Woodcrofts Residential Homes Limited

Woodcrofts Residential Home

Inspection report

164 Warrington Road
Widnes
Cheshire
WA8 0AT

Tel: 01514245347

Date of inspection visit:
21 July 2022
26 July 2022

Date of publication:
29 November 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodcrofts Residential Home is a care home providing accommodation and support for up to 19 people with mental health needs. The service was supporting 15 people at the time of inspection. The building has two floors accessible via stairs and has on-site parking.

People's experience of using this service and what we found
Gaps and shortfalls in service provision meant that people were at risk of harm. Widespread infection control issues, lack of risk management systems, and short staffing contributed to our judgment that people were not safe. People received their medications on time, and staff understood what action they would take if they felt someone was being harmed or abused, however there was not an up-to-date safeguarding policy for staff to refer to at the home.

We found no evidence staff had been trained in MCA and DoLS. Some staff were keeping a log of their own training, however the provider had no oversight of this information so it was not possible to be sure what training staff had completed.

Governance systems were not in place, and therefore not effective in highlighting areas of concern. Action was not taken when there were concerns identified with the safety of the environment. The provider has not sent us evidence these concerns have been acted upon.

People felt well-cared for and staff knew about peoples preferred care needs. However, there was not always enough staff on shift to support people and ensure the environment was clean and tidy for people to live in.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Some people who lived at the home accessed the community independently. People told us they liked the home and the staff and felt well looked after.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published March 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider make improvements to their practice with regards

to supporting people's dietary needs. At this inspection we found the provider had acted on this recommendation and improved their approach to supporting people with their dietary needs.

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.

Why we inspected
We carried out an unannounced focused inspection of this service on 8 December 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve in relation to safe care and treatment, staffing, safeguarding and governance.
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. We also checked whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodcrofts on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, governance, staffing and the need for consent.

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

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well -led.

Details are in our well-led findings below.

Woodcrofts Residential Home

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
This inspection was conducted by three inspectors over two days.

Service and service type
Woodcrofts Residential Home 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. We had not requested a Provider Information Return for this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We spoke with six people who used the service. We spoke with seven members of staff including the registered manager and the maintenance person.

We reviewed a range of records. This included five people's care records and medication records. looked at one staff file 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 requested further information from the provider following the inspection, however the provider failed send us the information we requested.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Gas and electricity safety certificates were out of date and had not been scheduled to be completed, which meant we had no assurances the building was safe for people to live in. The registered manager had failed to respond to requests for additional health and safety monitoring records. This meant we could not be assured the registered manager was identifying or managing risks to the environment.
- Water temperatures in the bathrooms were above the safe temperature range and there had been no action taken to address this, which meant people were at risk of scalding.
- People were at risk of eating out of date food. We found various foods which were out of date still being stored in fridges and cupboards. Opened food was not stored appropriately in the fridge which meant people were at risk of being served contaminated food.
- There were risk assessments in place which described how to support people with their mental health and how to support people who were at risk of falling. However, other health needs such as Parkinson's, skin integrity and epilepsy had not been considered. For example, one person who had diabetes, did not have any information recorded in their care plan around what was a normal level for their blood sugars. Staff were recording their blood sugars every day, but did not have any further guidance on what action they should take if they were not in the correct range.

There was no evidence anyone had been harmed; however, these examples demonstrate a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection the provider was unable to show they had learned lessons when things went wrong and used this to improve service provision. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of

regulation 17.

● The provider was still unable to show they learned lessons when things went wrong.
● There remained no system in place for identifying, recording, or monitoring incidents.
● As a result, the provider could not demonstrate appropriate action had been taken following incidents, that any learning had been shared amongst the staff or with external agencies. For example, we reviewed an incident form on day one of our inspection which had not been appropriately referred to safeguarding. We highlighted this to the registered manager who was not aware of the incident.

We found no evidence that people had been harmed, however there were no oversight systems in place to identify issues of concern and make changes. This placed people at risk of avoidable harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider could not evidence they were able to manage infection prevention and control effectively. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation.

● The provider did not always manage infection prevention and control effectively. For example, when we walked around the home on day one of our inspection, we found widespread concerns in relation to infection control practices which we feedback on day one of our inspection. When we returned for day two, some of these concerns had been addressed, however some remained outstanding. For example, slip mats and bathmats were in place for communal use in the showers. However, there was no evidence they were being cleaned in-between use, which put people at risk of coming into contact with bodily fluids. A communal door leading to the downstairs areas which was accessible for people had dried blood on it, putting them at risk from blood borne viruses.
● We were not assured that the provider was preventing visitors from catching and spreading infections. There was no policy in place for visitors to follow when they came to the home.
● We were not assured that the provider's infection prevention and control policy was up-to-date. The infection control policy was not in date, and it did not have information around COVID-19 best practice as well as how to manage other outbreaks.
● We were not assured that the provider was using PPE effectively and safely. Staff were not wearing face masks on day one of our inspection. This had not been risk assessed in line with guidance and the provider had taken a conscious decision not to follow the guidance on face masks. When we retuned for day two, all staff had facemasks on.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was accessing testing for people using the service and staff.

We found no evidence that people had been harmed, however systems were still not in place to effectively manage infection prevention and control. This placed people at risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008n (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff on duty to provide support to people in accordance with their needs.

● All of the staff we spoke with, except one, told us they felt there was not enough of them on duty. When we pointed out some of the issues with the environment, one staff member said it was because they 'didn't get enough time'. Another staff member said, "I just want to do the job I am supposed to do. Most days I do a bit of everything." Another staff member said "It would be nice if we didn't have to do the cooking and cleaning as well, then I would have more time to spend with people."
● People's risk assessment in relation to their mental health stated staff were to spend time with them to observe if they were becoming unwell with their mental health, however, staff told us due to the tasks they needed to do, they don't get time to do this. Therefore, if people became unwell, they would be at risk of not getting the interaction they needed from staff.
● At the time of our inspection, staff told us two of the people who lived at the home were becoming more dependent on staff for their personal care due to their needs changing. There were no dependency assessments in place to reflect this. When we arrived on day one, there was only one staff member in the service, who had helped two people with personal care needs, then they were making breakfasts and dispensing medications. On day two of our inspection there were more staff on shift.

There was no evidence people had been harmed, however these examples are a breach of regulation 18 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

● Safe recruitment practices were followed by the provider to make sure newly recruited staff were safe to work at the service.

Using medicines safely

At our last inspection the provider could not evidence that medications were being given correctly This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspections improvement had been made to this part of the regulation and the provider was no longer in breach of regulation in relation to medications.

● People received their medication on time from staff who were trained to do so.
● Medication was stored correctly.
● There was enough stock of medicines to ensure people did not go without their medication.
● The medication policy, however, was not in date. We have reported on this in more detail in the well-led section of this report.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider did not have systems to safeguard people from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

At this inspection enough improvement had been made to ensure the provider was no longer in breach of regulation 13.

● There was a system to record and monitor safeguarding concerns, however none had been reported since the last inspection.
● There was a safeguarding policy in place however this had not been reviewed since March 2019, we have reported more on this under the well-led section of this report.
● The registered manager discussed what concerns they would notify CQC of, however there had not been

any.

● Staff had received recent safeguarding training and staff could describe appropriate actions they would take if they had any concerns.

Inadequate

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider did not evidence they were providing suitable training for staff. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation.

- Staff were not supervised, appraised and we could not be sure staff had the correct skills to enable them to do their job effectively.
- All of the staff we spoke with told us they had not had a supervision in over a year and had not had an appraisal.
- Some staff told us they had engaged on recent training using a e-learning system. However, there was no oversight of this training, and the staff training matrix was not up-to-date. Staff told us they would like to engage on specific training to help them understand how to support people with enduring mental health needs and felt this would benefit them in their role.
- We asked the provider to send us an updated training matrix or evidence staff had up-to-date training in place, however the provider failed to send us this information.
- This means we cannot be assured staff were being supported and trained in accordance with their roles and responsibilities, which could put people at risk of receiving unsafe care and support.

There was no evidence anyone had been harmed, however, these examples are a continued breach of regulation 18 of the health and social care act 2008 Regulated Activities (Regulations) 2014.

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 MCA 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 whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Not all decisions had been assessed in accordance with the principles of the Mental Capacity Act.
- There was some inaccurate information in people's care plans. For example, one person who was deemed to lack capacity and had a DoLs in place had no information contained in their care plan how they made decisions and how staff supported them with this.
- One person who was subject to a DoLs authorisation did not have an appropriate risk assessment in place around their DoLs to enable them to be supported effectively by staff. We highlighted this to the provider on day one of our inspection.

We found no evidence that people had been harmed however inaccurate information demonstrated a lack of knowledge of the principles of the Mental Capacity Act. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care

- Feedback from professionals was mixed, and it was not always evident the provider was working closely with other agencies to ensure the best possible outcomes for people.
- The provider did not always send information on time or make it available for other agencies as requested.
- We did however, receive some feedback people were happy and well looked after at the home, however, communication with other agencies in general required improvement.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had care plans and some basic risk assessments in place which took into account their needs, however, information around choices, preferences and people's additional needs lacked detail and was not person centred.
- Staff all knew people well and were able to talk to them about their care and support and what they needed on a day-to-day basis.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain their weight and have access to food they enjoyed. We asked people if they liked the food and everyone answered yes. One person said they felt there could be more choice.
- Menus were completed every four weeks by staff, however it was not always evident that people had any input into the menus.

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

- People told us they liked the home, and it was comfortable and met their needs.
- The provider had improved the communal areas since our last inspection and had provided air-conditioning units around the home to make sure people were comfortable.
- Some of the walls and corridors were bare, however, people had their own keys to their rooms and could decorate them however they pleased.

Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare services to improve their quality of physical and mental

health.

- The provider had referred one person to the frailty team following a fall in the home.

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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

At our last inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014. This was because we were not assured that governance systems were in place and robust.

- We were still not assured that the registered manager understood quality performance and risk and regulatory requirements. This was due to the number of shortfalls at this inspection, many of which were highlighted at our last inspection.
- We found continued issues in relation to risk management, infection control, and staffing. We found further concerns in relation to the MCA. These ongoing concerns had not been identified or highlighted through any governance process. There remains no viewable governance process in place at the home.
- There was a system to identify, record, monitor and manage incidents because staff were recording incidents and accidents when they happened. However, opportunities to identify themes, learn lessons and make changes were missed by the registered manager due to a lack of oversight and auditing of these forms.
- The provider had failed to respond to repeated requests for additional information relating to the safety of the environment. This meant we could not be certain their own systems had identified the issues we found or whether other aspects of the environment were safe; such as up-to-date inspection certificates and hot water temperatures.
- We have not received assurances around some of the information we have requested after the inspection.

The provider failed to implement robust and effective governance systems which had resulted widespread, significant shortfalls in the way the service was led. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a positive and friendly culture amongst the staff even though management systems were poor.
- Staff told us they enjoyed working at the service and could seek informal support when required and felt the home was 'one big happy family'.
- Several staff had worked there for many years. Staff knew people well, and cared about them.

● Staff said the registered manager was 'a nice person'. Some of the staff told us however, they did not see the registered manager much as they 'stayed upstairs'.
● People said they liked the staff, and they liked the registered manager because they felt Woodcrofts was their 'home'.

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 ;Continuous learning and improving care

● There was a form staff were using to record incidents, however these were not routinely analysed. This means opportunities to share issues of concern with people and their relatives could be missed. Therefore we were not assured the provider always acted on their duty of candour.
● We were not assured the provider was committed to improving care based on the findings of this inspection, the repeated issues from our last inspection and the limited action the provider has been taken to address the shortfalls in care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics/ Working in partnership with others
● It was not clear how the service engaged with the people using the service, public and staff. People we spoke with told us they knew the registered manager and could speak to them when they wanted.
● The registered manager told us they used questionnaires to check people's satisfaction levels, although we did not see any completed copies of these.
● It was not always evident the provider worked in partnership with other agencies as we received some mixed feedback that information was not always sent as requested.

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 People were not being supported under the MCA to manage restrictions placed on their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not trained, supervised or appraised in roles at the home. Therefore we could not be sure they were providing safe care and support.

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 Risks to people's health were not always assessed and mitigated. There was missing information regarding the safety of the premises and the environment. Infection control processes were poor and there was some significant concerns in relation to IPC.

The enforcement action we took:

We have served a Notice of Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not in place. There was missed opportunities to analyse incidents and accidents. When issues were identified, no action was taken to reduce the risk of harm to people.

The enforcement action we took:

We have served a Notice and Proposal to cancel the providers registration.