Millsted Care Ltd

# Woodcroft

## Inspection report

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Reigate
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## Ratings

| Overall rating for this service | Requires Improvement |
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| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Woodcroft is a residential care home providing personal care and accommodation to six people with learning disabilities at the time of the inspection. Five of these people lived at Woodcroft and a sixth person who had regular short stays at the service. The service can support up to six people in one building.

People's experience of using this service and what we found
People were not always safe at Woodcroft. Safeguarding concerns were not always shared with the local authority. We witnessed unsafe moving and handling taking place and risks to people were not always effectively managed. Some infection prevention and control guidance provided by Public Health England were not always followed.

Staff did not always receive the training they required to enable them to support people safely. There were people who were having their liberty restricted at Woodcroft who had not had the appropriate mental capacity assessments, best interest decisions or Deprivation of Liberty Safeguards (DoLS) applied for.

We saw some positive caring interactions between staff and people living at the service, however people were not always treated with respect or dignity. At times people were very limited in the choices they could make for themselves and access to activities for some people was limited.

People had individual communication plans in place and staff had a good understanding of how to communicate with them effectively. However, support plans were missing some important information. One person's records showed that they had a diagnosis of dementia, however how this may alter their support needs was not mentioned in their care and support plans.

The provider's quality monitoring processes were not effective at identifying and addressing shortfalls. Health and safety audits took place however there was not an effective system to ensure actions were completed as a result. Audits did not take place to ensure people were receiving their medicines safely. There had been one notifiable incident involving a serious injury to a service user which had not been reported to CQC when necessary.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, 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 assessments and judgements about services providing support to people with a learning disability and/or autistic people

Right support:
• People's support needs were not always correctly recorded to ensure they received the most appropriate care. This included information around risks to people and how to maintain their skin integrity.
Right care:
• Care practices did not always uphold or respect people's dignity. We saw examples of punitive responses recorded to address people and observed a lack of respect for people's home.
Right culture:
• The culture in the service was impacting negatively on people's experiences and care support. There was a lack of effective leadership and governance at the service. Systems in place were not being reviewed appropriately to promote positive changes for people.

The provider has acknowledged that improvements needed to be made to people's care and have agreed to work in conjunction with the local authority and other professionals to improve people's experience of living at the service.

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 on 9 November 2018).

Why we inspected
The inspection was prompted in part due to concerns received regarding infection control, safeguarding and staffing. A decision was made for us to inspect and examine those risks.

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 COVID-19 and other infection outbreaks effectively.

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 safe care and treatment, consent for support, good governance, and notification of incidents.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 caring?**

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

# Woodcroft

**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 who visited the service and an assistant inspector who supported the inspection remotely.

Service and service type
Woodcroft 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 sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service about their experience of the care provided. We spoke with four members of staff including the registered manager, operations manager and support workers.

We reviewed a range of records. This included two people's care records and multiple 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 training data, people's support notes and quality assurance records. We spoke with a further 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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Personal Emergency Evacuation Plans (PEEPs) had been recorded for people living at the service, however some of these advised staff to support individuals to remain in their bedrooms and wait for emergency services in the event of a fire instead of evacuating the building. This 'stay put' approach is not advised in care homes by emergency services.
- One person's PEEP included the following advice to staff, 'if [person] is in his bedroom at the time of the emergency for his own safety his door must be closed and locked with him in the room so that he is isolated from the danger.' This could place the person in further danger in an emergency. These concerns about people's PEEPs were raised with the provider during the inspection and the provider reviewed them with support from the fire service.
- Risks about people's skin integrity had not been effectively mitigated. Health professionals had advised that one person required turning every two to three hours due to being at risk of pressure sores. The person's daily notes had no record of regular turning having taken place despite this advice being recorded by a member of staff.
- People were not always supported to move safely. We witnessed a member of staff using an unsafe moving and handling technique when supporting someone to transfer from their wheelchair into an armchair. A visiting professional told us they had witnessed a similar unsafe moving and handling technique when they had recently visited the service.
- National guidance about people isolating when they entered or re-entered the care home or about people being tested for COVID-19 regularly was not always followed. Risks had been considered, assessed and mitigated but the recording around the decision-making in people's best interest and weighing risks needed to be more clearly documented.

The provider had failed to assess and mitigate the risks to people's health, safety and welfare. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the

premises.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Safeguarding concerns at the service had not always been reported to the local authority by the registered manager or the provider. The local authority informed us of two recent safeguarding concerns involving care at the service which had been reported to them by a third party.
● One person we spoke to told us that they felt safe living at Woodcroft. Staff we spoke to understood what safeguarding meant and that they would need to report concerns to their manager, however they were unsure about how to report concerns directly to the local authority should they need to do so.
● The provider had a whistleblowing procedure in place for staff to raise concerns, however this did not contain contact details for outside agencies such as the local authority and CQC.
● Systems in place to record and report accidents were not always effective at ensuring lessons were learnt. An example of this was a person had recently developed a pressure sore following the use of a pressure relieving mattress which had not been functioning correctly for approximately two weeks. There was no written evidence of any analysis or learning from this.
● The registered manager informed us that team meetings took place regularly where learning was shared and staff we spoke to confirmed this is the case.

Staffing and recruitment
● There were some gaps in records of staff employment history, this could impact safe recruitment decisions being made. Checks on staff suitability were undertaken on all new staff prior to their appointment. Identity checks, criminal records check, and appropriate references had been obtained on newly appointed staff.
●There were enough staff to maintain safe staffing levels and staff were available when people needed them. The registered manager told us that staffing numbers fluctuated depending on the needs of the people who were at the service. Rotas that we looked at supported this.

Using medicines safely
● Individual records were in place detailing people's needs for using medicines safely, we observed medicines were administered safely and stored appropriately in a locked cupboard. A member of staff told us "the shift leader checks the temperature [of the medicines cupboard] every day".

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 good. At this inspection this key question has now deteriorated to requires improvement. 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.

- Some people were having their liberty restricted without the correct processes having taken place. For instance, some people who were noted to lack capacity to make some complex decisions were restricted from being able to leave the service without support, but the provider had not carried out a mental capacity assessment or recorded a best interests decision in relation to this.
- The provider had not always applied to the local authority for a relevant DoLS for all people who were having their liberty restricted. This included restrictions such as not being able to leave the service without staff and having bed rails in place.
- One person had access to their preferred activity in the community restricted depending upon their behaviour. The registered manager told us the person had given their consent for this however no mental capacity assessment was recorded to show this person was able to understand the consequences of this agreement.

The provider had failed to act in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had been assessed under the MCA and appropriate applications made to authorise restrictions on their liberty.

Staff support: induction, training, skills and experience
● Staff had not always received appropriate training to support their skills and knowledge to enable them to carry out their duties. For example, training data provided to CQC showed that several staff had not received training in essential areas such as safeguarding and fire safety.
● New staff had to complete an induction checklist when starting work at the service. We looked at the induction of one member of staff who had started five weeks before the inspection. They had completed the basic induction requirements within the first week but had not yet competed any of the training that formed the rest of their induction. Systems to oversee staff training were not effective and we have reported on this in Well-led.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-assessments of people's care needs were completed before they moved into the service. The registered manager told us normally they would visit people to complete these however during the COVID-19 pandemic these assessments took place via video calls.
● The registered manager told us that they kept up to date with guidance and changes in the sector through meetings with other providers and training.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to maintain a healthy and varied diet. We heard staff offering healthy snacks such as fruit and asking people what they would like to have for lunch.
● We observed that people were supported to eat foods in line with recommendations from a speech and language therapist (SALT). For instance, one person who was at risk of choking was given their lunch in the required consistency and staff were close on hand in case they needed support whilst eating.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked alongside health and social community services such as GPs, dentists and occupational therapists to support people to maintain their physical health.
● People had personalised health passports which were used to share key information about their health care needs should they need to be admitted to hospital.
● The provider had a positive behaviour support lead who worked with other agencies to help work with the staff team to support people with behaviours which could be challenging.

Adapting service, design, decoration to meet people's needs
● One person's room had very few signs of personalisation. The registered manager told us that this was because pictures on the wall had been broken by another person and assured us that support was being provided to replace these.
● One bedroom was used for regular respite stays. There was mould on one of the walls and the room appeared to be in need of redecoration. The operations manager told us that this had not yet been completed due to difficulties getting decorators to come to the service during the COVID-19 Pandemic.
● Woodcroft is a bungalow which provides level access throughout. There were physical adaptations in place for people with restricted mobility including a disabled access bath.

Requires Improvement

# Is the service caring?

## Our findings

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

● People were not always treated with respect. We observed that people were asked to leave their dining room table in the afternoon to enable staff to use this for the shift handover meeting.

● We heard staff talking about people in a way that was not respectful. When referring to two people who were in the room one member of staff said to another, "[person] and [person] are being very weird today."

● We witnessed some positive caring interactions between staff and people. When one person was unwell staff supported them to get to their bedroom and stayed with them to monitor their wellbeing.

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

● Staff did not always respect people's dignity. When someone was using the toilet, we observed the registered manager enter the bathroom without knocking first.

● People were sometimes restricted from making simple choices independently. When one person asked for crisps a member of staff informed them that they were not allowed crisps due to health reasons and other people at Woodcroft having a risk of choking. This was later discussed with the registered manager who said that people were allowed crisps if they wanted them.

● We observed people being offered a choice of activities to do with support from staff. These included walking in the garden, playing board games and drawing. When somebody declined these activities they were offered support to put on a film of their choice instead.

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The provider used digital record keeping systems for the management of care plans and daily records. Managers and staff consistently reported that internet connectivity within the service was poor and that online records were often unavailable. This impacted on staffs' ability to access important information as there were not always hard copies available to refer to.
- Woodcroft supports some older adults, however not all of these people had records of the support that they may prefer at the end of life. One person had an advanced care plan from 2017 that noted the manager at the time would make decisions on their behalf. This manager no longer worked at the service.
- People's care plans were detailed and daily records had been completed detailing the care and support people had received and activities they had engaged with.

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

- Activities recorded for people were not always meaningful. Restrictions due to COVID-19 made it more difficult for staff to provide activities however people's records showed there were days when they had engaged in no activities and on other days there was only one very basic activity recorded such as 'having a nap, watching TV.' There was no explanation for this recorded in people's care notes.
- We observed that if people wanted to go for a walk they did not leave Woodcroft and were supported to briefly walk around the garden.
- People were encouraged to attend activities such as aromatherapy and support groups. At the time of the inspection access to these was limited because of the COVID-19 pandemic.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had detailed communication plans in place to help staff to understand them. These included Makaton signs and frequently used words and phrases that individuals may use to help them to communicate their needs.
- Staff had a clear understanding of people's communication needs and had developed methods to communicate with people about their support. A member of staff told us about supporting one person to eat who did not communicate verbally. They said, "we tap the spoon on her lips, so she knows we are going to feed her."

Improving care quality in response to complaints or concerns

- People had accessible information in their rooms detailing how to make a complaint.
- There was a complaints procedure in place. The registered manager told us, "We have a complaints procedure. We haven't got a logbook now. We tell everyone the procedure and how they would go about recording it." The registered manager told us there had been no recent complaints but did not put a timeframe on this.

Requires Improvement

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider and registered manager did not have sufficient oversight of the service. Governance systems were not effective, with gaps in auditing and monitoring. The concerns identified throughout the inspection process had not been highlighted or addressed through the provider's auditing and monitoring process.
- The registered manager lacked oversight of staff skills, knowledge and training. Staff training records showed gaps in training for fire safety, safeguarding and food hygiene. There was not a robust plan in place to rectify this.
- Staff did not always receive consistent guidance from management. The operations manager told us that people were not allowed to eat crisps, but the registered manager told us this was not the case. The operations manager told us that staff had been asked not to use a hoist that was awaiting inspection but the registered manager told us that they did use the hoist as there was not an alternative available to safely support people.
- The fire risk assessment for the building was not suitable. It made reference to annual portable appliance testing (PAT testing) being carried out in all rooms to reduce the risk of a fire but this had not been completed.

The provider had failed to implement effective systems and processes to assess and monitor the service. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Incidents had not always been reported to CQC when necessary. One person sustained an injury which should have been reported to CQC but this was not done by the provider. This meant we were unable to check the provider had taken appropriate action in response to this incident.

This failure to notify CQC of a significant incident was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

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; Working in partnership with others

- The provider understood their duty of candour and appropriately informed people's representatives of

any concerns relating to their care.
● People had access to healthcare and other professionals such as GP's, community nurses and advocates.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The manager told us satisfaction surveys had been distributed recently to people's families but that no feedback had been provided. No further attempts had been made to contact relatives and seek their feedback.
● Staff told us the registered manager was approachable and supportive. One member of staff told us "[registered manager] listens, shows you and teaches you. You can contact her at any time."
● Residents' meetings were taking place regularly. People were asked for their views about the menu and activities they would like to try.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Statutory notification had not been sent to CQC for notifiable events that had happened at the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The service was not always working within the principles of the Mental Capacity Act 2005 (MCA). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people's health, safety and welfare had not been appropriately assessed and mitigated. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to implement effective systems and processes to assess and monitor the service. |