual improvement
- The provider's systems to monitor safe recruitment of staff were not consistently effective and had failed to ensure records were maintained and risk assessments relating to recruitment checks were completed and followed as required.
- Systems to ensure staff were provided with up to date guidance around Covid 19 were not robust. We found that staff had not been provided with up to date guidance around the use of PPE. In addition, the practice of wearing PPE in the service was not in line with the provider's own policy. Furthermore, whilst the provider had detailed risk factors associated with Covid 19 they had not carried out individual risk assessments for people or staff.
- Systems to monitor care practice were not effective. Before our inspection we received concerns that people were being woken early and supported by staff. At our inspection four people were being woken early and supported by staff. The provider could not demonstrate that this reflected people's preferences and choices and the providers oversight had not identified this practice. We have asked the provider to investigate into these matters.
- Systems to ensure care plans were up to date not always effective. For example, we found discrepancies in the instructions given to staff around how often to monitor a person's weight. Whilst the registered manager was able to provide information about the persons current needs they had not ensured systems were robust enough to identify the discrepancy in the records.
- The providers own tools to measure risk factors in peoples care were not always understood by the provider. Whilst we found that no one had come to harm the provider was not able to explain what implications the scoring from certain tools meant for peoples care.
- The providers own systems for monitoring safe staffing levels had not identified recording errors on staff

rotas. This meant that there were ineffective systems in place to monitor safe staffing levels in the service.
● Systems to record action taken as a result of unexplained bruising, for one person, was not consistently robust. Whilst we saw that action had been taken and recorded in one instance, the provider had not fully explored all instances.
● Systems to ensure medicines were given in line with prescribing instructions were not always effective. The ineffective processes in place to audit medicine administration had led to us needing to prompt the provider to address medicine concerns on the day of the inspection.

Systems failed to effectively monitor and improve the quality of the service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had acted on some of the findings from our last inspection report. For example, we found improvements had been made in the recording of staff supervision, more detail was available in the PEEP's that we reviewed and the risks associated with peoples care were being identified and assessed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We found that there was some evidence available in people's care plans of their interests, hobbies and preferences for care. We discussed with the provider additional information that could be included in records to enable staff to have a wider understanding of people's individual preferences.
● Staff we spoke with knew people well and could tell us about the relatives who were important to people. We saw kind, caring interactions between staff and people.
● We received information following the inspection around concerns about a lack of open and transparent communication with family members. We have asked the provider to investigate these concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had notified us of events that had occurred in the home in line with their statutory responsibilities. However, we noted that the provider also notified us of events we did not need to be informed of. This demonstrated that the provider had failed to have a clear understanding of notifiable events within the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We saw that surveys had been carried out by people, their relatives and staff to seek their views of the service. Many of the completed surveys provided positive feedback and satisfaction with the service. The provider had not yet analysed this information to help drive continuous improvements to the quality of the service.
● There had been opportunity for people to have meetings to feedback their views about the service. This also served as an opportunity to update people about any changes in practice due to Covid-19. We noted that a small number of people were present at these meetings and it wasn't clear how all the people living at the home had been consulted for their views.
● Most of the staff we spoke with felt supported in their role and felt able to raise concerns or suggestions. One staff member told us, "Yes [the manager] is approachable, she would listen to me."

Working in partnership with others
● The service worked in partnership with other healthcare agencies such as GP's, Physiotherapists and

district nurses to ensure people received care in line with their needs.