Woodcote Hall Limited

# Woodcote Hall

## Inspection report

Woodcote
Newport
Shropshire
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Tel: 01952691383

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20 April 2021
26 April 2021

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## Ratings

| Overall rating for this service | Inspected but not rated |
|---|---|

| | |
|---|---|
| Is the service safe? | **Inspected but not rated** |
| Is the service effective? | **Inspected but not rated** |
| Is the service well-led? | **Inspected but not rated** |

# Summary of findings

## Overall summary

About the service
Woodcote Hall is a residential care home providing personal and nursing care to 47 people at the time of our inspection. The service can support up to 56 people over the age of 18 years.

Woodcote Hall is a large building set in a rural location. The home has mainly single rooms, but a number of shared rooms are available. The home supports a high number of people living with dementia and mental health conditions.

People's experience of using this service and what we found
People were not kept safe from the risk of cross infection. The risks associated with people's care were not always assessed or monitored. The deployment of staff compromised people's safety at times.

People 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. However, the systems in the home were not used effectively and so did not support this practice.

People's care files often had out of date information which made it difficult to see their current care needs. Some people were kept waiting for their meals. Not all staff completed their required training.

The oversight of the provider's policies and systems continued to need improvement. Staff did not always complete their responsibilities fully but this was not identified by the leadership and management at the home. The provider continued to fail to make sure required improvements were made and sustained at the home.

The provider had systems in place to review accidents and incidents. People received their medicines when they needed them. Checks were completed on potential new staff to make sure they were suitable to work with people living at the home.

Staff knew the people who lived at Woodcote Hall and many had worked there for a number of years. People were comfortable and settled around staff, with many enjoying the communal areas of the home.

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

Rating at last inspection
We completed a focused inspection on 30/07/2020 where we just looked at the key questions of safe and well-led. This report was published on 2/09/2020.

Why we inspected
This inspection was prompted due to concerns received about people's safety and the culture within the

home. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We 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.

We have found evidence the provider needs to make improvements. Please see the safe, effective 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 Woodcote Hall on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the management of risk, consent and the quality and governance of the service at this inspection.

You can see what action we have asked the provider to take at the end of this full 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?**<br>The service was not always safe.<br>Details are in our safe findings below. | **Inspected but not rated** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Inspected but not rated** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inspected but not rated** |

# Woodcote Hall

**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 completed by three inspectors on our first day and two inspectors on our second day.

Service and service type
Woodcote Hall 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. However, we gave short notice of the inspection from outside the home. We wanted to give notice due to the risks associated with Covid-19. We needed to know of the Covid-19 status in the home and discuss the infection, prevention and control measures in place prior to us entering the home.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we ask 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 reviewed information we had received about the service since the last inspection. We received feedback from the local authority, Healthwatch and other professionals who work with the service. We used all of this information to plan our inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with twelve members of staff including care staff, the activity co-ordinator, senior carers, domestic assistants, the deputy manager and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records, and multiple records relating to consent, medication and risk. We looked at three 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
The registered manager gave us contact details for relatives and we spoke with five relatives by telephone. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inspected but not rated

# Is the service safe?

## Our findings

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

The purpose of this inspection was to check concerns we had about risk management. We will rate the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

● Risks associated with people's care were not always monitored or recorded. We saw some people walking around the home in just their socks. Some but not all wore 'gripped' socks, which placed them at risk of slips or falls especially as most of the flooring throughout the home was not carpeted. The registered manager told us this was people's choice. However, this risk had not been assessed to ensure people were kept safe, including those who would not have the capacity to make this decision.

● Some people did not sit at the dining tables for their meals and chose to sit in their armchairs. Suitable tables were not used to facilitate this and we saw some people had their meals on low coffee tables. The registered manager told us this was people's choice, however no risk assessments had been completed to consider and mitigate potential risks to people.

● People's fluid intake was not always monitored. Staff recorded what people drank, but there was no evidence to show these records had been reviewed or monitored. It was also not clear how much people should drink throughout the day. If people do not drink enough fluids it can impact on their skin integrity and could be a contributing factor to an increase in falls.

● People's bowel movements were not always monitored. Where people needed staff to monitor this we found action had not always been taken. One person had two five day gaps where they had not had their bowels open. Staff could not find any records to show this had been monitored and action taken if needed. This placed people at risk of constipation.

● Risks to people were not always recognised. We found used plastic razors, a charger, shaving foam and prescribed creams left in a communal bathroom cupboard. We also found dirty urine bottles left in a bathroom, which were there for the two days of our inspection. The registered manager told us they completed a daily walkaround of the home, however these risks had not been identified.

● On the second day of our inspection people were placed at risk of avoidable harm due to poor deployment of staff. For a period of approximately 40 minutes, there was just one staff member in the main communal dining/living area. During this time two people were arguing loudly, one person was calling for help and asking to be moved, another person was asking for assistance, one person had their feet in their spilt drink. We also saw the food warmer lamps had been left switched on. The area and surface beneath the lamps were hot to touch and people were walking around this area. The registered manager told us they were short by two staff but had not been aware there had only been one staff member in this communal area.

Preventing and controlling infection

● People were not always protected against the risk of cross infection. Staff did not clean moving and handling equipment after use to help minimise the risk of cross infection. Equipment which is used with different people must be cleaned in accordance with current COVID-19 national guidance.

● Not all staff practiced good hand hygiene or wore PPE in line with current COVID-19 national guidance or the provider's own policies. We saw staff touching their masks or having contact with different people without washing or sanitising their hands. This places people at risk of cross infection.
● The provider had systems in place to prevent the risk of infection, especially in regard to the risk of COVID-19 transmission. However, the registered manager had failed to ensure these systems were safely followed by all staff. This included no infection control lead for the home, staff wearing jewellery and faeces smeared commode pans being left in a bath and one person's bedroom.

People were placed at risk of avoidable harm due to poor risk management and infection control practices needing improvement. 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 the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff. Visitors were screened for symptoms of Covid-19 before entering the home.
● 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 registered manager to resources to develop their approach.

Staffing and recruitment
● People's needs were mostly responded to in a timely manner. There were times throughout the inspection, such as mealtimes, when the deployment of staff needed improvement to ensure people received supervision at all times. The registered manager told us they believed they had enough staff but would review this for key times of the day.
● The provider followed safe recruitment practices to ensure staff were suitable to work with people at the home. Staff recruitment records were up to date and the required employment and identity checks had been completed prior to new staff starting work at the home.

Using medicines safely
● People's prescribed topical creams were not always kept secure. We found one person's prescribed creams left on a table in the bedroom, with the bedroom door left open. We also found a box in the care office on top of a cupboard which contained another person's prescribed creams. This person was deceased but staff had not disposed of the medicine. These medicines were dealt with during our inspection.
● People were supported by staff to take their medicines when they needed them. We saw staff supported people safely to take their medicine and completed the required records accurately.

Systems and processes to safeguard people from the risk of abuse
● Staff and managers understood their responsibilities to safeguard people from harm. However, we found this understanding was not always applied in their practice. They did not always recognise or report potential hazards or dangerous situations such as the food warmer lamps or people eating meals on low tables.
● The provider had systems in place to respond to and report concerns about people's safety. The registered manager reported safeguarding concerns to the local authority and to us as required.
● One relative told us they were happy their family member was safe living at the home. They said, "I've never been concerned about their safety."

Learning lessons when things go wrong

● We saw evidence of actions taken in response to accidents and incidents. However, it was not always clear where any lessons had or could have been learnt from these incidents.
● The provider had oversight of all accidents and incidents and the registered manager told us the provider monitored the actions they had taken.

Inspected but not rated

# 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.

The purpose of this inspection was to check concerns we had about people's health needs being met and how they were supported to give consent. We will rate the key question at the next comprehensive inspection of the service.

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.

- The provider had not ensured people's records around capacity were in line with the MCA Code of Practice.
- We looked at eight people's capacity assessment and best interest records. These covered decisions relating to COVID-19 testing and the COVID-19 vaccination. All these records read the same because they had been photocopied and reused for each person. This does not demonstrate a person-centred approach in regards to the principles of the MCA and does not protect people's human rights.
- Although staff could demonstrate they had a good understanding of the MCA and DoLS principles, they could not always tell us who had a DoLS in place and the reason for it. Staff must be aware of any person who is subject to a DoLS because of the importance of meeting any conditions attached to those authorisations and the impact this could have on people's human rights.
- One person's capacity assessment stated they had a health condition which they did not have. A best interest decision had been made on their behalf for them to have the COVID-19 vaccination. This decision had been based, in part, on the fact they had received a flu vaccination previously, however this person had refused the flu vaccination. The records used for this person were the generic, photocopied records which had been used for all other people. The registered manager had failed to adopt an individual and person-centred approach to support the person to make this decision.

● On the second day of our inspection, the registered manager told us they had started to re write the capacity assessments and best interest decision records. However, this goes against the MCA as records relating to a person's capacity to make a particular decision must be made at the time the decision needs to be made. Therefore, the records would not be a true and accurate reflection of the decision made three months earlier.

The provider had failed to ensure capacity and best interest decisions were made in a way which protected people's human rights and followed current legislation. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs were assessed and care was planned to meet those needs. However, people's care files contained information which was out of date and therefore made it difficult to identify people's current needs.
● We found equality, diversity and human rights (EDHR) had not been included during the assessment process. However, one staff member told us, "These adults are on a difficult journey and my job is to listen. I use life stories to understand a person's likes and dislikes and their culture."
● External specialist support was utilised to help staff meet people's needs and to encourage staff to use current best practice. The registered manager told us they relied on these health professionals to inform them and tell them what to do. Staff and managers should be aware of current best practice in relation to people's needs, such as updated dementia guidance specifically for the current COVID-19 pandemic.

Staff support: induction, training, skills and experience
● The registered manager told us due to the current COVID-19 pandemic, some practical training could not take place for staff. However, staff had access to on line learning. We saw whilst most staff had completed their on line training, there were several staff who were either out of date or had not completed this. This places people at risk of receiving care which is not consistently effective.
● People and their relatives told us they felt staff were well trained, knew how to do their job and knew their family member well.
● Staff told us they had regular supervision within their roles and felt supported by managers at the home. Staff told us when they first started working at the home they had a good induction and worked alongside other staff to ensure they were confident and competent.

Supporting people to eat and drink enough to maintain a balanced diet
● People were bought to the dining tables early and then had to wait for their meals. At lunchtime one person was sat at the dining table for at least 40 minutes before they received their meal. At breakfast we saw some people had fallen asleep at the table. We spoke with the registered manager about this and they told us they would review this.
● People had their nutritional needs documented and when necessary were referred to specialist teams if needed for dietary advice. However, people did not have their fluid intake effectively monitored which could prevent intervention if they were not drinking enough.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare services within the home. Records showed people were seen by community health and mental health teams, district nurses and GP.
● The registered manager told us they had a weekly GP telephone call as a minimum. This was where concerns could be discussed to identify any actions which needed to be completed, such as blood tests, a

district nurse or GP home visit.

Adapting service, design, decoration to meet people's needs

● The home had been adapted to help meet people's needs. To help direct people around the home signage was displayed and we saw posters illustrating lifts and toilets and arrows pointing towards bedrooms. Some people may benefit from more personalised bedroom doors to help them find their rooms easier.

● To help people move safely around the home handrails were in place along corridor walls. The provider had adapted bathrooms to support people to use these facilities independently where they were able to.

● Several relatives told us the environment had been an important factor for their family members when choosing the home. The environment at Woodcote Hall suited them because it was rural, set within large grounds and had a small care farm. One relative told us their family member had "thrived" since they had been there.

Inspected but not rated

# 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 purpose of this inspection was to check concerns we had about the culture and management of the home. We will rate the key question at the next comprehensive inspection of the service.

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

- The provider had failed to ensure continuous and sustainable improvement within the service. This places people at significant risk of not receiving high quality, person-centred care.
- The provider's audit and governance systems were not effective. The use of these systems had not identified where improvement was needed to help mitigate risk to people's health, safety and welfare.
- The provider's governance arrangements were not supported by all staff. The oversight of people's care records needed improvement, such as the checking of daily charts including fluid and bowel charts. Staff recorded how much people drank, but it was not clear if these records had been checked and monitored by managers. Although this had not caused any negative impact on people, if people's health declined there was a potential risk this may not be identified.
- Staff had not always completed shift handover records fully and this had not been identified by managers. This document prompted staff to sign for tasks they had responsibility for completing, but these were not always signed. We also found staff had signed against tasks to show they had been completed, when it was evident they had not, such as the cleaning of hoists.
- The registered manager told us people's temperatures were taken and recorded twice daily. This is current best practice during the pandemic to help monitor people for any emerging symptoms of COVID-19. The records we viewed did not support this and for March 2021, there were 21 out of 31 daily records which could not be found. This placed people's health and welfare at risk.
- The provider's governance systems had not identified staff did not follow current national guidance or the provider's own policies for infection control. This included poor hand hygiene, poor PPE practice and disposal of body fluids. This is especially important during the COVID-19 pandemic to minimise risk of infection.
- The provider's governance systems had not identified out of date information in care files or the use of generic and incorrect capacity assessments and best interest decision records. This can significantly impact on people's equality, diversity and human rights because difference has not been acknowledged.
- The registered manager had not kept up to date or implemented current national guidance for personal protective equipment during the current sustained COVID-19 transmission in England. Failure to keep up to date can impact on people's health, safety and wellbeing.

The registered persons had failed to ensure the systems in place were operated effectively to continually assess, monitor and improve the quality and safety of the service provided. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw the last rated inspection was displayed, as required, within the home and on the provider's website.

Working in partnership with others
● Prior to our inspection, external stakeholders told us they did not feel management had been collaborative or shared information with them effectively. We will work with external stakeholders to monitor this.
● The registered manager told us people were supported by community health teams such as district nurses, GP and a community matron who all visited as needed to support people's health and wellbeing.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Prior to our inspection, we had received concerns about the culture at the home not being open. We found people looked content and were complimentary about the support they received. Our observations and discussions with staff did not give rise to concerns of a closed culture at the home.
● Staff spoke positively about the leadership of the home and felt the managers were supportive. They told us they had confidence any concerns would be addressed.

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
● Relatives told us they considered management to be open. The home had a COVID-19 outbreak earlier in the year and one relative told us staff had phoned to keep them up to date on visiting arrangements and the COVID-19 status at the home following the outbreak.
● The duty of candour requires registered persons to act in an open and transparent way with people receiving care or treatment from them. The registered manager understood their responsibilities under duty of candour and during our inspection took steps to rectify some of the issues we found.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were supported to keep in touch with relatives. Throughout the COVID-19 pandemic staff had helped to facilitate telephone and video calls for people. A visiting 'pod' had been installed in the home's grounds and feedback from relatives was positive in the use of this.
● Relatives told us staff at the home kept in contact with them and gave regular updates on their family member. One relative told us they felt they had good communication with the home and felt it was honest information they received.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to ensure capacity and best interest decisions were made in a way which protected people's human rights and followed current legislation. |

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<br><br>The provider failed to ensure service users were protected against the risk of cross infection.<br>The provider failed to ensure the risks associated with service user's care were monitored and recorded.<br>Staff had failed to recognise and take action to minimise risk to service users. |

**The enforcement action we took:**

We issued a warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered persons had not ensured the audit and governance systems were effective in identifying where improvement was needed and mitigating risk to service users health, safety and welfare.<br>The registered persons had not ensured their records relating to the care and treatment of service users were complete, legible and accurate. |

**The enforcement action we took:**

We issued a warning notice