Woodford House Healthcare Limited

Woodford House

Inspection report

Watling Street
Dartford
Kent
DA2 6EG

Tel: 01322401030
Website: www.hc-one.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service
Woodford House is a residential care home providing personal and nursing care to up to 39 people. The service provides support to people needing short term nursing or personal care, and some people living with dementia in 1 adapted building. At the time of our inspection there were 28 people using the service.

People's experience of using this service and what we found.
Although we received positive feedback from people and their relatives, we found multiple and significant shortfalls throughout most areas of the service. People were not always treated with kindness, dignity and compassion. Parts of the service were overwhelmingly odorous and staff had failed to identify and address this. People were referred to as numbers instead of using their names; people were not dressed in the manner they were used to which impacted severely on them.

There was a lack of oversight and effective leadership at the service. The provider took over the service in August 2022, however a compliance audit was only completed in March 2023. Although this audit identified areas for improvement, it did not give any deadlines for important actions to be completed, or detail any support needed to complete the actions. The registered manager completed some audits, however these were ineffective in implementing improvements. Opportunities to learn lessons were not used, and we could not be assured that accidents and incidents were documented by staff.

Guidance for staff to inform them how best to support people and mitigate health risks were not sufficiently detailed. Assessments completed before people moved into the service were basic and not detailed. When people received support from external healthcare professionals this was not always documented, and healthcare professionals told us staff were not open and honest.

Staff lacked understanding around mental capacity and had failed to document and review restrictions placed on people. Best interest meetings had not been documented and capacity assessments were not always completed. People were not supported to have maximum choice and control of their lives and staff did not 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.

Although staffing had been reviewed and matched the providers dependency tool, relatives, staff and healthcare professionals told us staffing levels were not sufficient. Staff lacked specific training on how to support people with a learning disability, and induction of agency staff was not sufficient. Recruitment processes were not robust.

People did not receive personalised care specific to their needs. Care plans were basic and difficult to read in places. People did not have specific communication plans in place, and activities did not focus on the needs of people living with dementia or those with a learning disability.

Complaints were not effectively documented and responded to. Relatives told us they found contacting the service challenging and that they were not always kept up to date with their loved one's care.

The management of medicines was safe although there were areas we identified improvements were needed. People had end of life care plans in place however these were not detailed.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and/ or who are autistic.

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
This service was registered with us as a new provider on 30 August 2022 and this is the first inspection.
The last rating for the service under the previous provider was good, published on 18 August 2021.

Why we inspected
The inspection was prompted due to concerns received about people's safety, dignity and respect, staffing. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding vulnerable adults, management of risk and learning lessons, medicines management, staffing, recruitment, people's rights under the MCA, person centred care, dignity and respect, complaints and management and leadership at this inspection. We have made a recommendation about accessible information and communication.

We took enforcement action against the provider and have applied a condition to their registration requiring them to send us monthly reports detailing the action they are taking to make improvements.

Follow up
We will monitor information we receive about the service including the providers monthly reports, 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Woodford House

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 three inspectors 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
Woodford House 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. Woodford House 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, however they were in the process of working their notice.

Notice of inspection

This inspection was unannounced.

What we did before 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. The provider was not asked to complete a 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 7 people who used the service and 19 relatives about their experience of the care and support at Woodford House. We spoke with 12 members of staff including the nominated individual, registered manager, deputy managers, operations and compliance manager, head of care, clinical lead, nurse, senior carers and carers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 2 healthcare professionals.

We reviewed a range of records including 8 care plans and multiple medication records. We looked at 4 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including auditing and monitoring records were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people had not been fully assessed and mitigated. People lived with a range of complex healthcare conditions, some of which posed a risk. However, the guidance for staff was insufficient to inform staff how best to support people.
- People were at risk of receiving unsafe care as significant risks to their safety had not been mitigated against. Some people had diagnosed mental health issues. Specific care plans and risk assessments were not in place to provide staff with the guidance needed to recognise signs of deterioration or what may trigger an episode of mental ill health.
- Some people were at risk of constipation. 1 care plan identified this risk, however there was no guidance to inform staff how best to support people to ensure they did not become unwell.
- One person needed to have dialysis regularly. Dialysis is a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to. There was no care plan in place to inform staff how to support them with this and how to identify if they were unwell. Staff were not documenting the person's fluid and liquid intake and were unaware of the need to do this. There was no record kept of the dialysis visits.
- People who smoked had risk assessments in place, however previous incidents of concern were not recorded to highlight the increased risk.
- Some people lived with diabetes, and care plans and risk assessments were not detailed to inform staff of what to do in the event that someone's blood sugars were too low or too high. Details relating to people's usual blood sugars were not always documented within care plans.
- People living with epilepsy did not have detailed care plans informing staff on action to take if someone was to have a seizure, or what kind of seizures the person had.
- People did not have robust and detailed personal evacuation plans (PEEPs). A fire risk assessment completed in December 2022 identified that PEEPs were not being stored in the fire grab bag in case of a fire, however we identified this was still the case. Since the provider took over in August 2022, there had only been one fire drill during the day, and none at night.
- There were no radiator covers in place throughout the service. The provider had implemented a risk assessment; however this was not robust to mitigate risks to people. The provider ordered radiator covers during the inspection.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was not a robust system in place to document and learn from accidents and incidents. Accidents and incidents had not always been documented on the relevant documentation to ensure that lessons could be learnt and improvements implemented. For example, 1 person's daily notes identified that a person had fallen twice. These had not been documented within the care plan or on incident forms.

● Following the falls identified in the person's daily notes, their care plan was not reviewed or updated to reflect the increased risk.

● Accident and incident oversight was not robust. Analysis of accidents and incidents had only been completed from January 2023. Records showed only 1 incident had been captured for the two months analysis completed, however the provider could not be assured that this information was correct.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were supported by staff who had not always been recruited through safe recruitment processes. Gaps in staff employment histories had not always been explored, and dates of employment did not match dates given by previous employers on references. Where this occurred, the provider had not checked this information to ensure they had a full and complete employment history.

The registered person failed to have safe and robust recruitment processes in place. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There were enough staff to keep people safe. The provider used a dependency tool to assess the number of staff needed. We checked rotas and identified that staffing numbers were in line with the dependency tool.

● During our inspection we observed call bells being answered in a timely manner, and people not waiting for support. There were sufficient numbers of staff to support people with their needs.

● Feedback from staff and healthcare professionals was that staffing was not always in line with the needs of people. Prior to the inspection, the provider made the decision to pause admissions to the service. Staff told us that staffing levels were currently stable, however, when the service admitted new people staffing levels were not always considered and this left staff stretched.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Staff had received training in safeguarding and told us they understood how and where to raise concerns about people. 1 staff member told us, "100% I would raise any abuse every time."

● The registered manager investigated concerns raised and worked with the local authority safeguarding team to address any issues highlighted. However the recording of this could improve. Safeguarding concerns were not kept in an organised way and full records, such as copies of investigations into incidents and the outcome were not recorded to enable the registered person to effectively analyse trends.

Preventing and controlling infection

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some parts of the service were odorous and had not been identified as in need of deep cleaning.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visitors were able to visit people as often as they wanted. Some visitors we spoke with went to the service daily to spend time with their loved ones.

Using medicines safely
● People received their medicines safely and as prescribed. Medicines were stored safely and securely.
● PRN ('when required') medicines protocols were in place for all medicines and were detailed and person centred. This helped to support staff to know when and how to administer these medicines to people safely. When they were administered, staff recorded why it was needed and if it had been effective.
● Medicines with additional storage requirements were stored safely and securely. Records showed that these medicines were checked regularly and a spot check of these found no discrepancies.
● People's MAR charts included a cover sheet which recorded allergies, an up-to-date photo and other supporting information about a person's care and treatment including how they liked to receive their medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff did not always understand and implement the principles of the MCA. DoLS applications had been made in response to incidents, and not following an assessment of a person's capacity when necessary, to assess their understanding of why they needed care and treatment in a care home.
- Staff we spoke with did not show a good understanding of the MCA. For example, staff were unaware that they were not legally authorised to stop someone leaving the service without an authorised DoLS in place. All staff we spoke with told us they would stop someone from trying to leave the service without an authorised DoLS. There were instances where staff stopped a person leaving the service.
- One person had restrictions placed on them. Their care plan did not regularly review the restriction or consider if it was the least restrictive option.
- When people lacked capacity, mental capacity assessments and best interest meetings had not been completed. There was no evidence that staff had sought support from healthcare professionals to ensure decisions were made in a person's best interest with the relevant stakeholders.

The registered person failed to put in to practice the requirements of the MCA. This is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training , skills and experience

● Staff lacked the skills, experience, and training to effectively support some people. Some people living at the service had a diagnosis of learning disabilities and Autism, however staff had not undergone any specific training in supporting people with these conditions. We observed staff did not know how to support people with a learning disability during our inspection and that clear guidance was not in place to make sure they received appropriate support. Staff did not understand how a persons learning disability impacted on the way they communicated their frustration and lacked the skills to de-escalate any distress the person showed.
● A third of staff had not updated their MCA training, and not all staff had up to date training in DoLS. We found staff lacked understanding of the MCA and DoLS. Not all staff had up to date fire awareness training. We found that fire drills had also not been completed, and PEEPs were not stored in the fire grab bag.
● The induction for new agency staff was not robust enough to ensure that they could safely meet peoples care needs. There was a reliance on agency nurses to provide support to the service, however we identified there was a lack of induction for agency staff. The agency nurse on duty during our inspection was only given a sheet listing people's names and room numbers and did not include important health information. People were at risk of not receiving the care and support they needed, due to staff not knowing their needs.
● Relatives told us they felt the training needed to be improved. Relatives told us, "The training is getting better since the new people took over but I think they need more training," and, "Some are experienced in what they do. They struggle with recruitment therefore there is a lack of experience and it does show. Some don't know what they are doing."

The registered person failed to ensure staff were appropriately skilled. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had an onsite training team who delivered training to staff. Staff had received a range of training to support people, including training to move people, dementia training and safeguarding people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People did not always receive consistent effective care. Staff did not follow advice from healthcare professionals relating to people's care. One person had a condition which caused their skin to breakdown and be at higher risk of infection. There was no clear plan of how staff could support them to maintain their personal hygiene to mitigate the risks, as suggested by healthcare professionals.
● People were not always supported to live healthier lives. Records we reviewed evidenced that some people had not been supported to clean their teeth for up to 2-3 days at a time.
● Some people left the service for regular health care appointments. These were not documented in the person's care plan, and their relative told us the person had missed appointments.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always robustly assessed prior to them moving into the service. Prior to people moving in, an assessment of their needs was completed. Assessments did not always contain the level of information needed to inform care plans. Assessments were not always fully completed or contained one-word answers. Staff lacked information needed to create detailed and informed care plans. We discussed this with the provider who agreed improvements were needed to the assessment process.
● Staff were not aware of guidance relating to supporting people with a learning disability, for example Right support, Right Care, Right Culture. We found the principles of this was not implemented within care planning or providing to support to people with a learning disability or autistic people. We discussed this with the registered provider who shared the guidance with staff and planned to review and implement the guidance.
● Staff used recognised national tools to support their assessment of the person. For example, people had

MUST assessments in place to help assess their risk of malnutrition. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition.

Adapting service, design, decoration to meet people's needs

● The design and decoration of the service did not meet everyone's needs. Parts of the service were homely and well maintained, with people's personal possessions. However, other rooms were bare, with no personal items. People who were at the service for a short period of time had very little in their rooms to identify them.

● There was no dementia friendly signage or adaptations to support people who may become confused to their surroundings. For example, door and walls were the same colour, which could make it difficult for people to distinguish between the two.

● The design, layout and furnishings in people's rooms did not always support peoples individual needs. For example, one person did not have access to plug sockets in their room to charge their mobile phone. They raised this with staff, who told the person they would supply them with an extension lead.

The registered person failed to provide appropriate support in a person-centred way. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat and drink sufficient amounts. Staff told us that the food had improved since the new provider had taken over. Staff told us, "They have improved the catering lists in the morning. We used to wing it and it kind of worked but now it's more structured."

● When people moved into the service, staff completed nutrition documentation that was shared with the chef. We spoke with the chef, and they showed a good level of understanding of risks to people, any specific dietary requirements people had including if people needed their food adapted for example if they had swallowing concerns.

● Relatives gave positive feedback about the food including, "The food is good. Mum has a varied diet with lots of chicken which she enjoys. She's on a diabetic diet which is catered for," and, "The food is much better since the new people took over."

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Although we observed kind and caring observations when staff supported people, people were not always treated in a dignified way. For example, on numerous occasions during the inspection, we observed staff referring to people by their room number, not by their name.
- The provider told us they were aware of this practice, and had discussed this with staff, however this was a practice we continued to observe.
- People were not always supported to express their views and be involved in decision making. For example, there were no records to confirm people had been supported to make complex decisions about their care.
- 1 person had expressed they wanted to move out of the service into a more independent living environment. There were no records to evidence staff were regularly liaising with other healthcare professionals to achieve this, or discuss this further, including or updating the person in a way that was meaningful to them.
- People were not always treated with dignity and respect. Parts of the service, including the communal lounge smelt overpoweringly of urine. Staff told us some people refused support with personal care. However, there was no evidence that they encouraged people in an individual way, such as at different times, or with staff they favoured, to support them with personal care and to ensure their dignity was maintained.
- Some people looked visibly unkempt, with un-brushed hair and stained clothes. Staff did not identify and could not evidence what support they had given people to complete their personal care routines.
- A relative told us their loved one was not always in their own clothes, or appropriately clothed when they visited, they said, "When we visit, [name] has someone else's underpants on or none at all."
- Staff had not considered if people were matched with staff and as a result, people were not always at ease, happy, engaged and stimulated.
- People did not always have the opportunity to try new experiences, develop new skills and gain independence.

The registered person failed to ensure care was provided in a caring and dignified way. This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- We received positive feedback from people and their relatives about the care they received. Relatives told us, "The staff are very kind and caring, friendly and helpful and they talk to [name]," and, "They know him

well. They treat him with respect, they ask him what he would like and call him Mr. They keep him private when he goes to the bathroom."

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive personalised, person-centred care specific to their needs. Care plans were not person centred and lacked information including how people like to be supported with personal care.
- Staff we spoke with told us that there was not always time to review care plans. One staff told us they would benefit from a 1 -page document informing them how best to support people. This would also be beneficial for agency staff supporting people for the first time.
- None of the relatives we spoke with told us they had been involved in the developing or review of their loved one's care plan.
- The provider was in the process of moving to an electronic care planning system. We reviewed a newly created care plan, which was an improvement on the current care plan, however this contained errors and did not provide sufficient detail on how best to support the person.
- Staff did not support people through recognised models of care and treatment for people with a learning disability or autistic people. Staff did not always have good awareness, skills and understanding of individual communication needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The provider carried out a resident's survey in January 2023. At this time, mostly positive feedback from people was given regarding 'learning new life skills and being independent.' However, when we spoke with relatives, they told us that people were not always engaged in meaningful activities. Six relatives told us that their loved one did not take part in activities. They said, "They do play bingo but Mum has dementia so she can't always join in," and, "They do have activities but [name] isn't able to do anything like that."
- Some relatives fed back concerns relating to activities. A relative told us, "[Name] has never done any activities, they are awaiting an activities coordinator. She needs to do some basic activities and have some engagement. She hasn't been out on any trips. I've raised this with the manager but they don't have the staff to do this." Other relatives told us, "I've spoken to the manager about this and staffing levels but nothing changes."
- There was no clear structure to provide activities who stayed in their rooms to ensure people were engaged and not at risk of social isolation. A relative told us, "They don't have the time to sit and chat, they clean him and change him but that's all they have the time to do."
- 1 person had been offered additional funding to take part in additional activities. This had not been taken forward my managers to ensure the person was supported to go out more frequently and take part in other activities.
- The provider had reviewed staffing levels for activities staff for this service and the providers other service

and increased these. However this had not yet positively impacted people receiving 1:1 activities or consideration into specific activities for people including those who were cared for in bed, or people living with dementia or a learning disability.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People did always not have individual communication plans/ passports that detailed effective and preferred methods of communication, including the approach to use for different situations.

● There was accessible information for example pictorial or large print documents, however these were displayed on a busy notice board, and there was no evidence people had been supported to access and review this information in a meaningful way.

The registered person failed to provide appropriate support in a person-centred way. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There was not an effective system in place to document and respond to complaints. Not all complaints received had been documented and it was not clear that people were happy with the outcome of their complaint.

● Before our inspection there was no system in place to look at trends and patterns and implement any improvements relating to complaints raised. Two complaints that were raised related to a lack of personal care. Although the complaints had been responded to and shared with staff there was no evidence of any learning from the complaints.

● Three relatives we spoke with told us they struggled to contact staff at the unit. They told us, "You try and ring the home and you can't get through on reception, sometimes fifteen, twenty times," and, "When you ring it's like its non-existent as no one answers the phone. I've given up ringing," and, "When I ring up nobody answers the phone, I can't get through."

● Two people had signs in their rooms from their loved ones relating to clothing items going missing. Staff had not considered investigating concerns and feeding back to people and their loved ones about any improvements made to the laundry service. A relative told us, "Clothes go missing in the laundry. This has gone on for weeks. We are constantly raising these issues and nothing changes. We get no feedback."

● On the second day of our inspection a new complaints log had been implemented, and additional complaints had been added to the log.

The registered person failed to follow a process to investigate and monitor complaints. This is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

End of life care and support

● People had end of life care plans in place, however the quality of these varied, and they could be improved. Staff told us not all people wanted to discuss their wishes of the end of their lives, and in these cases they would re-visit those decisions at a later date, however this was not documented within the care plan. We discussed this with the provider, who told us they were in the process of re-writing all care plans to make them more person centred.

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.

This is the first inspection for this newly registered service. This 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

- We found significant concerns at Woodford House. The leadership and oversight at the service was not adequate to identify and implement improvements to the service and ensure people received safe consistent support.
- Senior staff did not always understand and did not always demonstrate compliance with regulatory and legislative requirements. For example, the registered manager and registered provider were not aware of guidance to support people with a learning disability or autistic people and were not meeting aspects of this guidance. Care planning did not include the individual, consideration had not been given to goals and aspirations or continuity of staffing people may need. Care plans were handwritten and difficult to read in places.
- The registered manager completed a number of audits; however these did not address the issues highlighted during in the inspection. For example, the IPC audit identified that not all residents were wearing their own clothes. There were no actions to be completed, and no deadline to ensure people had access to their own clothes.
- There was not a culture of learning and improving within the service. We identified multiple areas where the service needed improvement, including care planning, incident recording and management, induction, complaints handling, dignity issues relating to odours, the lack of person-centred care.
- The provider took over the service on 30 August 2022. However, the providers compliance team only completed 1 audit of the service, and this was in March 2023. Although some issues we highlighted had been raised within the audit, the audit was ineffective. There was no deadline or detail of who and how improvements would be implemented. We found these issues remained unaddressed during our inspection.

- The provider's oversight of the service was ineffective. Although the provider and their senior team told us during the inspection they were aware of issues at the service, they had not taken timely action to ensure the safety and quality of care improved for people.
- The service did not complete quality control checks for the calibration of its blood glucose monitoring machines. These machines are used to support staff to know how to help manage a person's diabetes. Without completing these checks there is a risk that they could administer medicines based on inaccurate readings. We discussed this with the staff team who confirmed they would complete quality checks on the equipment.

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

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Although some people and their relatives told us they were happy living at the service, we found that there was not a positive person-centred culture.

● People and their relatives were not always consulted in relation to decision making about their care. Feedback from relatives included "They don't communicate or tell me if anything is getting better or worse," and, "No I don't get any calls from them, and I've not met the new manager."

● Staff did not always encourage people to be involved in the development of the service. People and their relatives told us they were not involved in care planning. A relative told us, "There is no communication or poor communication. They don't keep me informed."

● Since the provider took over the service, there had been 1 relative's meeting in January 2023. However some issues raised from the meeting had not been addressed at the time of our inspection. For example, concerns regarding laundry were raised, and we found these issues remained, there was also discussion about pictorial food menus to support people choosing their food which were not in place when we inspected.

Working in partnership with others

● The registered manager worked with other healthcare professionals where necessary to provide joined up care to people, however some healthcare professionals told us that staff were not approachable.

● Staff contacted healthcare professionals when needed to ask for advice and guidance. However, healthcare professionals we spoke with told us staff and the management were not welcoming towards them.

● Staff did not always have the information needed to work with other professionals. A healthcare professional told us, "Staff were rather rude and when asking for documents to review were unable to produce them." Another professional told us, "The staff are defensive. Rather than them being cooperative."

The registered person failed to keep accurate records and to operate a robust system to monitor the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Senior managers had links with other organisations to encourage improvement and learning, such as skills for care and were part of the registered managers forum.

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 registered provider and registered manager were aware of their duties in relation to the duty of candour.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person failed to put in to practice the requirements of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person failed to have safe and robust recruitment processes in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to ensure staff were appropriately skilled.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person failed to provide appropriate support in a person-centred way.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person failed to ensure care was provided in a caring and dignified way.

The enforcement action we took:

We imposed a condition on the providers registration.

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	The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The registered person failed to follow a process to investigate and monitor complaints

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Treatment of disease, disorder or injury	governance The registered person failed to keep accurate records and to operate a robust system to monitor the quality and safety of the service provided.

The enforcement action we took:

We imposed a condition on the providers registration.