Nestlings Care Ltd

# Woodhall House

## Inspection report

City Gate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Date of inspection visit:
22 September 2022

Date of publication:
06 April 2023

## Ratings

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

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

# Summary of findings

## Overall summary

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

About the service
Woodhall House is a children's home providing treatment of disease, disorder or injury to up to three people. The service provides support to children and young people aged between 10 and 18 years who have difficulties with emotional wellbeing and mental health. At the time of our inspection there were three people using the service.

Ofsted are the lead regulator for Woodhall House as it is a children's home. The service is also registered with the Care Quality Commission for the regulated activity of treatment, disease, disorder or injury.

People's experience of using this service and what we found
The provider had taken steps to make improvements to the services provided since the last inspection visit.

Systems and processes had been strengthened to make sure that children had been kept safe from avoidable harm. This included the risk of sharps as well as ligatures.

Additional steps had been taken to make sure that appropriate procedures were in place for staff and children to be able to exit the home safely in the event of an emergency.

The management team had made sure that policies and procedures used by staff were in date and contained references to the most up to date best practice guidance and legislation.

However, we found that the provider remained in breach of regulations 12 and 17.

Risk management plans did not always reflect up to date information about known risks or provide enough guidance for staff to follow in keeping children safe from harm.

Although overall improvements had been made in the way that ligature risks had been identified and managed, prescribed observations had not been consistently completed. This meant that there was an increased risk of potential harm to children who used the service.

Incident investigations had not always identified important areas of improvement or demonstrated that all identified actions had been completed. This limited the opportunity for learning as well as to reduce the risk of similar incidents happening again.

Although the provider had been successful in strengthening some systems to monitor the services provided,

this had not been yet been fully effective.

An effective system to manage identified risks had not been used, limiting the ability of the provider to demonstrate that they had been mitigated as much as practicably possible.

Rating at last inspection and update
The last inspection of this service was 6 July 2022.
The provider completed an action plan after the last inspection to show what they would do and by when to improve.
Although some improvements had been made, at this inspection we found the provider remained in breach of regulations.

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

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about.

Enforcement and Recommendations
We have identified breaches at this inspection and have issued warning notices in relation to safety and governance.

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 and will re-inspect the service to make sure that improvements have been made.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inspected but not rated**

We have not looked at all of the key question at this inspection as the purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

### Is the service well-led?

**Inspected but not rated**

We have not looked at all of the key question at this inspection as the purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

# Woodhall House

**Detailed findings**

## Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) and Regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection team consisted of a CQC children's services inspector. The service was also inspected by an Ofsted inspector on the same day.

Service and service type
Woodhall House is a children's home, providing support to children and young people aged between 10 and 18 who have difficulties with emotional wellbeing and mental health.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced which means that that the provider was unaware of the inspection until we arrived on site.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

During the inspection visit we spoke to people who lived at Woodhall House. We spoke to staff members, including managers, as well as members of the senior leadership team.

We reviewed information during the visit, such as policies, procedures and personal records. The provider also sent us information following the inspection visit.

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 if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At our last inspection we found that risk management plans reflecting all identified risks for service users were not immediately available. This placed people at risk of harm. 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 remained in breach of regulation 12.

- All service users had risk management plans which contained key information to support staff in keeping them safe. We saw evidence that regular risk reviews had been undertaken to determine if any further action was needed and positive behaviour support plans had also been completed.
- However, service user records including the most up to date risk management plans did not always reflect all risks that had been identified. This meant that there was not always enough guidance available for staff to follow so that identified risks could be reduced as much as practicably possible.

At our last inspection we found that the risk of ligaturing had not been fully assessed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation12.

- Since our last inspection, the provider had completed full environmental risk assessments which had been made readily available for staff to support them in reducing the risk of ligaturing. This had included maps of all areas in the home where ligature points were present.
- In addition, individual risk assessments for ligatures had been completed for all children who lived at the home.
- Staff who we spoke with during the inspection knew about the updated risk assessments and were aware of the risk that was present for each child who lived at the home.
- However, documented evidence indicated that prescribed observations had not always been completed as expected. This was important as frequent observations had been implemented to reduce the risk of children ligaturing, particularly those who had been deemed high risk.

● For one child, between 1 and 22 September 2022, we found five occasions when this had not been completed as expected. On one occasion, we found that there was a documented gap in observations of three and a half hours despite there being prescribed 15-minute observations in place. Records indicated that the child had attempted to ligature during this period.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service as prescribed observations had not always been completed as expected. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that sharps had not been managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation12.

● The provider had implemented a new system to manage sharps since our last inspection. Staff who we spoke with knew about the system and indicated that it had been more effective.
● Records indicated that regular checks had been completed to make sure that all sharps had been locked away safely. Staff had been supported by clear checklists and photographs of what needed to be present for checks to be complete.

At our last inspection we found that the provider did not have effective systems in place for staff and service users to follow in the event of an emergency. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● The provider had completed fire risk assessments, which included personal emergency evacuation plans for service users (PEEPS). Staff who we spoke with knew about the plans and where to find them if needed.
● The provider had made sure that all staff and visitors had a set of keys to be able to exit the home safely in the event of an emergency. Records indicated that keys had been signed in and out to help maintain security.
● All staff had received updated fire safety training since our last inspection and regular fire drills had been undertaken by the management team.

Learning lessons when things go wrong

At our last inspection we found that not all incidents of self-harm had been fully investigated. This placed people at risk of harm. 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 remained in breach of regulation 12.

● The provider had taken steps to strengthen the system used for reporting and managing incidents. For

example, the incident reporting form had been revised to support staff to include more detailed information. In addition, the management of all reported incidents had been overseen by a member of the senior management team.

● However, on sampling 10 incidents that had been reported between 24 June and 22 September 2022, we found that it was not always clear of whether actions that had been identified to reduce the risk of similar incidents happening again had been completed.

● In addition, we found that incident investigations had not always recognised important areas for improvement, limiting the opportunity for learning as well as making changes to the way in which risk was managed, reducing the risk of harm to children who used the service.

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 if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found that systems had not always been effective in monitoring the service provided. For example, making sure that important daily, weekly and monthly checks had been completed. This placed people at risk of harm. This was a breach of regulation 17(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 remained in breach of regulation 17.

- Since our last inspection, the provider had made improvements to the overall governance systems that were in place. This included strengthening the quality assurance systems that were used to maintain oversight of all services provided.
- Members of the management team demonstrated a commitment in making sure that systems that had been changed were done in a way that was sustainable as well as supporting staff in playing active roles in the improvements.
- We sampled records for daily, weekly and monthly checks that had been completed between 24 June and 22 September 2022, finding that these had been completed fully. Staff who we spoke with were aware of their responsibilities to complete expected checks and when these needed to be done.
- However, we found that monitoring systems had not always been effective in maintaining oversight of some important aspects of the services provided. For example, the provider had not recognised that the documented evidence for prescribed observations had not always been available, potentially placing children at an increased risk of harm.
- Following the inspection, the provider told us that they had planned to put further measures in place to make sure that observations had been completed as expected.

At our last inspection we found that an effective system had not been used to make sure that all policies that were being used were up to date, included the most up to date best practice and legislation and contained up to date information that reflected current systems and processes. This placed people at risk of harm. This was a breach of regulation 17(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 remained in breach of regulation 17.

● The provider had made sure that policies and procedures had been updated since our last inspection. On sampling a range of these, we found that they were up to date and contained references to the most up to date best practice guidance and legislation.
● An electronic system had been used to make sure that all staff had easy access to policies and procedures when needed. The provider had recently introduced a check and sign system to make sure that all staff had read and understood all updated information. Staff were in the process of completing this at the time of the inspection.
● However, no steps had been taken to make changes to the policies and procedures which were in place to support staff in reporting and managing all incidents. Although there was a serious incident management policy in place, there was no guidance of how all other lower level incidents should be managed. This meant that there was an increased risk that incident investigations would not always be completed in a way that was expected and did not provide support to staff at different levels in understanding their responsibilities when managing incidents, particularly when making sure that there was documented evidence that actions had been taken to reduce the risk of similar incidents happening again.

At our last inspection we found that risks had not always been identified or had not always been mitigated as much as practicably possible. This placed people at risk of harm. This was a breach of regulation 17(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 remained in breach of regulation 17.

● Although the provider had a corporate risk register, no formal risks had been highlighted for Woodhall House. This meant that there was limited information of how risks had been identified and whether mitigating actions had been put in place to reduce them as much as practicably possible.