Woodcote Hall Limited

Woodcote Hall

Inspection report

Woodcote
Newport
Shropshire
TF10 9BW

Date of inspection visit:
30 July 2020

Date of publication:
01 September 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodcote Hall is a residential care home providing personal care to 49 people aged 65 and over. The service can support up to 56 people. Woodcote Hall is a large building set in a rural location. The home has mainly single rooms, but a number of shared rooms are available. The home supports a high number of people living with dementia.

People's experience of using this service and what we found
People were protected from the risk of harm. Staff were knowledgeable of safeguarding procedures and told us they felt confident reporting concerns. Lessons were learnt when things went wrong which ensured people remained safe within their environment.

Some of the providers policies were not being fully met and some of the contingency plans to manage the risk of Covid-19 needed to be formalised. Action was taken to address this at the time of inspection.

Risks to people's safety were assessed in a person-centred way. This ensured they were not unnecessarily restricted. Good infection control practice was observed, and staff were complying with the Personal Protective Equipment (PPE) guidance.

There was sufficient staff to meet people's needs and staff were recruited following safe recruitment procedures. People received their medicines when they needed them from staff who had been trained and, deemed competent in the safe administration of medicine.

People were engaged by the provider and their feedback was sourced to drive improvements. We saw evidence of continuous learning. The provider worked in partnership with others but suggested they would like to improve relationships with some agencies.

Rating at last inspection
The last rating of this service was requires improvement. At this inspection the rating remains the same (published 17 January 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident which staff had reported to the registered manager. As a result, this inspection did not examine the circumstances of the incident but explored the culture within the service to ensure it was not a closed culture.

We found no evidence during this inspection that people were at risk of harm.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was 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.

Woodcote Hall

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.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Woodcote Hall is a 'care home'. People in care homes receive accommodation and 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
We gave a short period notice of the inspection. This was to establish the current status in the home in relation to Covid-19 and confirm the infection control procedures in place for visiting professionals.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought information from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We observed the care people received throughout our day. We spoke with eleven members of staff including the registered manager, deputy manager, senior care workers and, care workers.

We reviewed a range of records. These included five people's care records, incident forms and medication records. We looked at one staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service, policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of harm. We discussed the recent incident with the registered manager and found investigations had been completed and action had been taken as a result of the findings.
• Staff had received training in safeguarding and were able to describe the different types of abuse they needed to be aware of. One staff member told us, "I would protect the residents against any form of abuse, it's my job, that's why I'm in this job."
• Staff were aware of the whistleblowing process and told us they were confident in speaking up. One staff member told us, "All the contact phone numbers we need are on the wall in the staff room. We can always talk to [registered manager] about anything that worries us but if I couldn't, I would call safeguarding or CQC."

Assessing risk, safety monitoring and management
• Risks to people's safety were assessed and plans were in place to mitigate the risk of harm. We found risk assessments had been completed following any accident or incident and these were reviewed on a regular basis. Staff were able to explain the risks they needed to be mindful of when working with certain people.
• Risk assessments were person centred and ensured people were not unnecessarily restricted. We observed people with a history of absconding being able to enjoy time in the garden because of the security measures in place.
• We reviewed recent correspondence from one family member which said, "I know my [relative] is safe, they have settled, and their behaviour has become much more manageable at Woodcote Hall."
• Safety monitoring within the property was being maintained. On the day of inspection, routine maintenance of the fire alarm system was carried out and the hoists had been recently serviced.

Staffing and recruitment
• People were supported by sufficient numbers of staff to meet their needs. Staff were able to provide appropriate supervision and were seen responding to people's needs in a timely manner.
• Staff told us their assigned workload was manageable and any shortfalls in the staff team were covered by colleagues. This meant outside staffing agencies were not required.
• Recruitment systems were reviewed, and the service continued to ensure the character, background and qualifications of new staff were reviewed before a position was offered. One staff member told us, "It is quite a challenging service to work in due to people's complex dementia. We all love it as every day is different, but it is not for everyone. We do lose some new staff early on as they decide it's not for them."

Using medicines safely
• People received their medicines when they needed them and in a safe way. We saw staff maintained good

infection control practices when they supported people with their medicine. Staff gave people the support they needed to take their medicine and stayed with them whilst they took them.
•Some people had medicines which they took only when they needed them, such as medicine to relieve pain. Staff had guidance and protocols in place which informed them why and when people would need to take these medicines. Staff monitored how effective these medicines were. This helped to ensure people's medicines remained effective for them.
• Where staff administered medicines covertly, they had obtained the necessary agreements from other health professionals. This ensured the medicine was safe to be given in this way and in the person's best interest.
• The provider's systems and processes continued to ensure the safety and security of people's medicines and staff competence to manage and administer people's medicines was regularly checked. This helped to ensure staff practice was safe.

Preventing and controlling infection
• People were supported in a clean and tidy environment where the risk of cross infection had been minimised. Due to the Covid-19 pandemic, extra measures were in place to help keep people safe. We saw staff followed and had received training in the current national guidance for the use of masks, gloves and aprons.
• The registered manager ensured current national guidance was followed. All staff and visitors had to follow good hygiene practice when entering and leaving the service. Visitors completed a Covid-19 declaration and had their temperature taken prior to entering the service. This helped to minimise the risk of staff and visitors spreading any infection onto people.

Learning lessons when things go wrong
• Lessons were learnt when things went wrong. Staff fulfilled their responsibilities to raise concerns and report accidents and incidents. The management team reviewed all reports received and actions were taken to ensure events were not repeated. For example, ensuring certain items were not in reach of people known to put things in their mouth
• Staff told us they felt confident reporting as they knew action would be taken. One staff member said, "There is always a senior or the manager around to talk to and, we get told of any changes."

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

• As this inspection has been a focussed inspection, we have not examined all the improvements highlighted on our last visit. Therefore, we would not be able to change the rating for the service. However, when looking at some of the providers policies and procedures we did find not all the policies were being fully met.

• The provider's moving and handling policy stated slings used to hoist people should, where possible, be allocated to individual people. Staff told us people shared slings and there was no cleaning schedule in place. The deputy manager took immediate action, which included ordering new slings to ensure people each had their own.

• We discussed the guidance which has been issued in relation to the current pandemic and found the majority of it had been met. However, not all continuity plans had been formally documented. For example, the service had discussed how they would isolate people in the event of a Covid-19 outbreak, but the outcome of those discussions had not been documented. The registered manager advised us they were working through all the guidance and would document a plan to share with staff.

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

• As part of the inspection process we reviewed the culture within the service and found it to be positive. All the staff we spoke with told us they felt well supported and able to speak to the registered manager about anything. One staff member told us, "[Registered manager] always has time for us and there is nothing they don't know about dementia. Whatever the issue, they will always support us and find a solution."

• We observed the care people received throughout the day. We saw people were settled and appeared happy in their environment. Staff were attentive to people's needs and people were supported to engage in activity, as well as interact with others in the service. One person told us, "The staff are good to us."

• We noted a high number of people in the service were living with severe dementia and for some this led to complex behaviours. When reviewing their care plans, we found positive outcomes for people were promoted, people were encouraged to continue to engage in activities they enjoyed, and risk reduction strategies were person centred.

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 provider was aware of and acted upon their duty of candour. Families were kept informed when

something happened, and conversations with family members were recorded on the incident forms.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were involved in discussions about the service. We reviewed the minutes of the residents' meetings and saw people were able to make requests for things they would like to see happen. For example, in one meeting people requested certain movies be shown, favourite sweets to be added to the sweet trolley and items purchased for the garden. By the next meeting these requests had been fulfilled and new requests were added to the list.
• Arrangements had been put in place to facilitate safe indoor visiting in response to the current restrictions on care home visits. Families were notified by letter of the arrangements and a booking system is in place. Staff were also supporting people to speak with family via the internet.

Continuous learning and improving care
• There was a strong emphasis in the service of continuous learning and developing. New projects were underway in the grounds of the service, with a view to improving people's quality of life.
• Staff told us they were encouraged to review everything and make changes where necessary. One staff member told us, "We work with some complex people, but we learn something new every day. The management team investigate anything we tell them and make recommendations to help us."

Working in partnership with others
• The provider worked in partnership with a number of different agencies. The registered manager explained this was usually a positive experience, but it was an area they wanted to see improve. They explained, "Sometimes other professionals have a set agenda and do not always listen to our view point. This can be frustrating as it leads to advice that is not in the persons or the services best interest."
• We shared this feedback with the local authority, in order to support the service moving forward.