Portland Care 4 Limited

# Wood Hill Lodge

## Inspection report

522 Grimesthorpe Road
Sheffield
South Yorkshire
S4 8LE

Tel: 01143952093

Date of inspection visit:
10 October 2023
30 October 2023

Date of publication:
16 November 2023

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Wood Hill Lodge is a care home that provides accommodation, nursing and personal care for adults living with physical disabilities and/or mental health issues, including older adults living with dementia.

The home can accommodate up to 99 people in one purpose-built building over four floors, each of which has separate adapted facilities. At the time of this inspection there were 44 people residing at Wood Hill Lodge.

People's experience of using this service and what we found
Risk assessments and care records for people were not always in place or up to date to provide staff with the information they needed to support people safely. Medication systems were not managed safely to ensure people received their mediation as prescribed. We found people had not received some medicine and others had been given the incorrect dose. This put people at risk of harm. Infection, prevention, and control (IPC) systems were not robust. Staff did not always follow IPC procedures to manage the risk of cross infection. We found areas of the home were not clean and some areas not well maintained, so were unable to be effectively cleaned.

Some required staff training had been delivered since our last inspection. However, from observations it was not clear if this had been effective. For example, staff had received training and supervision regarding choking risks, yet we observed people being given incorrect thickened drinks and not positioned correctly to reduce risks of choking. We also found some training was still to be delivered to ensure all staff were trained in line with the providers policy.

The registered manager completed a dependency tool and a staff rota. However, it was not clear if adequate staff were effectively deployed to meet people's needs. Some people were commissioned to receive 1 to 1 staffing hours and it was not evident if these hours were always provided.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. However, since our last inspection the registered manager had applied to renew the authorisations for Deprivations of Liberty Safeguards (DoLS).

Staff were aware of what actions to take to safeguard people from the risk of abuse. However, we identified issues during inspection that had not been picked up by the quality monitoring systems and we made 2 safeguarding referrals to the local authority.

We found governance and audit systems were not effective in identifying and reducing the risk to people's safety. There was a lack of effective leadership and oversight of the service.

Accidents and incidents were recorded. However, the documented audit/log was not up to date, and it was not clear if all incidents had been reported correctly. Following our site visit we found 2 incidents that had not been reported.

We received mixed feedback, regarding management and staff from people and relatives. Some spoke highly of the staff and service provided, while others were not happy with the care and support. Staff we spoke with told us the management team were not approachable, they could not raise concerns as they were not listened to and they were not supported

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

Rating at last inspection and update
The last rating for this service under the previous provider was good (published 12 May 2021)

We carried out a targeted inspection on August 2023 and identified breaches of regulations. However, we did not provide a rating. (Published October 2023)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced targeted inspection of this service in August 2023. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and governance.

We undertook this focused inspection to check if they had followed their action plan and to confirm if they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and Well-led which contain those requirements.

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 is inadequate. This is based on the findings at this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment , person-centred care and governance.

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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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?

**Inadequate**

The service was not well-led.

Details are in our well-led findings below.

# Wood Hill Lodge

**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 inspection was carried out by 2 adult social care inspectors, a medicines inspector, a regulatory co-ordinator, and an 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
Wood Hill Lodge 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. Wood Hill Lodge is a care home with 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.

Notice of inspection
This inspection was unannounced.

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 spoke with 8 people who used the service and 3 relatives about their experience of the care provided. We spoke with 13 members of staff including the registered manager, deputy, nurses, nursing assistants, team leaders, senior care staff, care workers, activity co-ordinator and domestic staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included people's care records, multiple medication records, staff files in relation to supervision and training and quality monitoring records.

Inadequate

# 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 in August 2023 we did not rate this key question. This is the first rated inspection of this newly registered service. At our last inspection in April 2021 with the previous provider, we rated this key question good. At this inspection the key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 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.

● People were at potential risk of harm as the provider had not always identified, mitigated, or safely managed risks to people. We had identified issues at our inspection in August 2023 and we found risks were still not managed to ensure peoples safety.
● Risk assessments and care plans were not always in place, accurate or sufficiently detailed to enable staff to support people safely. People at risk of choking, had contradictory information recorded in their risk assessment and care plan, it was not clear which record contained the correct information in relation to the care and support the person required.
● Records were not always up to date and accurate. For example, we found people at risk of weight loss were placed on food charts, but these had not been completed properly, were not reviewed, monitored, or evaluated. Therefore, it was unclear whether the people were receiving adequate nutrition or supported appropriately. This had not been identified by the providers quality assurance processes.

The provider had failed to ensure risks were managed to ensure peoples safety. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were not managed safely which placed people at risk of harm.
• Some people's health was placed at risk of harm because their medicines were unavailable or out of stock. One person missed daily doses of their laxative for 10 days and another person was unable to have 14 doses of their anxiety medicine and they experienced severe anxiety.
• Medicines that needed to be taken at specific times were not given safely. One person was given their doses of Paracetamol too close together for safety. Antibiotics and other medicines that must be given on an empty stomach were given at mealtimes which meant they may not be effective.
• Stock checks for some medicines showed they had not been given as prescribed or incorrect doses had

been given because the supporting care plans and associated paperwork were not updated properly. One person was given incorrect doses of their insulin placing their health at risk of harm. People who had swallowing difficulties and were prescribed a thickening agent to add to their drinks, were at risk of not having them thickened as prescribed because the thickness was different on different documents.
• One person was placed at significant risk of aspiration pneumonia because staff had not thickened their fluid properly and it was too thin for them to drink safely.
• Medicines prescribed 'when required' were not managed safely or consistently. The guidance in place for staff to follow when medicines were prescribed in this way or with a choice of dose was incomplete and not personalised. Staff did not have the information to tell them when someone may need the medicine or how much to give.
• Information was missing to help staff give covert medicines safely. There was no information from the pharmacy about what food and drink each medicine could be mixed with.
• Medicines were not stored always stored safely. The fridge temperatures recorded showed insulin had been stored above recommended temperatures for 3 days, which meant that the insulin may not work properly.

The provider had failed to ensure safe systems for the management and administration of medicines. We found no evidence that people were harmed at the time of the inspection because the harm is not always immediate. However, people were placed at increased risk of harm by unsafe management of medicines. This demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not protected from the risk of infection and staff did not follow infection prevention and control procedures.
● Staff were not using PPE correctly and did not don and doff correctly. Staff were observed leaving rooms after personal care whilst still wearing gloves and not washing hands when required, to reduce risk of cross infection.
●The service was not well maintained. We found areas of the home were not clean and other areas that were not well maintained, which meant they were unable to be thoroughly cleaned. For example, soiled seat cushions, mattresses, and bed linen. Kitchenettes were damaged and broken with engrained dirt which was not possible to clean. Storerooms were cluttered, disorganised and therefore unable to be sufficiently cleaned.

The provider had failed to ensure people were protected from the risk of infection. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● People were supported to maintain relationships with family and friends who were welcome to visit the home without restrictions.

Staffing and recruitment
● We could not be assured there was enough staff on duty to meet people's needs. Some people were commissioned to received 1 to 1 hours, but the rotas in place did not clearly record which staff were allocated to provide these hours. Staff told us that people received 1 to 1 hours, however, we observed people who should be receiving 1 to 1 were sat in the lounge with other people with no specific staff member engaging with them.
● Staff were task orientated and the care provided was not person centred. For example, staff in communal

areas were seen to be supervising rather than engaging with people or offering an activity of their choice.
● People told us the care staff were lovely. People and relatives told they felt there was predominantly enough staff on duty. One person said, "There is enough staff, and they are kind, and we have our banter." However, some felt there were not enough staff on duty. One person said, "There are not enough staff, and their hours are too long." Another person said, "They could do with more staff." Relatives told us they struggled to get in and out of the building at weekends as no staff were around and they could not get through on the phone at weekends. One relative said, "Telephone contact just goes through to reception and there is nobody there on a weekend."
● Staff had received some training following our last inspection in August 2023. The registered manager told us staff were still to receive moving and handling training and this had been booked by the provider. Staff had also received supervisions in September 2023. However, staff we spoke with told us they were not always supported. One staff member said, "Support could be a lot better."
●The provider's recruitment policy helped them recruit suitable staff. This included pre-employment checks such as Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● The provider had a system in place to record and analyse accidents and incidents. However, the audit tool and log we were shown was not up to date and we found a number of issues that had not been identified as part of the provider quality monitoring systems. Therefore, the system in place to record incidents was not effective. This is covered in our well led section.

Systems and processes to safeguard people from the risk of abuse
● The provider had a system in place to safeguard people from the risk of abuse. The majority of staff had received safeguarding training. Staff we spoke with were knowledgeable about safeguarding procedures. However, staff told us they would report to the local authority or CQC as they were not confident the management would respond appropriately.
● The registered manager kept a record of any safeguarding concerns and could evidence issues they had identified were reported to the safeguarding authority. However, the record was not up to date and did not contain all the recent incidents that had been submitted by the registered manager. We also identified a number of issues that had not been picked up by the staff or the registered manager. Therefore, were not reported to the local safeguarding authority. We submitted 2 safeguarding referrals following our inspection.

● People told us they felt safe at the home. One person said, "I feel safe, there are people around."

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was predominantly working within the principles of the MCA. People were able to make decisions. However, they were not always supported to have maximum choice and control of their

lives. At our inspection in August 2023, we found DoLS had expired or had not been applied for when required. At this inspection we found improvements. The registered manager had submitted new applications and applied to renew peoples DoLS where they had expired.

Inadequate

# 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 in August 2023 we did not rate this key question. This is the first rated inspection of this newly registered service. At our last inspection with the previous provider in April 2021, we rated this key question good. At this inspection the key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; Continuous learning and improving care

At our last inspection in August 2023 the provider failed to ensure effective systems and processes were in place to assure themselves of the quality of service and care being provided. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● As described in the Safe sections of this report we identified a number of serious concerns around risk management, medicines, incident reporting, IPC, person-centred care, and staffing. These had not been effectively identified by the provider's quality assurance or auditing processes.
● Audits were minimal and ineffective to assure safe care delivery and environmental safety. For example, the IPC audit completed in October 2023, a few days prior to our visit did not identify any of the shortfalls we found during our inspection.
● A lack of good governance and effective management meant there was no evidence of learning. Incidents had not always been logged on the audit system and there was a lack of evidence that they were investigated adequately to explore where improvements could be made.

The provider failed to ensure effective systems and processes were in place to assure themselves of the quality of service and care being provided. This was a continued breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider did not have an effective system in place to engage with people and relatives. We were given a copy of the last relatives meeting minutes, which was held in January 2023. No other meetings had taken place since. One relative said, "They (provider) called us to a meeting and said they were going to do regular meetings, but they haven't in a year."
● People had attended a meeting in October 2023, however, one person said, "I have never had a

questionnaire to see if I am happy."
● Staff told us they did not feel supported. There was no recorded evidence that regular staff meeting took place.
● It was not clear how the provider engaged with staff to obtain their feedback and ascertain any support or training requirements. Staff had received supervisions since our last inspection in August 2023. However, staff told us this was not an effective supervision and they had just been given pieces of paper to sign. We observed the choking supervision had not been effective. We observed staff were not supporting people safely with thickened fluids.

This was a breach of regulation 17(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; 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 did not have a fully supported management structure. The provider's system did not always effectively monitor the quality of care provided to drive improvements.
● The provider had not always learnt from feedback to help improve the quality of care provided. The provider was made aware following the inspection in August 2023 of improvements that were needed and whilst we found improvements in some areas, such as training and supervision, not all the concerns we had found in August 2023 had been adequately addressed.
● We received mixed view regarding the management. Some people spoke high of the registered manager and deputy. One person said, "The management is good, well run, lovely." While others said the management was poor or were not aware of who the registered manager was. One person said, "The management is poor, they could do with more management." Another person said, "I don't know who the manager is."
● Staff were not supported, deployed, managed, or directed appropriately for them to be able to fulfil their roles and responsibilities. One staff member told us, "We [staff] do not have support from the higher management of the service. They [managers] say they do supervisions, but all this involves is to give you [staff] something to read and then you have to sign to say that you have done it."

The provider had failed to ensure effective systems and processes were in place to ensure managers and staff were clear about their roles. This was a breach of regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
● The provider did not have a system to provide person-centred care that achieved good outcomes for people.
● We observed staff were task focused. There was little or no engagement between staff and people. However, when staff did engage it was caring and appropriate. People were sat in the same chair or wheelchair all day with no change of environment or social stimulation. The terms staff used to describe people were not always person centred. Staff referred to people as 'walkers' and 'wheelchairs.' This is not appropriate and was not picked up by management.
● The environment was in a poor state of repair. We found bedrooms sparsely furnished, most had broken furniture. For example, chest of drawers broken, no fronts on drawers or/and drawers collapsed. We found chairs that people were sat in stained with urine, bedding stained with faeces and mattresses unclean.
● Staff did not support or empower people to make decisions or encourage people to engage in

conversation to improve their well-being and achieve good outcomes. There was an activity coordinator who was very passionate about providing positive outcomes for people. However, they were limited in what they could do with budget and staff to support with outings.  One person we spoke with said, "I am bored, nothing to do."

The provider had failed to promote a positive culture that was person-centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.