Kodali Enterprise Limited

Woodside Care Home

Inspection report

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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
Woodside Care Home is a residential care home providing personal care for up to 42 people aged 65 and over. At the time of the inspection there were 28 people receiving care.

People's experience of using this service and what we found
Service users were at an increased risk of acquiring COVID-19 as the provider failed to have systems in place to identify and protect people in the high-risk category.National infection prevention guidelines were not followed. The provider failed to ensure staff and people living in the service were tested regularly for COVID-19 in line with government guidelines.

The service was unclean, the provider failed to ensure there were checks to keep the service clean. Measures were not put in place to protect people if COVID-19 were to get into the service. Some staff were not wearing PPE and some staff were wearing PPE incorrectly.

People were at risk of harm due to poorly managed health conditions such as diabetes and urinary tract infections. People were at increased risk of dehydration and urine infections as there was no oversight of what people drank; fluid charts were not completed or were inconsistent. This increased the risk of dehydration.

People at risk of falls were at risk of harm from falls and altercations between residents due to a lack of review and analysis and inconsistent recording.

Environmental risks were not managed which increased the likelihood of people tripping and falling; equipment was not secured to walls, and lighting was not sufficient. Temperature checks of water were not being carried out which increased the risk of people being harmed from scalding hot water.

People were not protected from abuse. The leadership of the service did not create a positive environment where people felt safe to speak out and report abuse. Incidents such as alleged theft, neglect and physical altercations between people were not reported to the relevant authorities and notifications to the CQC and local authority safeguarding team were not made.

Staffing levels were not sufficient provide safe care to people. Low levels of staffing during the night-time meant staff would not be able to evacuate people safely in an emergency. Low levels of staffing during the daytime meant people did not receive the care they needed to keep them safe from harm from other people living in the service.

The provider failed to ensure adequate leadership or oversight. The service was not person centred and people were provided with institutional care which was task focussed.

The provider failed to create an open culture and failed to investigate serious incidents and share information with partner agencies.

The provider failed to operate effective systems to assess, monitor and improve the service. Their failure to review audits affected the safety and quality of the service. Because of this, outcomes for people were poor and the safety of the service was inadequate and placed people at an avoidable risk of harm.

People received their medicines as prescribed. Medicines were stored safely.

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

Rating at last inspection
The last rating for this service was requires improvement (published 3 June 2019)

Why we inspected
This was a planned inspection based on the previous rating. The inspection was prompted in part due to several concerns received about neglect, staffing and abuse. A decision was made for us to inspect sooner 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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 12 safe care and treatment, Regulation 13 safeguarding, Regulation 17 good governance, Regulation 18 staffing, Regulation 19 fit and proper persons employed and Regulation 18 notification of other incidents (Registration).

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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor

progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Woodside Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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.

Service and service type
Woodside Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A manager was in the process of applying to become the registered manager. They are referred to throughout this report as the 'manager'. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection
We gave the provider 24 hours' notice of our inspection on our first day of inspection. This was due to the risks associated with COVID-19 and allowed inspectors to conduct a risk assessment. The second day of inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. 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.

During the inspection
We spoke with six people who used the service. We spoke with ten members of staff including the provider, manager, assistant manager, senior care workers, and care workers.

We reviewed a range of records. This included sixteen people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- The provider had not ensured people were protected from the risks associated with COVID-19. Risk assessments had not been carried out to establish who was in the high-risk category due to pre-existing health conditions. No plans were in place to ensure those in the high-risk category could be safely cared for in the event of an outbreak. This increased the risk of people being harmed.
- People using the service and staff had not been tested for COVID-19 in line with government guidelines. Staff did not always follow the latest government guidance in relation to wearing PPE. Staff were seen not wearing PPE at all and other staff were seen wearing masks incorrectly. This greatly increased the likelihood of transmission of COVID-19 from staff who were asymptomatic and had not been tested.
- Arrangements for staff to put on and take off their PPE was unsuitable. Staff had to walk through communal areas without wearing PPE prior to putting it on.
- People were at risk of cross infection. The service was not clean and hygienic. Several communal toilets and ensuite bathrooms were visibly dirty.
- Despite several requests for training information to be provided to inspectors, the provider failed to supply up to date training information to assure us staff had received appropriate training in infection control practices.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- There was a systematic failure to manage known risks to people. For example, one person who was at risk of falls had fallen twice during four days, but these falls had not been reviewed by the manager and the persons risk assessment had not been reviewed and updated. The person fell again two months later and required hospital treatment for injuries they sustained. The persons risk assessment was not reviewed until four weeks later and did not include any information about the recent falls and what interventions would be required to reduce the risk of falls in the future.
- Risk assessments for people with diabetes had not been carried out. This reduced the ability of staff to recognise if they became unwell. Daily records for one person with diabetes showed that staff had assumed they were feigning a seizure and failed to seek medical assistance for the person. The manager confirmed staff had not received diabetes training. Although the person was not harmed, the failure to assess the risks combined with the lack of training and poor staff attitude placed people with diabetes at risk of harm.
- Accidents and incidents were frequently not recorded and reported appropriately. For example, records of staff handovers showed several incidents throughout July, August and September 2020 where people had fallen, been pushed over by other service users and had sustained minor injuries. These incidents were not recorded in the accident book and had not been investigated. The manager confirmed they did not review accidents, incidents and falls. This meant that lessons were not learned, and people were placed at risk of

avoidable harm.
● The provider had not ensured the building was safe and did not have a system in place to ensure maintenance and repairs were carried out. On the first-floor lighting was not working which increased the risk of people not being evacuated safely in an emergency. Wardrobes in people's bedrooms were not secured to walls and presented a risk from falling on people. The manager confirmed told us water temperatures were not being checked which increased the risk of people being scalded by hot water.

Taken together the provider had failed to ensure risks associated with infection control, environmental risks and known risks to people were managed. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. The provider and manager had failed to develop a culture where people could live in an environment which was safe and secure. Inspectors observed several incidents between people living in the service where verbal aggression and threats of physical aggression were used. Staff confirmed these types of incidents were frequent.
● One person told us another person living in the service would go into their bedroom at night uninvited and they had to shout at them to leave. Staff were aware of this and informed us that the person often behaved in this way with several other people. Staff had not recorded this and there was no risk assessment in place to support the person and keep others in the service safe from their behaviour.
● The manager failed to investigate concerns raised by people and staff. For example, daily records showed one person had reported they had £20 stolen and had also raised concerns about staff attitudes toward them. The manager failed to investigate this and report it to the relevant authorities. A handwritten statement showed a staff member had reported concerns that a colleague had allegedly neglected a person. The manager confirmed they had spoken with the staff member but had not carried out an investigation or reported the issue to appropriate authorities.

The provider had failed to ensure people were protected from abuse. This placed people at risk of avoidable harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
● Staffing levels in the service were inadequate and placed people at risk of avoidable harm. The manager used a dependency tool which had not been reviewed for over three months and during this time ten people had left the service and 11 new people had moved in. Staffing levels had not been adjusted or reviewed despite the changes.
● Staffing levels at night were inadequate and would not enable a safe evacuation in an emergency. Following the second day of inspection staffing levels at night were increased with immediate effect to ensure people were safe.
● Several staff told us they were concerned about staffing levels and had raised their concerns with the manager and provider but were not listened to. Staff were not always available to provide care to people when they needed it most. Two people told us there would often be no one available to support them to use the toilet and staff would tell them to urinate themselves. One person told us they had experienced severe physical pain and frequent infections because of this.
● Staff were not always in the vicinity of communal areas when incidents occurred between people using the service. On two separate occasions inspectors had to find staff to intervene in altercations between people to reduce the risk of the incident escalating.

The provider failed to ensure sufficient levels of staff were deployed to ensure people received safe care. This placed people at risk of avoidable harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

● People were at risk of being cared for by unsuitable staff. Staff were not recruited safely and in line with current legislation. Recruitment records for four staff did not include evidence that they had a criminal record check carried out by the disclosure and barring service (DBS). The DBS enables organisations to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially involving children or vulnerable adults. The provider told us they had carried out DBS checks, but failed to provide us with the evidence to confirm this.

● References to check candidates suitability and previous good character were not always obtained and full employment history from leaving school was not always supplied.

● One staff member had disclosed a prior criminal conviction, but the provider had failed to carry out a risk assessment to determine the suitability of the staff member.

The provider had failed to assess the risks relating to the safe recruitment of staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Staff told us they received training to administer medicines to people and had their competency checked by a qualified staff member. Following the inspection, the provider supplied us with evidence that some staff had received medicines training but did not provide us with records to corroborate competency assessments had been carried out.

● Records of administration showed people received their medicines as prescribed.

● Medicines were stored appropriately and securely.

● The provider had a policy relating to medicines which had been reviewed.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to 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.

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

- Leadership in the service had systematically failed to develop an open and inclusive person-centred culture. Inadequate staffing levels and ineffective leadership resulted in people receiving institutionalised task focussed care. People spent large amounts of time sat in the communal lounge with very little interaction and stimulation. People were observed sleeping in wheelchairs and looked uncomfortable.
- Some people told us about the negative impact on their health and wellbeing. One person said, "Being told to wet yourself because there aren't enough staff is undignified." They went on to say, "I have had people come into my room seven times in one night. It is very scary when you wake up and can't remember where you are straight away and see people in your room."
- One person told us how distressed they were from being exposed to challenging behaviour from other people living in the service. They told us "One person who lives here says to me 'I own this building I want my rent' and then hits me. I have told staff and they just say it is because they have dementia."
- People told us they had raised issues with managers and senior staff and were not listened to. One person said, "Senior managers don't care, and they cover up issues." One person told us they had become reluctant to make complaints for fear of reprisals from some staff.

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

- The manager was in the process of applying to be the registered manager after previously holding the position of deputy manager. They had not acted as a registered manager previously and was inexperienced. Despite being aware of this, the provider had not put systems in place to assure themselves the manager was effective in their role and was supported appropriately.
- The provider had failed to provide scrutiny and hold managers to account. The manager told us senior staff carried out some audits and checks of quality. Records relating to audits were inconsistent, there was no action plan in place and the manager confirmed they did not review the audits carried out by senior staff.

- The provider told us their role was mainly focussed on finances and purchases and they did not check the safety and quality of the service being provided. The failure of the nominated individual and the manager to ensure the service was providing safe care had resulted in people experiencing poor care and an increased exposure to avoidable harm.
- Some staff were observed making genuine and concerted attempts to manage incidents of challenging behaviour and reassure people. However, some staff told us they had not received training to manage

challenging behaviour and support people with dementia. We asked the provider to supply us with training records, but they failed to provide these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and their relatives were not involved in developing the direction of the service. Many people living in the service who were living with dementia and disabilities were not provided with the accessibility they required to play an active role in the service and within the community.
- People told us they were not asked for their views and were concerned if they provided negative feedback this would result in reprisals.
- Prior to and during the inspection partner agencies and healthcare professionals had expressed concerns about the culture of the service and the willingness of staff to engage in collaborative partnership working

The provider had failed to effectively assess, monitor and improve the quality and safety of the service and mitigate risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 manager and the providers failure to appropriately investigate allegations of theft, neglect and abuse meant that serious incidents were not reported to the local authority safeguarding team. The provider failed to carry out their legal responsibility to notify the CQC of serious incidents.
- Failure to record and report incidents and conduct investigations had resulted in repeated incidents occurring which staff had become accustomed to as the norm. Opportunities to reduce incidents and improve the lives of people living in the service were frequently missed.

The provider had failed to notify the CQC of incidents of alleged abuse. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.