Carisbrooke Healthcare Ltd

The Woodlands Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The Woodlands Care Home is owned and managed by Carisbrooke Healthcare Ltd. It is registered to provide accommodation for up to 40 older people. The service is provided over two floors, the first floor housed people living with dementia. On the day of our inspection 32 people were using the service.

We carried out an unannounced comprehensive inspection at Woodlands Care home on 7 8 25 and 29 April 2016 following concerns raised about a number of retrospective RIDDOR reports sent to us by the local authority. During this inspection we found breaches of requirements.
After this visit we then received further information of concerns from the local authority in relation to a number of areas following several safeguarding investigations and quality monitoring visits.
As result of this we undertook a focussed inspection on 31 May 2016.

This report only covers the areas in Safe and Well Led focussed on during this inspection. You can read the report from out last comprehensive inspection by selecting the 'all reports' link for Woodlands Care Home on our website at www.cqc.org.uk.

At the time of this inspection the service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.
We found that although the registered provider had engaged a consultant team to drive through improvements in the service, this had not resulted in people being given safe care and support, and the service lacked the leadership to improve the quality of care given to people.

People were still not protected from the risk of abuse, as staff were not escalating concerns made to them by health professionals to the management team and as a result some serious safeguarding issues had not been investigated by the management team.

People were still not protected from the risk of harm, due to ineffective systems in place to protect them. There was a lack of information in people's care plans to show how risks to their safety should be managed.

People were exposed to environmental risk as equipment used in the service was not properly maintained and there were a lack of assessments to ensure safe use of this equipment for people

Staffing levels were sufficient to support people's needs but staff were not supported by the management team and there was a lack of supervision and performance monitoring.

There was still a lack of appropriate governance and risk management framework and this resulted in us finding ongoing breaches in regulation and negative outcomes for some people who used the service. There

was still a lack of effective systems in place to monitor and improve the quality of the service provided.

The overall rating for this service remains 'Inadequate' and the service therefore remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from
operating this service. This will lead to cancelling their registration or to vary the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Action had been taken to improve some areas of safety but people were still not being protected from harm.

People may not be protected from abuse because the provider had not ensured there were systems in place to protect people from the risk of abuse.

People were exposed to risks unnecessarily because ways on minimising these risks were not always identified.

There were enough staff to meet people's needs but the staff did not receive supervision or support to assist them in their role.

Is the service well-led?

Inadequate

The service was not well led.

The provider was failing in their statutory duty to notify us of significant events in the service.

Although systems had been introduced to improve the way the service was monitored these systems had not been used. As a result they had not been effective in improving the quality of care some people were receiving.

The Woodlands Care Home

Detailed findings

Background to this inspection

We undertook a focused inspection of Woodland Care home on 31 May 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 7, 8, 25 and 29 April 2016 had been made. We inspected the service against two of the five questions we ask about services: is the service safe? and is the service well led? This is because the service was not meeting the legal requirements in relation to these questions when we visited in April 2016.

This unannounced inspection took place on 31 May 2016. The inspection team consisted of two inspectors. Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with one person who lived at the service and with three members of staff and the consultant employed by the service to assist with its running.

We looked at the care records of three people who used the service, three staff files, as well as a range of records relating to the running of the service, which included audits carried out by the registered manager.

Inadequate

Is the service safe?

Our findings

At our last inspection we found people were not always protected from abuse and the provider was in breach of regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. Not all staff employed at the service had been given safeguarding adults training and some staff we spoke with did not know how to report safeguarding issues to the local authority.

At this inspection whilst we found staff we spoke with had received safeguarding training their understanding of raising issues and communicating concerns was poor. There had been a number of safeguarding referrals by health professionals to the Multi Agency Safeguarding Hub (MASH) as a result of staff failing to follow instructions given to them by health professionals. Staff were not escalating concerns made to them by health professionals to the management team and as a result some serious safeguarding issues had not been investigated by the management team. For example two safeguarding referrals approximately six weeks apart made by health professionals involved one member of staff. There had been an investigation completed for the first referral by the local authority safeguarding team and the results had been fed back to the management team. However no internal investigation had taken place by the management team to show lessons had been learnt for either incident. There was no record of supervision or support offered to the staff member involved in the incident this meant the provider was continuing to fail to protect people in their care from potential abuse.

Heath professionals told us salient information wasn't always handed over by staff from shift to shift. As a result people were not given the care they needed. One person had required staff to undertake an assessment of an aspect of their care, a health professional had requested the assessment four times on different occasions. When they did receive the information they found it was unreliable and could not be used to assist them with the person's care.

This meant the provider was still in breach of regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our last inspection we found people were not always provided with safe care and treatment and the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At this inspection we found people were still not protected from unsafe care and treatment. At our last inspection we examined the care records of a person who had significant needs around mobility and pressure damage. We found their care plan was incomplete and essential information was missing. There was a lack of essential assessments and care plans to assist staff manage the person's care. When we examined the same records at this inspection we found that whilst there had been some assessments completed, the care record still lacked essential information to assist staff in managing the person's care.

The daily communication notes for one person recorded a meeting with a health professional that highlighted a number of care issues. The health professional had asked for staff to record when the person

was assisted with particular aspects of their care. Despite our requests to the management team we were unable to find any evidence that this recording had taken place. This lack of recording of these essential tasks resulted in the deterioration of an aspect of the person's health. This meant the care given to the person had fallen below the accepted standard of care, and resulted in harm to the person.

A second person's care record we examined during both our last and this inspection, did not give sufficient detail around an aspect of the person's health needs to enable staff to assist them with their care. We highlighted the issue at the last inspection. At this inspection, we found essential information was still lacking. During this inspection we found there had been an occasion when the person's condition had been unstable and staff did not give appropriate treatment and care. We discussed this with a senior member of staff who told us that all staff should be aware of the person's needs as they had lived in the home for some time. However we could find no information in the care record to support this assertion. We highlighted this to the management team who told us they would address this shortfall. However the person had received unsafe care as a result of staff not having the correct information to assist them with the person's care.

When we last inspected the service we found people were not always protected against environmental risks. People's needs in relation to moving and handling had not been properly assessed to ensure they were provided with appropriate equipment to maintain their safety during transfers. At this inspection we found people were still not being protected against environmental risks. We saw where defects had been noted on equipment, no action had been taken by the provider to ensure the safety of these pieces of equipment and their continued use.

We also found that communal slings were in use and highlighted this to a senior member of staff who found further slings that were not in use to allow people to have their own slings. However we found these slings to be unsuitable for the purpose of general moving and handling. When we asked whether people had been assessed to establish the most suitable type of sling to meet their individual needs we found they had not. There was no guidance available for staff on the type and size of sling and any configurations of loops or leg attachments to be used. This meant people were continually exposed to unsafe moving and handling manoeuvres.

During our inspection we asked for a list of people who required hoisting and were most at risk, this list was not given to us despite a number of requests. We highlighted this serious risk to the provider during our inspection and as we were so concerned we followed this with a letter to the provider to request urgent action and made a referral to the local safeguarding team.

This meant the provider was still in breach of regulation 12 of the health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our last inspection we found people were not always provided with enough suitably qualified staff and the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At this inspection we found the staffing levels had improved and people we spoke with felt there was enough staff to assist them. Staff we spoke with also felt the increase in staff numbers had assisted them to give better care, one member of staff told us, "There are more staff so things are better." However some staff we spoke with told us there were differences in the way the first and ground floors worked and this caused some issues when they were asked to work on a different floor. As there were a large number of new staff these differences would not help staff as they learnt the processes and protocols of the service.

Another staff member told us that staff covering night duty did not always complete essential paperwork relating to the care they had given. This meant staff were not always aware of what care had been given to people on previous shifts and as result people may not receive the care they required.

Our observations during the inspection showed that staff still lacked supervision and some staff told us they still did not feel supported by the senior staff. The senior management were still not giving staff regular supervisions or appraisals. One member of staff who had been in the service two months told us they had received no supervision since starting in post despite being moved between floors, which had affected their morale adversely.

During our last inspection we found recruitment processes were unsafe as some people had been employed without suitable checks being undertaken. There was a lack of disclosure and barring service (DBS) checks prior to employment. These checks are to assist employers in making safer recruitment decisions. At this inspection we found that the DBS checks had been undertaken prior to employment of staff. However we also found following our inspection the provider had employed people in key positions without suitable references.

This meant the provider was still not effective in supporting staff or making safe decisions with regard to recruitment and was still in breach of regulation 18 of the health and social care act 2008 (regulated activities) Regulation 2014.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service we found the provider was in breach of Regulation 18 of the Care Quality Commission (registration) Regulations 2009 part 4. They failed to notify us of significant events in the service which had an effect of the people who lived in the home. During this inspection we found the provider still wasn't fulfilling their regulated duty of notifying us of these events.

The provider had failed to notify us of significant events in the service, for example we examined the care records of a person who had required treatment in hospital following a fall almost a month prior to this inspection. We also saw that people had developed grade 3 pressure ulcers. We had not been informed of these events. Prior to our inspection the local authority informed us they were undertaking a number of investigations related to safeguarding issues raised by health professionals visiting the home. Our records showed that the provider had also failed to notify us of these safeguarding investigations.

The provider has a statutory duty under Regulation 18 of the Care Quality Commission regulations to inform us of any injury to a person who lives in the home that requires treatment by a health professional and they must inform us of any abuse or allegation of abuse in relation to a person who lives in the home. As a regulator we would expect the provider to be open about events in the service with an ongoing plan to reduce adverse events that have a poor outcome for the people in their care. The lack of these notifications show an ongoing lack of openness and transparency in the service.

Our discussions with the provider highlighted that the management team were not aware of all the safeguarding issues being investigated by the local authority despite social workers coming into the home talking to staff and requesting care records. There was a lack of communication between staff and the management team this resulted internal investigations of key issues with regard to safeguarding not being undertaken. This meant people continued to be at risk of receiving inappropriate care.

This showed the provider was still in breach of Regulation 18 of the Care Quality Commission (registration) Regulations 2009 part 4

When we last inspected the service we found there were significant issues around the documentation of risk assessments, care plan and monitoring records for people who lived in the service. Records were not accurate, complete or contemporaneous and there was a lack of audit and analysis both at registered manager level and provider level. This resulted in poor outcomes for people and meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

During this inspection we found there had been little improvement in the way risk assessments and care plans were managed and audited. This continued to affect outcomes for people who lived at the service. We had been made aware by health professionals that one person had a pressure ulcer. We examined the person's care record and found information in the communication with health professionals section about the care needs related to the person's pressure ulcer. However this information had not been transferred into their tissue viability care plan and there was no record of the instructions of the health professionals

being carried out by staff providing support to the person. As a result the person's pressure ulcer had worsened. This lack of evaluation of essential care records to ensure they met the needs of people showed the provider lacked the clinical oversight of people's care needs

During this inspection we saw there was new documentation in place to assist the management team to undertake and analyse essential audits. However whilst the documentation was in place the actual audits required had either not taken place or were not completed properly.

There had been a provider audit tool put in place. The audit had been undertaken by the provider on the 1 and 8 May 2016. The audit tool required a walk around the service to undertake a visual inspection of the home to identify any infection control issues and health and safety issues and record a series of checks. However these checks did not include monitoring of moving and handling equipment and, repairs and servicing of equipment which meant the provider was not fully overseeing the health and safety aspects of essential equipment in used in the service.

One section of the audit tool which looked at issues such as falls, RIDDOR reports, pressure ulcers, nutrition, hospital and para medic attendances and safeguarding reports had a large amount essential information missing. For example the number of falls had been left blank. As the information was first collected on the 1 May 2016 this should have reflected the number of falls in April 2016, the information we acquired from accident books during this period was that there had been 13 falls. The safeguarding reports had a value of nil against it and there had been two safeguarding investigations during April 2016. This showed the provider still did not have the required oversight of the service to ensure people received the safe standard of care required.

We saw some incident reporting and analysis documentation in place. One completed document was meant to analyse falls and identify control measures. The document had been completed in February 2016 but the information about the number of falls individuals had suffered differed from the information we had collated following our inspection in April 2016. We had identified some individuals had suffered more falls than the information on the analysis had recorded.

The analysis recommended a number of control measures to be put in place including all future falls to be fully analysed using the incident reporting and analysis documentation introduced. A further written entry on the 11 May 2016 documented that this had not taken place, that the falls risk remained high and to review in one week. We could find no evidence that this review had taken place. We also saw a blank proforma for auditing of accidents and incidents in the service's audit file which had a date of issue of April 2016. This had not been completed and there had been no further audit or analysis of accidents and incidents.

Further examination of the incident reporting and analysis documentation completed for other incidents showed that on review of the documentation some essential control measures that had been recommended had not been put in place for some incidents. For example one incident involved management of one to one staffing for a person. The control measure which stated management to ensure that staff numbers accommodated the number of hours required for that person's one to one care had a hand written cross against it. A hand written note on the 11 May 2016 stated that not all control measures were in place and review in one week. We could see no further reviews and there was no further information to show if these issues had been addressed and the person had received the one to one care they required.

This meant that the management team were failing to ensure this person received the care they required and the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) regulations 2014.

When we last inspected the home there was a registered manager in post. It is a condition of the provider's registration to have a registered manager in post to manage the service. When we inspected the service on the 31 May 2016 the registered manager was no longer in post. There was team of consultants supporting the service and a Deputy Manager in post.

Staff we spoke with told us the management team were visible but there were times when there were too many managers in the building at once and as a result staff were unsure who was responsible for what. One staff member told us they were not feeling supported by the management team. Another member of staff told us staff didn't feel they could talk to the management team and there was a lack of openness with key staff working on the floor.

The deputy manager told us they met with one of the consultants on a regular basis, but there were no minutes or notes of these meetings to show what issues had been discussed. We asked if the management team met regularly to discuss their progress on the action plan they had implemented. We were told the consultants and provider did meet but no minutes were taken and there was a lack of feedback to staff on progress. This meant staff were not always aware of the changes taking place in the home and caused confusion amongst staff.

One member of staff told us that some members of staff didn't respect the seniors and managers and they had concerns about how particular groups of staff were managed. We asked for records of management of staff performances but none were produced. This meant that staff working in the service were not led and supported by the management team.

We discussed a number of issues relating to how care plans and daily records were managed with the management team and found there was a lack of communication over how long daily record sheets would be kept in people's files and where they were stored following removal from the files. We found that records we examined had daily records removed and archived on a weekly basis and this meant staff who had been off for a number of days would not be able to look back on aspects of care on their return to work. There was confusion in the management team as to where these archived records were kept. This meant there would be a lack of direction for staff who needed to update themselves on recent issues that had affected people in their care and could result in inappropriate care being given.