

Nestlings Care Ltd

# Woodhall House

## Inspection report

City Gate  
Gallowgate  
Newcastle Upon Tyne  
NE1 4PA

Date of inspection visit:  
06 December 2023

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05 April 2024

### Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Inspected but not rated**

Is the service responsive?

**Inspected but not rated**

Is the service well-led?

**Inspected but not rated**

# Summary of findings

## Overall summary

### About the service

Woodhall House is a children's home providing treatment of disease disorder or injury to up to three children. The service provides support to children and young people aged between 10 and 18 years with their emotional and mental health. At the time of our inspection there were 3 children using the service.

Ofsted are the lead regulator for Woodhall House as it is a children's home. The service is also registered with the Care Quality Commission for the regulated activity of treatment of disease, disorder or injury (TDDI).

### People's experience of the service and what we found:

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessment and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Children 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](http://www.cqc.org.uk)

### Rating at last inspection

CQC do not rate services that are defined as being a children's home and which are also registered with Ofsted.

### Why we inspected

The inspection was prompted in part due to concerns CQC received about medicines processes. A decision was made for us to inspect and examine those risks.

We completed a targeted inspection to examine those risks and looked at parts of the key questions; Safe, Responsive and Well Led.

We found medicines were stored safely within the home. Medicines were administered in a way that respected young people's preferences. However, improvements are required regarding the oversight of

medicines optimisation, incident reporting, the medicines policy and multi-agency working including working in partnership with families and carers.

You can see what action we have asked 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 Woodhall House on our website at [www.cqc.org.uk](http://www.cqc.org.uk).  
Enforcement [and Recommendations]

We have identified breaches in relation to:

HSCA 2008 (RA) Regulations 2014. Regulation 9(3)(a) Person centred care.

HSCA 2008 (RA) Regulations 2014. Regulation 17 (2)(a) Good governance.

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

We have made recommendations that the provider should;

- ☐ improve the oversight of medicines processes
- ☐ review processes to include multi-agency partners and parents and carers in care planning

#### Follow Up

We will meet with the provider following this report being published to discuss how they will make changes to the services provided. 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?

The service was safe.  
Details are in our safe findings below.

**Inspected but not rated**

### Is the service responsive?

The service was not always responsive.  
Details are in our responsive findings below.

**Inspected but not rated**

### Is the service well-led?

The service was not always well-led.  
Details are in our well-led findings below.

**Inspected but not rated**

# Woodhall House

## 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. CQC do not provide a rating for the TDDI that is provided from this location.

#### Inspection team

The inspection team consisted of 1 CQC children's services inspector and 1 CQC medicines inspector.

#### Service and service type

Children's Home

Woodhall House is a children's home where the children receive accommodation and care which is regulated by Ofsted. CQC regulate the treatment of disease, disorder or injury (TDDI) provided at Woodhall House.

#### 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 there was a registered manager in post.

#### Notice of inspection

The inspection was unannounced.

#### What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

#### During the inspection

During the inspection we spoke with children who lived at Woodhall House and their relatives. We also spoke to staff members, including managers as well as members of the senior leadership team, prescribing doctor, mental health nurse, commissioners and members of the external multi-disciplinary team. We observed a carer who was administering medicines. We reviewed a range of information both during and following the inspection. This included important information such as children's care records, risk assessments, policies and procedures and minutes of meetings.

The provider has a nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

We found that all staff had received medication training however there were some areas that the provider could make improvements such as infection control processes and accurate documentation.

### Using medicines safely

People were supported to receive their medicines safely.

- ☐ The provider used medication administration record (MAR) charts produced by the service to record the administration of medicines. All children's allergies were recorded on their MAR chart.
- ☐ We observed staff ensuring that young people's privacy and dignity were considered when administering medicines.
- ☐ All staff had received medication training and completed medication competency training.
- ☐ There were no facilities for handwashing or cleaning equipment where administration and stock checks of medicines were taking place. This meant that the equipment used was not cleaned between use leading to potential cross contamination.
- ☐ Each young person had a physical health plan in place which documented the monitoring required. This was being routinely recorded except for one child who had not had a full measurement of physical health since February 2023. Reasons and attempts to deliver this were not clear in the child's records.
- ☐ We saw that the controlled drugs policy was not being followed and that the controlled drugs register was signed and witnessed 2 hours before the medicine was administered by a different member of staff. This meant that staff were not always giving medication according to the provider's policy and the lines of accountability were not always accurate.

# Is the service responsive?

## Our findings

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

We have identified a breach of regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

Children were supported as individuals, in line with their needs and preferences for day to day life. However, they were not always supported to maintain relationships as part of their healthcare planning.

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

- ☐ We had concerns about how some young people's families, including health professionals and people with parental responsibility, were included in the care and treatment planning. This includes collaborative working with wider agencies that support children. For example, external professionals and family members were not invited to multi-disciplinary meetings, this includes care planning approach meetings and not being updated of important alterations such as medication changes. This means that important external parties did not feel well informed about care and care planning and it limited the opportunities for holistic care and successful transition planning.

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

- ☐ Staff listened to concerns raised by children and responded appropriately. Children valued the regular meetings and used other opportunities to feedback when they had concerns between those meetings. This meant that children's views were listened to and acted upon.

# 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.

The provider's systems did not always effectively monitor the quality of care provided to drive improvements.

The provider recognised these failings at the time of the inspection and was working proactively to address the issues.

The failure to ensure robust governance for medicines optimisation was in breach of regulation 17(2)(a) HSCA RA Regulations 2014 Good Governance.

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

- ☐ Inspectors spoke to children during the inspection and the children knew what medication they took and why and what the side effects were.
- ☐ The provider's medicine policy states that only the doctor or the mental health nurse (RMN) can make changes to the MAR chart for administration of medicines. We found that handwritten changes had been made to numerous MAR sheets and changes were unsigned. Some entries were unclear as to the directions for administration. The code 'O' for 'other' was used when young people did not receive their medicine but no explanation was given. Some special requirements were missing from the MAR chart such as 'to be taken with food'. In one case there was a duplicate entry for the same medicine. In another case there was no directions included for the administration of a nasal spray. This is not in line with the provider's medicine policy.
- ☐ The medicine policy did not address the necessary cleaning procedure for equipment used in the handling of medicines.
- ☐ It was not always clear as to why medicines were given 'when required' (PRN). Protocols were not always in place. It was unclear what procedures should be followed before the administration of the medicine and the monitoring needed after administration. Documentation in the young persons 'log-book' was not clear as to the reason for administration and what other de-escalation techniques had been used before the administration had taken place.
- ☐ The medicine policy states that drugs must be appropriately labelled with name, drug name, dosage, dates and time of administration when a young person is temporarily absent. Staff did not follow this policy and there was confusion about how this was to be recorded on the MAR charts.
- ☐ The medicine policy states that during appointments with healthcare professionals outside of the home, the young person or care worker would have a copy of current medication with them. This was not being followed which limits timely access to multi-agency assessments and treatments for children.
- ☐ The roles and responsibilities of the prescribing doctor and the procedure for medicines reconciliation were not documented in the medicine policy.

- There was no reference to temperature monitoring of medication within the medicine policy. We found that the maximum fridge temperature reading was 24.6 degrees Celsius, and the minimum was 1.7 degrees Celsius. There were no medicines stored in the fridge at the time of the inspection.
- The procedure for administration of home medicines was explicit for staff to be able to follow. However this was not dated which meant it was unclear whether there had been an annual review in line with the medicines policy. In addition, authorisations were not in place from the GP.
- Not all medicines were being stocked in line with the provider's policy.
- Waste medicines were not always returned to the pharmacy and disposed of in line with the policy.

### Continuous learning and improving care

The provider had not consistently created a learning culture at the service which meant people's care did not always improve.

- The provider's medicines policy states that medicine audits must be completed by a mental health nurse and registered manager. However, we found that support staff had completed the audits and errors had not been identified. This practice had continued despite it having been highlighted in the internal medicines management committee meeting report in October 2023.
- Staff we spoke to told us that they felt well supported by the management team at Woodhall House. They felt that they could raise concerns with the registered manager and that this supported them in improving care for children. Inspectors examined evidence that staff had accessed mandatory training to support them in their roles.
- Learning from previous inspections was embedded in practice at Woodhall House.
- Most of the provider policies needed reviewing and were out of date according to their own timelines for review. The provider had plans to complete this.

### Working in partnership with others

- Documentation relating to the delivery of TDDI was not always easy to locate because different parts of the children's records are stored in different places. The provider acknowledged this challenge and shared plans to move to a fully electronic record keeping system to address this issue. The current record keeping system made it difficult to understand how holistic care is being delivered.

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
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider has failed to carry out, collaboratively with the relevant person an assessment of the needs and preferences for care and treatment of the service user.</p> <p>Regulation 9 Good Governance (2)(a)</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider has failed to ensure there were robust processes for medicines optimisation</p> <p>Regulation 17 Person-Centred Care (2)(a)</p>