Holmwood Residential Care Limited

Glenfield Woodlands Care Home

Inspection report

11 Holmwood Drive
Glenfield Woodlands, Glenfield
Leicester
Leicestershire
LE3 9LG

Tel: 01162871696
Website: www.pearlcare.co.uk

Date of inspection visit:
04 July 2023
05 July 2023

Date of publication:
28 November 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Glenfield Woodlands is a residential care home providing personal care to up to 17 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 16 people using the service.

People's experience of using this service and what we found
Risk assessments did not always ensure people's safety in relation to falls. We were not assured infection prevention and control measures were sufficient to protect people from the spread of harmful bacteria.

Medicines were not always safely administered, and people were not always protected through the effective use of the providers safeguarding system.

People were supported by enough staff, and safe recruitment checks were in place. The provider was responsive to concerns raised during our inspection and took action to improve safety and quality of care.

People's dignity and respect was not always promoted by staff, and there was a lack of daily activities. Staff competency and people's needs were not always fully assessed. People were not always provided with meal options during mealtimes, and fluid monitoring was not always effective to ensure people drank enough.

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; the policies and systems in the service supported this practice.

Quality assurance systems and service oversight was not always effective. The nominated individual had a good understanding of their legal responsibilities in relation to duty of candour.

People and their families spoke positively about the care staff and the atmosphere at the service. Feedback from staff indicated they enjoyed working at the service and felt valued by the provider. Staff had opportunity to raise concerns and receive guidance during supervision with their line manager. Staff told us they felt comfortable raising concerns.

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 5 March 2019).

Why we inspected
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 received concerns in relation to medicines, moving and handling, care planning and meeting people's dietary needs. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

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 changed from Good to Requires Improvement based on the findings of this inspection.
We have found evidence that 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 Glenfield Woodlands on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safety, respect and dignity, and governance at this inspection. We issued warning notices to the provider for regulation breaches related to safety and governance, requiring the provider to become compliant with these regulations.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Glenfield Woodlands Care 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 Health and Social Care Act 2008.

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 service was inspected by 2 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Glenfield Woodlands is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Glenfield Woodlands is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was a registered manager in post. However, the provider told us the registered manager had terminated their employment with immediate effect, shortly before our inspection of the service, and they would be actively looking to recruit for the position. A manager from another service and the Nominated Individual were providing managerial support to the service in the absence of the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
The first day of inspection was unannounced. We gave approximately 20 hours' notice for the second day of the inspection.

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 used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited the service on 2 separate days to complete the inspection. We checked the environment on each site visit. We spoke with 7 people living at the service and 3 relatives, to gain feedback on their experiences of using the service. We spoke with 9 staff including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a selection of records including 14 people's care files, and multiple medicine records. We looked at 4 staff files in relation to recruitment and reviewed the providers training and supervision monitoring documents. A variety of records relating to the management of the service including, quality checks, policy and procedures, and health and safety were examined.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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; Using medicines safely

- Risks were not always managed effectively. People's needs in relation to choking and swallowing were not always adequately assessed. This meant risk assessments in place for people who required specialist diets were not always accurate. This put people at risk of harm due to potential choking and/or aspiration related incidents. We raised this with the provider, and they immediately reviewed people's care plans and risk assessments to ensure staff had access to accurate guidance.
- Risk assessments did not always ensure people's safety in relation to falls. For example, people's personalised falls risk assessments did not always consider the use of certain medicines or the impacts of health diagnoses. This meant their falls risk assessments were not effective at evaluating the level of risk, and therefore, did not keep people safe from the potential risk of harm.
- Medicines were not always safely administered. Staff did not always remain with people when supporting them with their prescribed medicines to ensure safe administration. We raised this with the provider, and they told us additional training for staff was planned to improve safe medicine practices.
- People did not always receive their 'as and when required' medicines safely. Time gaps between administrations were not always in line with prescribing instructions. This put people at risk of potential harm. We raised this with the provider, and they put in place extra checks to ensure people's safety.
- Medicine records were not aways accurate. For example, the reasons for, and the effectiveness of the administration of 'as and when required' medicines, were not always recorded. This did not promote safe medicines practices.

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections. For example, painted handrails were chipped, exposing textured surfaces that are difficult to sanitise effectively, creating a risk of bacterial build up. After the inspection, the provider sent us pictures of freshly painted handrails. The work appeared to have been completed to a high standard.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises, or that the provider was supporting people living at the service to minimise the spread of infection. We found some areas of the kitchen where cooking equipment was stored to be visibly dirty.
- We were not assured that the provider was admitting people safely to the service. We found some mattress covers to be stained and this had not been identified by staff when completing checks.
- We were not assured that the provider was using PPE effectively and safely. Staff administering medicines wore disposable gloves, but did not always sanitise their hands between administrations, in accordance with best practice guidance.

Unsafe medicine practices, poor risk management and poor infection prevention and control measures, put people at risk of potential harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider supported people to have access to visitors including health and social care professionals, friends, and family.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected through the effective use of the safeguarding system. Incidents were not always effectively recorded or adequately reported to the Local Authority. This put people at risk of abuse or improper treatment. We raised these concerns with the provider, and they explained this failure was the responsibility of the registered manager, who had since left the service.
● People using the service and their relatives told us they felt safe. One relative told us, "Oh yes, [they] are safe, [name] is happy here".
● Care staff received safeguarding training and understood how to recognise signs of abuse and how to report concerns to their line managers. Most staff knew when to escalate concerns to the Local Authority or the Care Quality Commission.

Staffing and recruitment
● Safe recruitment checks were in place to ensure staff were suitable. For example, the provider completed DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider obtained references and completed interviews to ensure staff were suitable for their role.
● People were supported by enough staff. One person told us, "I'm safe here, there's plenty of people to look after you."

Learning lessons when things go wrong
● The provider was responsive to concerns raised during our inspection and took action to improve safety and quality of care.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- People's dignity and respect was not always promoted by staff. We observed a person tell staff they felt uncomfortable sat in their wheelchair all day, however, staff did not respond and support the person to become more comfortable. In addition, there was no guidance within the person's care plans or considerations within their assessments regarding the daily use of their wheelchair. We raised this concern with the provider, and they told us they made a referral for an assessment to be completed.
- People's care plans did not provide staff with sufficient guidance to ensure people received support with their hearing aids. We observed people struggling to communicate with visitors due to staff not supporting them with their hearing aids. We raised this concern with the provider, and they told us they updated people's care plans after the inspection.
- People were not always supported with activities as detailed within their care plans, and there was a general lack of engagement by staff with daily activities. One person told us, "We don't do any activities here we just talk to each other." One relative told us, "I haven't seen any activities going on, there used to be."
- People's needs were not always fully assessed when admitted to the service. We found people's admissions assessments were not always fully completed and did not always contain crucial information about their care. For example, details about medical needs.

A lack of activity engagement, meeting people's communication needs, and poor response by staff to people expressing discomfort, was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's private rooms were personalised. People had pictures up of their family members and personal items on display. One relative told us, "It's a lovely home, their room is always clean and tidy."

Staff support: induction, training, skills and experience

- People were not always supported by competent staff
- Staff medicine administration competency assessments were not always fully completed. This meant the provider could not be assured staff had the required knowledge and skills to administer medicines safely. We observed unsafe medicine administration practices.
- There were no moving and handling competency assessments completed by the provider. This meant the provider could not be assured staff had the required skills and knowledge. We observed staff using a damaged sling when supporting people to transfer with a hoist, which put the person at risk of potential

harm. We raised these concerns with the provider, and they told us they had replaced the damaged sling and intended to implement moving and handling competency assessments.
● New staff completed an induction before supporting people. This included shadowing other experienced members of staff to learn people's care routines.
● Care staff completed The Care Certificate as part of their training. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always provided with meal options during mealtimes. Menus and meal boards only presented one option at mealtimes. Staff told us if people didn't like their food, they would prepare an alternative meal, but people were not initially provided with a choice. One person told us, "I don't get a choice at lunchtime they just put it in front of you." We raised this with the provider, and they told us people should be getting a choice of meals and told us they would review this.
● Fluid monitoring was not always effective to ensure people drank enough. Both digital and paper-based monitoring charts were in place to monitor people's fluid intake. This created disorganised records that prevented effective daily oversight by staff. We raised this with the provider, and they stated they would review how staff record fluid intake to improve monitoring.
● We received mixed feedback regarding the quality of the food. One relative told us, "My [relative] is not keen on the food." Whereas another person told us, "The food is excellent here, but I don't always get a choice."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals to health and social care professionals were completed when needed. For example, a referral was made to The Speech and Language Therapists to assess a person's swallowing ability.
● People had access to visits and treatment from health care professionals such as district nurses. One person told us, "When I've needed the doctor, they take me."

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.

● Where people were deprived of their liberty, the provider had appropriate authorisations in place and

ensured conditions were met.

- The provider maintained effective oversight of DoLS applications through the use of a monitoring matrix.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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

- Quality monitoring systems for care plans were not effective. Care plan reviews did not identify missing information about people's care needs. For example, details about people's skin care needs or the use of hearing aids. In addition, there was no quality audit process in place for care plans and shortfalls had not been identified or addressed.
- Medicines audits did not always identify shortfalls or unsafe practices. For example, when administrations of 'as and when' required medicines had not adhered to the manufacture's safety guidelines. This meant systems and processes did not keep people safe or ensure quality of care in relation to the use of medicines.

- Oversight of pressure relieving mattresses was not effective. There were no checks in place to ensure air flow mattresses were set to the correct pressure for the person using them. The absence of effective oversight put people at risk.
- Complaints procedures were not always used effectively to ensure thorough oversight. One Complaint had not been logged within the complaints monitoring folder and this was not identified by audit processes. Although only one, it meant the concerns raised were not reviewed to protect people from potential harm. Thorough oversight of the complaints procedure was required to ensure the quality of care improved.

Quality assurance processes and service oversight was not always effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service was being supported by the nominated individual and a temporary manager. Both demonstrated good knowledge in relation to the legal requirements of duty of candour.

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

- People and their families spoke positively about the care staff and the atmosphere at the service. One person told us, "The staff are excellent, I have no problems with staff." Another person told us, "I'm happy with the atmosphere here."
- Feedback from staff indicated they enjoyed working at the service and felt valued by the provider. Care staff spoke highly of the administrator who consistently provided a lot of support to staff and people alike.

● We observed positive interactions between the nominated individual and people using the service. The nominated individual had an increased presence at the service in the absence of the registered manager to support staff and the day to day delivery of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff had opportunity to raise concerns and receive guidance during supervision with their line manager. Staff told us they felt comfortable raising concerns.
● The provider used feedback forms to gain input from people using the service and their relatives.
● The service worked in partnership with other agencies to ensure people received the healthcare they needed.

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 10 HSCA RA Regulations 2014 Dignity and respect A lack of activity engagement, meeting people's communication needs, and poor response by staff to people expressing discomfort, was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Unsafe medicine practices, poor risk management and poor infection prevention and control measures, put people at risk of potential harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance processes and service oversight was not always effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice