Todaywise Limited

Woodheyes

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodheyes is a residential care home providing personal care to older people with dementia and sensory needs at the time of inspection. The service can support up to 38 people. At the time of our inspection there were 33 people living at the service.

Care was delivered over two floors in one building, with lift access.

People's experience of using this service and what we found
At the time of our inspection there was an outbreak of COVID-19 at the service. We found multiple failings in the provider's infection prevention systems and processes which increased the risk of the transmission of COVID-19, and placed people at significant risk of harm.

There were not enough staff to monitor people who posed risks to others from acquiring COVID-19, and opportunities to provide staff with the appropriate training in relation to COVID-19 were missed. The service did not support people who required oxygen therapy in a safe way. Staff did not have all the skills and knowledge needed to provide safe care.

Whilst the service was visibly clean there were not enough housekeeping staff to ensure the enhanced cleaning required during an outbreak of COVID-19.

People's care plans and risk assessments had not been reviewed following the outbreak of COVID-19. The service was not safe to support people who required specific therapies to maintain their health specifically from the complications arising from contracting COVID-19.
People were not protected from avoidable harm, and their privacy, dignity, needs and preferences were not always met.

There had been inconsistent management of the service both prior to and following the COVID-19 outbreak. This was further compounded by the registered manager and deputy manager contracting COVID-19.
Quality assurance systems and processes had lapsed which prevented the concerns we found during the inspection being identified.

People's medicines were managed safely.

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 10 July 2020).

Why we inspected

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about an outbreak of COVID-19 at the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with infection prevention systems and processes, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, caring and 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 Woodheyes 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection control, safe care and treatment, safeguarding and the services governance arrangements 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
The overall rating for this service is 'Inadequate' and the service is therefore 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 rating, 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.

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.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Woodheyes

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.

Service and service type
Woodheyes is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used this information to plan our inspection.

During the inspection
We could not meet with people to discuss their views of the service due to the risks associated with an

outbreak of COVID-19 at the time of our inspection. We spoke with seven members of staff including the registered manager, care workers, laundry, maintenance and domestic staff.

We reviewed a range of records. This included people's care records and a sample of medicines records. 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.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection; Staffing; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not protected from the risk of acquiring infectious diseases including COVID-19. At the time of the inspection, there was an outbreak of COVID-19 in the service affecting 23 people and 22 staff.
- We found multiple failings in the provider's infection prevention systems and processes, including but not limited to; people with COVID-19 not isolating in their bedrooms; staff not following government guidance relating to the safe use of personal protective equipment (PPE); unsafe laundry management and disposal of PPE; not enough cleaning staff and no evidence of enhanced or more frequent cleaning to include high touch areas such as door handles and light switches.
- We were not assured the correct type of cleaning products were in use on the day of the inspection. The registered manager and a member of the housekeeping team showed us the product used for all cleaning of surfaces and furnishings in the service. This product alone would not ensure the environment was safely disinfected.
- Staff did not always have ready access to the appropriate Personal Protective Equipment (PPE). Not all bedrooms had PPE stations outside them including those with confirmed COVID-19. and we observed staff entering and exiting these bedrooms without changing their PPE. Furthermore, we observed staff not wearing PPE to take their breaks in the main dining area alongside people living at the service.
- There was a risk people with COVID-19 would not isolate for the required 14 days as there was no readily accessible information for staff. For example, on people's bedroom doors to identify their isolation end dates. Furthermore, the provider confirmed that people's isolation period in place was 10 days and not 14 days which is the required isolation period for people who display symptoms of or have contracted COVID-19. This contradicts the providers own policy which states a 14 day isolation period must be adhered to.
- There were no temperature checks, or screening of COVID-19 symptoms for visitors to the service. This meant there was a risk visitors with symptoms of COVID-19 could enter the service. On the day of the inspection staff did not ensure the inspection team had their temperature taken. This is in direct conflict with the providers own policy.
- There were not enough cleaning staff to undertake more frequent cleaning of high touch areas and deep cleaning to reduce the risk of cross infection of COVID-19. On the second day of inspection, one floor had not been cleaned by 3pm. Whilst the maintenance staff were undertaking cleaning of high touch areas to support the housekeeper, they confirmed they had not received COVID-19 training. Training should include safe use of PPE, and the cleaning processes for care homes with possible or confirmed cases of COVID-19 in line with government guidance.

- People's risks were not always safely managed. Appropriate systems and processes, together with properly trained staff, were not in place to ensure safe management of oxygen therapy when required by

people using the service. The inspection team identified concerns for one person who required urgent medical attention that were subsequently admitted to hospital.
● People's COVID-19 risk assessments had not been updated following the COVID-19 outbreak in the service. This meant people's individual risks had not been considered and staff did not have the guidance they needed to keep people safe. For example, did not know how to support people to isolate effectively.
● These shortfalls identified meant there was an increased risk of further transmission of COVID-19 in the service that could lead to more people and staff acquiring the infection.

Staffing and recruitment
● There were not enough care staff to support people to isolate effectively. On both days of inspection, we observed people with COVID-19 in communal areas, mixing with people that did not have COVID-19.
● The registered manager confirmed they did not use a dependency tool to assess the number of staff required to keep people safe. No review of staffing levels following the outbreak of COVID-19 had been undertaken to ensure there were enough staff to monitor people safely in response to the risks identified during the inspection.

Learning lessons when things go wrong
● Lessons were not learned. Despite national guidance in place to both reduce the risk or manage an outbreak of COVID-19 the provider and registered manager did not ensure this was followed. This meant there was an increased risk of an outbreak or further transmission of COVID-19 in the service.

The provider failed to ensure people were protected from the risk of infection; systems were either not in place or robust enough to ensure infection prevention measures were effectively managed; insufficient numbers of staff were deployed to keep people safe; serious risks to people's health were not monitored safely, and lessons not learnt. This placed people at risk of harm. These failures are a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff received safeguarding training and were aware of the signs of abuse and what action they should take in response to any concerns they held for people's safety.
● The registered manager understood the importance of their responsibility to act when safeguarding concerns were identified and report them to the relevant agencies including the local authority and CQC.

Using medicines safely
● Medicines were managed safely. We saw medicine administration record (MAR) charts were in place, these showed people received their medicines as prescribed.
● When people were prescribed medicines 'as and when required' (PRN), the correct protocols were in place to inform staff when to administer these medicines. Records confirmed when and why they had administered PRN medicines.
● One staff member told us, "We, [referring to staff who administer medicines] have received training and our competence is regularly checked by the manager. If we have any concerns, we report them straight away".

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to requires improvement. This meant people were not always supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had failed to ensure people's individual risks and needs were met during the outbreak of COVID-19 at the service.
- There were not enough staff to meet people's individual needs and to provide safe and compassionate care, while respecting people's diverse needs.
- Staff had not received COVID-19 training which meant they had not been equipped with the skills and knowledge they needed, to ensure people were supported during the COVID-19 outbreak.
- There was a delay in seeking medical attention for one person who was found to be seriously ill.

Respecting and promoting people's privacy, dignity and independence;
Supporting people to express their views and be involved in making decisions about their care

- People's privacy and dignity was not always respected and promoted. We observed one person attempt to enter the bedroom of another person isolating, a member of the inspection team prevented this from happening.
- Some people did not understand the need to isolate in their rooms during the COVID-19 outbreak at the service. The provider had not considered how they could support these people to maintain their independence whilst maintaining their safety.
- Staff did not always refer to people by their name and used derogatory language which showed a lack of understanding of people's needs. One staff member, who was talking to another staff member said, "Number one [referring to the bedroom number of the person] is being awkward again."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- There were multiple failings in the provider's response to the COVID-19 outbreak. Infection control and environmental audits had not been reviewed following the outbreak. This meant the provider had not identified the concerns found during our inspection. The provider failed to identify non-compliance with government guidance for working safely in care homes.
- The provider failed to implement effective management cover when both the registered manager and deputy were absent from their duties during the outbreak at the service. The provider told us, they offered 'remote support' to the service due to the risks of entering the service themselves.
- The service did not always follow its own risk assessments and policies. For example, temperature checks were not undertaken for visitors to the service. There was no evidence that the provider had oversight of its own policies.
- People had limited opportunities to engage in activities of interest. This had been further impacted by the outbreak of COVID-19 at the service.
- The service had failed to identify people's individual needs and where they might need additional, personalised support to isolate effectively during the outbreak of COVID-19 at the service.

Working in partnership with others

- The registered manager had declined COVID-19 training offered by partner agencies to equip staff with the necessary skills to support people safely during the pandemic. Furthermore, the service had not provided any in-house training. This meant staff did not have adequate skills or knowledge to support people safely.

Systems and processes were either not in place or robust enough to demonstrate the regulatory activity was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives were kept informed about the outbreak of COVID-19.
- Annual surveys provided relatives, staff and professionals with opportunity to give feedback about the

service. There was positive feedback from the last survey which was carried out prior to the COVID-19 pandemic.

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 management team were aware of the duty of candour, which sets out how providers should explain and apologise when things have gone wrong with people's care.

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 The provider failed to ensure people were protected from the risk of infection; systems were either not in place or robust enough to ensure infection prevention measures were effectively managed; insufficient numbers of staff were deployed to keep people safe; serious risks to people's health were not monitored safely, and lessons not learnt. This placed people at risk of harm.

The enforcement action we took:

Notice of Decsion to impose conditions on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were in place or robust to demonstrate the service was effectively and safely managed.

The enforcement action we took:

Notice of decision to impose conditions on the provider.