

HC-One Oval Limited

Woodlands View Care Home

Inspection report

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Tel: 01438740230

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service:

Woodlands View is a residential care home that was providing personal and nursing care to 106 people aged 65 and over at the time of the inspection.

People's experience of using this service:

People and their relatives told us that permanent staff were good and they felt safe with them. People and their relatives told us that the use of agency staff was an issue. The home had a shortage of permanent staff and was very reliant on agency staff.

Permanent staff mostly knew people well and this included individual risks. Agency staff did not always have awareness of people's individual risks and were not always supervised by permanent staff.

People did not always receive appropriate pressure care management and were not always supported safely when assisted to eat and drink. Safe moving and handling was observed in most cases however were observed two instances where staff were about to use unsafe practice and corrected themselves when acknowledged they were observed. Where there were unexplained bruises or skin tears, a proper recorded investigation had not taken place in all cases.

Bedrails were not always used with bumpers and individual risk assessments and care plans in relation to risks were not always clear. Risk information passed to the manager was not always collated effectively which meant that the manager and provider's oversight of risk in the home was not always accurate. This had a potential to impact on staffing levels as the information shared with the department who planning staffing levels did not give an accurate level of dependency.

The manager and area director had been in post for a month prior to the inspection and were still developing and implementing plans to improve the running of the service.

Rating at last inspection: At the last inspection the service was rated as 'Requires Improvement'.

Why we inspected: This inspection was brought forward due to information of risk and concern.

Enforcement: Action we told provider to take at the back of the report.

Follow up: We will continue to monitor the progress of the service and plan the next inspection. We can inspect sooner if we receive further concerns.

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 well-led?

Requires Improvement ●

The service was not always well-led

Details are in our Well-Led findings below.

Woodlands View 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by information received by the CQC. The information shared with CQC indicated potential concerns about the management of risk of choking, falls, pressure care management, staffing and infection control. We also reviewed management arrangements as there had been changes to the manager in the home.

Service and service type:

Woodlands View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 who had applied to be 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.

Inspection team:

The inspection was carried out by two inspectors and two experts 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.

Notice of inspection:

The inspection was unannounced.

The inspection was carried out on 7 May 2019.

What we did:

Our inspection was informed by evidence we already held about the service.

We also reviewed feedback we received from members of the public and local authorities.

We spoke with the manager, the area director and 11 staff members. We spoke with two health care professionals.

We spoke with 20 people who used the service and 11 friends and relatives.

We reviewed 15 people's care records, medicines administration records and other records about the management of the service.

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing and recruitment

- At the inspection on 11 December 2018, there were not always enough staff to meet people's needs when needed.
- At this inspection we found that staffing had not improved. The home was still relying heavily on agency staff who did not always know people's care needs .
- People told us that there was not always enough staff. One person said, "Night time is when there are the least staff on duty and we really notice this. I go to bed at 10pm but some residents are pushed off to bed at 6.30pm, it is intolerable. Some residents go to bed for the convenience of the home and not the residents." Another person said, "No there are not enough staff here, the [staff] are very busy especially in the morning."
- The area director told us that staff hours were assessed in accordance with a dependency tool which calculated the number of hours of support people needed. This information was taken from a clinical risk report held by the manager. However, we found the needs of people on the report were not always accurate and did not factor in the use of agency staff who needed more supervision to ensure they were working in accordance with people's needs, so the information sent to the person who determined staff levels was not accurate. This meant, staffing was not based on the current assessed needs of people.
- Relatives also told us there was not always enough staff. One relative told us if their family member wanted to have their pad changed during a busy period they were told they had to wait.
- Staff told us they were rushed and short staffed. One staff member said, "We use agency and we have a set numbers of staff in each bungalow. We are told the ratios are fine, but they include the nurses and the seniors in the numbers as well, and they are not able to do care especially not in the morning." Another staff member told us, "Not enough staff because three call bells were going in the same time and I had to answer all. People wanted to have their pad changed so I asked them to wait and turned the bells off and asked them to wait which they didn't mind." A third staff member said, "Management don't look at the needs of people when they put staff on they are doing on ratios. A lot of people pass away on their own because there is no staff to spare so that they can be with someone."
- Health professionals also felt that staffing was an issue at the service. One said, "They haven't got enough staff, its visible here. The front leads are good."
- We observed the nurse administering medicines to people in the morning. The senior helped people in the lounge with breakfast and was dealing with the incoming phone calls and visiting professionals. They were not able to help people with personal care in the morning. This meant that four care staff had to attend the needs of the people living in a bungalow which varied from 24 to 29 people many of whom were living with complex health needs.
- This meant staff did not have time to give people the care and support they need and was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- We did not review recruitment files at this inspection.

Assessing risk, safety monitoring and management

- At the inspection on 11 December 2018, people's safety was not always promoted.
- At this inspection we found concerns in relation to safety.
- Permanent staff knew well who was at risk of falls and what measures were in place to mitigate the risk. Care plans evidenced that a risk assessment tool was used to measure the level of risk and to respond to this. However, the level of detail and accuracy of the plan in relation to mobility and number of falls experienced was not always accurately recorded. For example, the assessments did not always link health conditions that may impact on a person's mobility and staff did not have an overview of the number of falls a person had experienced.
- A nationally recognised tool was adapted by the provider to assess the level of risk for people developing pressure ulcers. Staff told us if people were at high risk and were unable to change position in bed they needed to reposition people. However, this was not robustly assessed and in place for all people putting them at increased risk of developing a pressure ulcer.
- For example, one person who was assessed as being very high risk and staff told us was immobile, was not repositioned regularly. Staff told us that sometimes they sat in their chair. However, we noted that the person was in bed on the day of inspection and their daily notes stated when in bed the person was always on their back.
- Another person was recorded as being on the opposite side to which they were laying on two occasions observed. This meant that staff could not be clear that they were not laying the person on an area of their body which had already been under pressure.
- Care plans did not always evidence what measures were in place to mitigate the risk of pressure ulcers developing. For example, there was no description of what pressure relieving equipment was used, if people had air mattresses what the setting should have been or if people at risk were able to change position in bed.
- Three people who had bedrails in place did not have the protective bumpers on to help protect them from injury. One person was noted to have extensive bruising to their arms and was seen knocking their arms in the wooden bedrails. Care plans did not always include a risk assessment or state that bumpers should be in use. Staff told us they should be in use. Staff told us they should have bumpers on and they did not know why there were no bumpers in use. Care plans did not always include accurate information in regard to bedrails.
- People had their individual risks assessed. Permanent staff were aware of these risks. We observed staff supporting people safely in many cases. However, we also noted two occasions where staff were attempting unsafe moving and handling but stopped when they acknowledged they were observed.
- The home used a high number of agency staff. They were not always informed of people's individual risks and not always supervised by permanent staff.
- People identified at risk of choking had risk assessments in place and SALT guidance. The care plan described how people should be supported to eat and drink safely and if any thickeners or specialist diets were needed. Care plans prompted staff to monitor for signs of choking, however it was not described what these signs were and what action staff should take if someone started to choke.
- We also observed that not all the staff assisted people at risk of choking safely. We observed two instances where people, who were assessed as being at risk of choking, were supported in an unsafe way by agency staff.
- An agency staff member was asked to support a person to eat. The thickener used for the drinks this person had were not stirred up in the cup and settled on the bottom. We alerted the nurse and showed them that the person was given un-thickened fluids and they changed this straight away.
- Another agency staff member gave a person food and drink and a fast pace including exceptionally long drinks from a beaker. The person was coughing but the staff member did not recognise this. The agency staff member told us that they had not been informed the person was at risk of choking.

- Prior to the inspection we received feedback that people were at risk of choking due to how they were supported to eat and drink. One relative told us how they had to intervene as their family member was coughing when being assisted.
- On one unit the sluice room was unlocked on three occasions we checked. Within the room there were cleaning chemicals. People living on that unit were independently mobile and living with dementia so this increased the risk to people's safety and welfare.

Due to people's safety not consistently being promoted with choking risks, pressure care management, bed rails processes, moving and handling, security of chemicals in the sluice rooms and the monitoring of unexplained injuries, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- People had their individual evacuation needs assessed. Staff were aware of how to evacuate people in case of a fire.
- Falls in the home were reviewed and action taken was recorded. This was reviewed by a member of the management team to enable them identify themes and trends.

Preventing and controlling infection

- At the inspection on 11 December 2018, staff did not always work in accordance with good infection control practices.
- At this inspection we found that systems were not in place to ensure infection control was sufficiently managed.
- People were not always protected from the risk of infections, although staff had received training and guidance, they did not always follow this. We saw on several occasions staff walking in corridors, touching door handles, with gloves on which they had used for personal care. We also saw soiled laundry on bedroom floors.
- People, relatives, staff and health care professionals told us that at times the home runs out of supplies. This includes continence products and wipes. We raised with the management team who were not aware of an issue.
- The home did not smell clean and fresh on arrival. However, this did improve throughout the visit in the main areas of the home and we saw the housekeeping staff working their way through the home to clean all areas.

Due to people's safety not consistently being promoted because of staff not practicing infection control, this was a further breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- We noted some people had a record of bruises or skin tears that could not be accounted for. We discussed this with the manager who told us that they had not recorded when they had done an investigation. We also noted that those injuries that were unexplained, had not been reported as a safeguarding concern.
- One person had suffered bruising around their torso. It was decided by the GP that the bruising was as a result of the person being transferred with a handling belt as staff told them the person did not cope well with the handling belt. However, staff had not recognised that this equipment was inappropriate for the person until the GP raised it.

People were not always protected from the risk of abuse, this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- Most people told us they felt safe. Those who had concerns told us staff were why at times they did not feel safe. One person told us that at times agency staff can be rough. Relatives told us they felt people were safe. One relative said, "When my [family member] did have a fall, a member of staff laid down beside them to make her feel reassured and not feel abandoned."
- Staff confirmed they received safeguarding training and they could tell us signs and symptoms of abuse. They told us in their training they were reminded that they could report their concerns to Local safeguarding authorities or CQC if they wished.

Using medicines safely

- At the inspection on 11 December 2018, people's medicines were not always managed safely.
- At this inspection people's medicines were administered, stored and recorded more robustly. However we found shortfalls in relation to three people's medicines.
- Regular checks and audits were completed.
- People told us that they received their medicines when they needed them. One person said, "My medication is always given on time."

Learning lessons when things go wrong

- Where an issue had arisen or an event had taken place within the home, this was shared with staff at team meetings, supervisions and any actions needed explained. However, this was not done consistently and as a result there continued to be shortfalls within the home.

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

RI: ☐ Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

- At the last inspection on 11 December 2018 we found that governance systems had not been effective in identifying and addressing shortfalls or addressing these areas.
- At this inspection we found that there were some areas that needed further development to ensure they were robust and consistently effective.
- The provider used their governance systems to help them identify and resolve issues in the home. These systems included audits, observations and checks. The manager delegated some checks to the deputy manager and unit managers. The manager also carried out their own assessments to ensure the team were working in accordance with their expectations.
- These checks had identified some of the issues found on the day of inspection, such as infection control issues and the sluice room being left unlocked. Action plans were developed following these checks and we saw the actions were signed off when completed.
- However, the audits and checks had failed to identify some of the issues found during the inspection in relation to the 'Safe' domain. They had failed to identify the risks relating to choking, pressure care concerns and moving and handling issues.
- One record used to give the management team an overview of the home and feed information to the staffing levels was not accurate. As a result, the manager did not have an accurate view of people's needs and could not be sure they were checking people received the care that they actually required. For example, one person who was observed as being high risk for developing a pressure ulcer and not having the correct care in place was noted as being low risk on the tool. Another person who was high risk was not on the tool at all.
- The provider was aware of the staffing vacancies and the high use of agency staff required to cover all vacant shifts. They had a member of the provider's team working on recruitment to try and help fill the vacancies. However, they had not implemented systems to ensure agency staff were supervised by permanent staff, properly informed of people's needs or risks and had not recognised the need to record which unit they were working on to allow accountability.

Continuous learning and improving care

- The home was monitored by the provider's quality team. They worked with the manager and staff to help drive improvement and address any shortfalls in the home. Staff told us that they felt the home had 'settled down' and things were 'ok'. They told us that the ongoing issues with staffing were the main concern.
- However, the provider had been made aware of concerns relating to unexplained bruising and had not

ensured the appropriate investigation systems were in place across their locations.

Working in partnership with others

- The manager was working with other agencies to keep them informed of any issues arising. The manager had links with various agencies which included the local authority and the clinical commissioning group.
- The provider was working with the CQC and the local authorities to help improve the issues in the home. However, at the time of this inspection, the issues found previously in safe and well led remained the same at this inspection.
- The service has been rated as requires improvement at the past four inspections. The provider has failed to consistently and robustly address the shortfalls within the service. We have previously met with the provider to discuss the concerns and imposed conditions on their registration to help drive improvement. The conditions imposed did ensure the necessary action was taken and the conditions were met. However, there has been a persistent failure to ensure the service meets the required standards and promote people's safety and welfare.

Due to the continued failure to meet the requirements people's welfare was at risk, this was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- The provider had appointed the current manager and quality team since the last inspection. They had been at the home for one month prior to this inspection. There were in the process of developing and implementing systems that would help achieve the standards they wanted for the service.
- Most people and their relatives told us that the manager was approachable and was seen around the home. One person said, "She is very approachable." Another person said, "I know there is a new manager but I do not know her name. I knew the old manager." Another person said, "I have met her. She came into my room and introduced herself and we had a natter."
- Staff told us that the manager and the other members of the management team were visible in the home and were available if anyone needed to speak with them.
- There were daily handovers detailing updates or changes to people's needs in some cases, and meetings with staff discussed all relevant information.

Engaging and involving people using the service, the public and staff

- People and their relatives had meetings to discuss the service. They kept informed about anything that affected the service. People told us they received a letter from the new manager introducing themselves. Some people said the manager had spent time with them on the units.

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
Treatment of disease, disorder or injury	People's safety and welfare was not always promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	People's needs were not always met in a timely and safe way.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place had not always identified or resolves issues in the home that may impact on people's safety and welfare.

The enforcement action we took:

We imposed a condition on the provider's registration to help drive improvement and promote people's safety and welfare.