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Woodlands

Inspection report

Woodlands
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31 August 2016

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07 October 2016

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 31 August 2016 and was undertaken by one inspector.

We carried out this focussed, responsive inspection because we received information of concern regarding pressure care management at the home. This report only covers our findings in relation to pressure care management and risk assessments within the safe section. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodlands on our website at www.cqc.org.uk.

Woodlands provide accommodation and personal care to a maximum of 20 people some of whom are living with dementia.

There was a registered provider for the service. Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Relatives and people who used the service were very positive about the staff and the way they were being supported at the home.

However, not all risks to people's safety had been properly assessed and therefore risk reduction strategies were inconsistent.

Risk assessments were not being appropriately undertaken in relation to the risks associated with pressure care, falls and nutrition and hydration.

People who were at risk of developing pressure ulcers were only being referred to the appropriate healthcare professionals when staff noticed a potential pressure ulcer and not when the risk had been first identified.

Not all toilets in the home contained hand washing soap or paper towels required to limit the risk of cross infection.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

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. The registered provider had not ensured that the risk of people developing pressure ulcers and other risks to their safety had been assessed, mitigated or monitored. The registered provider had not ensured that infection control procedures were being followed appropriately.

Woodlands

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Woodlands on 31 August 2016. We inspected the service against one of the five questions we ask about services: is the service safe. This was because the inspection was undertaken in response to information of concern that the CQC received in relation to the management of pressure care at the home.

Prior to the inspection we reviewed information we have about the provider, including previous inspection reports and notifications of any safeguarding or other incidents affecting the safety and wellbeing of people.

We spoke with three care staff which included the deputy manager. We also spoke with the registered provider.

We spoke with three relatives and nine people who used the service. We also spoke with the local authority safeguarding team and a healthcare professional who had regular contact with the home.

We looked at seven people's care plans and other documents relating to their care including risk assessments and treatment plans.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives were very positive about the staff at the home and told us they were well looked after. However, there were no detailed risk assessment tools to assess the risk of developing pressure ulcers, poor nutrition and hydration or falls in any of the care plans we saw. This meant that not all risks to people's safety had been identified and therefore risk reduction strategies were inconsistent.

We found that people were only being referred to the community nurse team for a formal pressure care assessment after they had developed redness or potential ulcers. The community nurse team was not being called in to identify and provide pressure relieving equipment which might prevent the pressure ulcers developing in the first place.

For example, one person had a pre-admission assessment form in their care plan dated 07/03/2014. Under the section related to skin care, it was stated that the person had oedema and cellulitis. Other information in the pre-assessment form included very poor mobility, incontinence and concerns about adequate nutrition and hydration. The following entry was made in this pre-assessment form, "Will need pressure cushion." There were no detailed risk assessment tools in relation to pressure care, nutrition or falls within the care plan. There were no referrals to the community nurse team in order to assess the person for pressure relieving equipment, given that the person had four high risk factors for pressure ulcers.

This person was referred to the community nurse team via the Community Health Assessment Team (CHAT) on 11/07/2016 after staff noticed a "bluish area" on the person's body. A pressure relieving cushion and mattress was provided for this person on 19/07/2016 following a community nurse assessment.

Staff had not undertaken any recent training in pressure care management. Staff understanding of the potential risk factors in relation to developing pressure ulcers was inconsistent. Although staff we spoke with told us they would report any redness they discovered on people's body, they were not always aware of the risk reduction strategies to reduce the risks of people developing pressure ulcers.

For example, one person's care plan dated 06/07/2016 stated that staff were to, "Monitor [person's] skin condition carefully as [person] is at high risk of developing pressure ulcers." There was no detailed risk assessment, in relation to pressure care, to indicate how a high risk of developing pressure ulcers had been assessed. No other preventative action had been recorded to reduce the risk of this person developing pressure ulcers apart from staff monitoring the person's skin condition. When we asked staff, no-one was able to tell us that this person was at risk of developing pressure ulcers.

We checked the four toilets and bathrooms on the ground floor. We found that only two had any hand wash soap available and all had cotton hand towels. Cotton hand towels present an infection control risk as they are shared between people. We discussed this with the registered provider who agreed that paper hand towels would reduce the risk of cross infection.

The registered provider was in breach of Regulation 12 (1) (2) (a)(b)(c)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that infection control procedures were being followed appropriately. Regulation 12 (1)(2)(h)

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 The registered provider had not ensured that the risk of people developing pressure ulcers and other risks to their safety had been assessed, mitigated or monitored. Regulation 12 (1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice