North East Care Homes Limited

Woodlands

Inspection report

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Tyne and Wear
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Woodlands Care Home provides residential care for up to 42 older people. At the time of the inspection there were 20 people living at the service, some of whom were living with a dementia.

People's experience of using this service: The location has a history of none compliance with regulations and has been inspected six times since July 2015. At no inspection during this period has the provider achieved an overall rating of good.

At the last inspection we found three breaches of regulations. There was a failure to provide safe care and treatment, a failure to ensure staff had the required training and a failure to assess, monitor improve and mitigate the quality and safety of the services provided.

The service was not well led. The provider failed to have sufficient oversight of the home and ongoing breaches of regulations were identified. In total, nine breaches of regulations were identified during the inspection.

The action plan devised by the provider in response to the findings at our last inspection had not driven improvement.

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. Consent to care and treatment was not always sought in line with the principles of The Mental Capacity Act 2005 (MCA).

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; the policies and systems in the service did not support this practice.

Appropriate action was not always taken to safeguard people from abuse. Incidents of a safeguarding nature were not always reported to CQC.

Training the provider deemed mandatory had not been delivered to staff.

Timely action had not been taken to address concerns regarding the environment. This placed people at risk of avoidable harm.

Support was not personalised and specific to the individuals needs and people were not always treated with dignity. Staff had not completed training in dignity and respect and had not recognised situations which were undignified for people.

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

Why we inspected: The inspection was brought forward as we received information of risk and concern.

Rating at the last inspection: The service was rated as requires improvement (the report was published in August 2018).

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have concluded.

Follow up: Following the inspection we referred our concerns to the local authority responsible for safeguarding. In addition, we requested an action plan from the provider, and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The overall rating for this registered provider 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 not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Woodlands

Detailed findings

Background to this inspection

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

Inspection team: The inspection team consisted of two 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 service.

Service and service type: The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the CQC. A registered manager 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: This inspection was unannounced.

What we did: Prior to the inspection, we checked all the information we had received about 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 with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We contacted the local authority commissioning and safeguarding teams and the local Healthwatch. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

Throughout the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them.

During the inspection we spoke with six people who used the service. We spoke with 10 members of staff including the manager and regional manager.

We reviewed the care records for 11 people. We looked at four staff personnel files, in addition to a range of records in relation to the safety and management of the service. After the inspection we reviewed further information which we had requested from the management team.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse.
• People and their relatives told us they felt safe however, despite this feedback, we found significant concerns about the safety of the home.
• Incidents of a safeguarding nature had been reported to the local authority for analysis and potential investigation. The local authority provided feedback that the appropriate action had not always been taken to safeguard people from harm or abuse. Safeguarding training had only been completed by the home manager.
• People with reduced mobility, for example who were unable to walk any distance and did not have their own wheelchair, were unable to leave the service. The manager told us, "People are being deprived of their liberty whether they have capacity or not due to the equipment not being available to leave the building."

These findings were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding.

• The provider had not notified CQC of all safeguarding allegations. This meant that the CQC did not have oversight of all safeguarding allegations to make sure appropriate action had been taken.

These findings were a breach of regulation 18 of the Care Quality Commission Registration Regulations 2009: Notification of other incidents. This is being followed up and we will report on any actions once complete.

Assessing risk, safety monitoring and management; Preventing and controlling infection.
• At the last inspection in July 2018, we asked the provider to take action to make improvements. Medicines were not managed safely, there were some fire safety concerns and the provider had failed to assess and mitigate some risks, and this action had not been taken.
• Accurate and robust risk assessments were not in place for all people who used the service and were not sufficiently clear to guide staff. For example, one person's personal emergency evacuation plan (PEEP) did not include information of how behavioural changes could impact on their mobility or if they would need additional staff support as a result of this.
• A fully addressable fire alarm system which directly linked to a fire control panel was not in place. This is recommended by the Department for Communities and Local Government (DCLG) Residential Care Premises Guide as best practice. The current system meant there would be a delay in staff being aware of the exact location of a fire, which could delay any evacuation. The manager said they would raise this with the provider however, this had still not been rectified.
• Equipment used by staff to provide care was not properly risk assessed to ensure it was safe for use. For example, bath lifts, hoists and wheelchairs were not referenced in people's personal risk assessments.

• Communal wheelchairs were used to support some people. Individual assessments had not been completed for the use of these. The manager told us, "Wheelchairs are not maintained by anyone."
• Moving and handling slings were shared and not laundered between each use. This was an infection control risk. The regional manager told us people should not be sharing slings and action would be taken to ensure additional slings were purchased.
• People were not supported to wash their hands or offered a hygiene wipe prior to eating their meal. This included people who had taken part in a pet therapy session and had been feeding biscuits to a dog.

Using medicines safely.
• Medicines were not always managed safely.
• Medicines were not always administered according to the prescription instructions or at the right time. For example, medicines that need to be given at a specific time to prevent side effects.
• Controlled drug medicine stock had not been monitored thoroughly. For one person who was prescribed a controlled drug we found this was not recorded on the medicine administration record (MAR) and there was no record of when the bottle of medicine had been opened. This is required to ensure the medicine is disposed of according to the instructions.

These findings were an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staffing levels and recruitment.
• Safe recruitment practices were generally followed.
• Gaps in the employment history of potential employees had not always been fully assessed. However, the provider application form only requests a 10-year employment history. We brought this to the attention of the manager who assured us they would bring this to the attention of the provider; appropriate pre-employment checks had not always been completed for example, checking references.
• There were enough staff on duty to meet people's needs. However, we received mixed feedback from people. One person said, "I think so [enough staff], but they don't have enough time to chat much."

Learning lessons when things go wrong.
• Accident and incidents were recorded. However, there was no detailed analysis of the reason why an incident had occurred, or consideration given to different ways of working to prevent repeated incidents.
• Staff did not reflect on their practice to consider better ways of working.

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience.
• At the last inspection in July 2018, we asked the provider to take action to make improvements. Staff had not received appropriate training to enable them to carry out their duties they were employed to do, and this action had not been taken.
• Training identified as mandatory by the provider had not been completed by staff. For example, staff had not received refresher training around moving and handling, Mental Capacity Act 2005, deprivation of liberty safeguards, challenging behaviour, fire safety and dignity and respect.
• Staff had not always completed training in topics relevant to the needs of the people they cared for such as behaviour which may challenge staff.

These findings were an on-going breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

Adapting service, design, decoration to meet people's needs.
• Maintenance of the property was poor and there were serious health and safety concerns regarding the environment and equipment.
• There was no formalised maintenance system in place to address any required repairs. For example, the electrical testing certificate dated 28-30 November 2018 was marked as 'unsatisfactory'. The testing report identified six potentially dangerous areas and one area where improvement was recommended. These needed to be addressed before a satisfactory certificate could be issued. The manager told us they reported this to the provider. However, it was not until March 2019 the funding for the work was authorised.
• Timely action had not been taken to address serious issues with the mechanics of the lift. This included the lift shaft filling with water due to a cracked water pipe, broken lift buttons and the lift base not being flush with floor level when the doors of the lift opened at the destination floor creating a tripping hazard to people. The manager reported this to their manager in February 2018 and repairs had not been completed at the time of the inspection.
• The home needed redecoration and the standard of cleanliness varied within the building. For example, there were numerous holes in walls and paint chips around the building. Ledges had not been cleaned effectively and cobwebs with dead flies were present around the environment.

These findings were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment.

• The home had some adaptations for people living with dementia. For example, pictorial signage which

helped people to orientate themselves.

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 Act 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 with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The manager had not always followed the principles and guidance related to MCA and DoLS authorisations.
• Capacity assessments had not been completed for decisions made on behalf of people. For example, people who received their medicines covertly [hidden in food].
• There were no capacity assessment or best interest decisions recorded in people's care plans to reflect how their diagnosis impacted on their ability to make decisions in relation to their care and treatment.
• Copies of Lasting Power of Attorney (LPA) were not available. Checks were not carried out to confirm a relative or friend had the legal right to make decisions on the person's behalf. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future.

The principles of the MCA had not always been followed, therefore this is a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014: Need for consent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• An assessment of people's needs had been completed. They did not demonstrate that people were involved in the planning of their care.
• Support plans contained limited person-centred information and varied in the amount of detail they contained.
• Care plans had not always been reviewed at the frequency identified by the provider. Reviews had not always taken place when a change in need was identified for the person.

Supporting people to eat and drink enough to maintain a balanced diet.
• Staff were knowledgeable about people's dietary needs and preferences. People told us they liked the food.
• Aspects of the meal time experience were task orientated. For example, staff moved between people to support them with their meal.
• People were asked what they would like to eat prior to the meal time. Menus were not available in picture format and people were not shown a choice to stimulate their senses, to help them make their decision. Alternative food options were available to people who did not want the choice of meal on offer.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
• People were supported to have access to a range of healthcare professionals to ensure they remained healthy.

Requires Improvement

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.

People did not always feel well-supported, cared for or treated with dignity and respect. Some regulations were not met.

Ensuring people are well treated and supported; respecting equality and diversity.
•The provider failed to recognise the importance of ensuring all staff were provided with training and support to allow them to provide care and support to people in a person-centred way.
• Dignity was not always maintained for people during hoisting procedures. For example, one person was observed to be wearing a skirt and during the hoisting procedure their skirt raised to their thigh. Staff continued with the hoisting manoeuvre and did not protect the person's dignity by covering their legs. Staff only adjusted the person's clothing once they had completed the transfer.
• Staff had not completed training on dignity and respect and this was reflected in the way they did not recognise when people were presenting in an undignified state. For example, we observed people being unshaven and lack of nail care.

These findings were a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 10: Dignity and respect.

• People we spoke with told us that staff were caring. Comments included, "It's how staff go on, they really care. Staff always ask how we are or if we need anything."
• Throughout the inspection we observed staff to treat people with warmth, compassion and kindness.

Supporting people to express their views and be involved in making decisions about their care.
• Records did not always evidence people had been involved in decisions regarding their care. Relatives told us they were involved in developing care plans for people.
• People's communication needs were recorded in care plans. Records varied in the amount of detail they contained.

• Advocacy services had been used to support people. An advocate helps people to access information and to be involved in decisions about their lives.

Respecting and promoting people's privacy, dignity and independence.
• Staff described ways in which they worked to maintain the privacy and dignity of the people they cared for during personal care support. Staff treated people with respect and always sought consent before carrying out any personal care support.
• People's confidential information was stored securely and could be located when required. This meant that people's confidentiality was maintained as only people authorised to look at records could view them.

Inadequate

Is the service responsive?

Our findings

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

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• People did not receive personalised care and support specific to their needs and preferences.
• There was a lack of meaningful activities for people and this was also highlighted in an audit completed in January 2019 by the provider. No action had been taken to address this issue at the time of inspection.
• Observations in the communal lounge showed a lack of engagement between people and staff unless a support task was being provided. Staff had not been allocated to ensure people were supported to take part in their chosen activity or interest.
• An activity coordinator was not in post and the only activities observed during the inspection were provided by external agencies.
• Care plans contained some contradictory information and it was not always clear if they had been reviewed and updated following incidents or changes in people's needs.
• There was limited information about people's preferences, likes, dislikes and cultural needs recorded within care plans and some sections of records were blank. Care plans did not always include information relevant to the person's life history.
• There was no documented information in relation to people's preferences to be supported by staff of the opposite gender for personal care. A male member of staff said, "I support the females with personal care." They confirmed they were not chaperoned to do so, and the manager said there was no policy or procedure in place for the provision of personal care.

These findings were a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9: Person-centred care.

• Care plans reflected involvement with other health and social care professionals.
• Visitors were welcomed into the home. Staff supported people to maintain relationships with their family.
• Some information was available for people in accessible formats. For example, some pictorial documents had been produced to support people who could not understand written words.

End of life care and support.
• End of life care plans were not in place. This meant staff were not given instruction about how people wanted their care to be delivered at this difficult time. We brought this to the attention of the manager who said, "We have tried to have the conversations with family members, but they haven't wanted to engage." There was no evidence of staff discussing end of life support with the people receiving care.

Improving care quality in response to complaints or concerns.
• Systems were in place for any concerns, complaints, or compliments to be acknowledged, investigated

and responded to.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
• The leadership of the service was ineffective. This led to unsafe practice for example, the provider and manager were not aware of the concerns we raised during our inspection.
• Timely action had not been taken to address the concerns regarding the environment which placed people at risk.
• The manager understood duty of candour. They described it as, "A duty to report anything to CQC and authorities. Understand legal requirement to report to ensure safety, to be transparent. Apologise to people and families if something goes wrong."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• At the last inspection in July 2018, we asked the provider to take action to make improvements. There was a failure to assess and mitigate some risks and monitor the quality and safety of the services provided, and this action had not been taken.
• The manager had been in post since before the last inspection however, they had not yet registered with the Commission. Woodlands had been without a registered manager for a total of 392 days at the time of the inspection. This is being followed up outside of the inspection process.
• The manager said they understood their role however, we found the location was not well managed and there were widespread and ongoing concerns identified.
• An effective system was not in place to ensure all required notifications were submitted to CQC.
• The registration certificate for the previous registered manager and previous nominated individual was on display within the home.
• Governance procedures had not been effective in identifying the concerns noted during this inspection.
• Provider audits had not been completed at the identified monthly intervals. Some audits had generated action plans however, actions had not been signed off as completed.
• The lack of oversight of records and the accuracy of these had resulted in a failure to assess, monitor and mitigate risks to the health and wellbeing of people using the service.

These findings were a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17: Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

• Meetings had been arranged with residents and relative's regarding the home. However, the manager explained attendance was low, so they were attempting to speak with people and family members on a one to one basis to update them on developments in relation to the home.
• Staff meetings were held with different departments and areas of concern were discussed.
• The provider did not use surveys to obtain the views of people, relatives, staff or external professionals.

Continuous learning and improving care.
• An action plan was submitted to the commission following the last inspection, but this had not been fully implemented. The manager told us they had not seen this action plan. We noted their name was documented on the action plan as one of the people who contributed to its development and as the person responsible for ensuring the actions were completed.
• There was no home improvement plan despite the provider and manager being aware that improvements were needed. There was no evidence of continuous learning and improving care.

Working in partnership with others.
• Some links had been established within the community. The local nursery visited the home with the children. The manager told us, "It's fantastic, people love it, they read to each other and the teacher feels it enhances the lives of the children and the residents." There was no evidence that risk assessments were in place for this engagement.
• Partnership working with the local authority commissioning team and safeguarding teams was not always apparent.

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 The provider failed to ensure they had done everything reasonably practicable to make sure people who used the service received person-centred care and support that was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1) (3) (a)(b)(c)(d)(e)(f)(g).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005. Regulation 11 (1)(2)(3).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment Not all risks had been assessed or action taken to reduce the risk of harm. Systems and processes in place failed to ensure that the premises and equipment used by the service provider were always clean and safe. Systems and processes failed to assure the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(d)(e)(g)(h).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems were not fully in place to protect people from the risk of abuse. Regulation 13 (1)(2)(3)(6)(b)(d)(7)(b).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Equipment and the premises was not always suitable, properly used or appropriately maintained. Regulation 15 (1)(a)(b)(c)(d)(e)(f)(2).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service nor to monitor and mitigate the risks to the health, safety and welfare of people who used the service. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing An effective system was not in place to ensure staff received appropriate training and support to enable them to carry out their duties they were employed to perform. Regulation 18 (1)(a).

The enforcement action we took:

Through enforcement action we cancelled the providers registration of this location.