

Greenacres Nursing Homes Limited

# Woodville Residential 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

Woodville Residential Care Home is a care home which provides personal and nursing care to 44 people aged 65 and over at the time of the inspection. The service can support up to 46 people.

### People's experience of using this service and what we found

Risk to people were not always assessed and actions taken to mitigate the impact. Medication was not always managed safely and where mistakes had been made, management did not have oversight to make improvements.

Infection prevention and control was not well managed, and areas of the environment required attention to ensure it was kept clean and in good repair.

Staff recruitment was safe, however, there was not sufficient numbers of staff to support people's needs. Staff were kind and committed to providing good care, however felt restricted by the lack of support, information and organisation.

The service lacked management oversight. Audits which had been completed were not always a true reflection and any areas identified were not followed up to ensure the changes or improvements were made. The provider had not ensured good oversight of the home in maintaining peoples care and safety.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

Rating at last inspection The last rating for this service was Good (published 11 January 2019)

### Why we inspected

The inspection was prompted in part due to concerns received about complaints and whistle blowing about the quality of the care being provided. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We have found evidence that the provider needs to make improvements.

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 Good 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.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodville Residential Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### 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 monitor the service to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, infection prevention and control, staffing levels, medicines and good governance at this inspection.

The provider responded swiftly to our concerns and has put an action plan in place to address the concerns raised and are working with us to monitor the service.

Please see the action we have told the provider to take at the end of this report.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

### Special Measures:

The overall rating for this service is 'Inadequate' and the service is 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 safe.

Details are in our safe findings below.

**Inadequate** ●

### **Is the service well-led?**

The service was not well-led.

Details are in our well-Led findings below.

**Inadequate** ●

# Woodville Residential 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 two inspectors

#### Service and service type

Woodville Residential 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 had a manager registered with the Care Quality Commission, however after the inspection they left the service and the provider placed an interim manager to run the service with support from the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We used the information the provider sent us in the provider information return. 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 spoke with the local authority and other health care professionals to obtain their view on the service. We used all of this information to plan our inspection.

#### During the inspection

We spoke with three people who used the service about their experience of the care provided. We spoke with nine members of staff including the deputy and registered manager. We spoke with a professional who regularly visited the service.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed. On this occasion we did not look at recruitment as we had no issue at previous inspections or with the providers approach to recruitment.

#### After the inspection

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

# Is the service safe?

## Our findings

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

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

### Staffing and recruitment

- There was insufficient staff to support people's needs. We observed some people had to wait for their care and this impacted on their dignity. Care was provided on a task basis due to limited staff and a lack of flexibility in recognising personalised care.
- Staff we spoke with felt there was not enough staff. One staff member said, "We need more staff, it would make a big difference, we would not be jumping from room to room; or people waiting for care." Another staff said, "I am not happy with the level of care and feel under pressure. I cannot give people the care they need".
- Another staff member told us they had other tasks to complete that further impacted on their ability to meet people's needs in a safe and timely way. This staff member said, "We have jobs not care related, like making the tea or additional cleaning."
- The registered manager completed a dependency tool to reflect the staff required against the level of people's needs. However, this had not been reviewed since April 2021, during this time the home had, three new admissions and some people's needs had increased due to a deterioration in their health. This meant that there may have not been the required levels of staff to support peoples needs.
- Within the PIR, the provider told us that the registered manager could request additional staff if there was a greater need due to events at the home. On the day of the inspection, one person was having a celebration party requiring additional staff support in preparing the party and in supporting a larger number of visitors with their LFT tests prior to entering the home. The home was also having two new admissions and another person required staff support to a planned hospital appointment. No additional staff were requested, which meant the staff had to encompass these additional tasks and this had an impact on people receiving timely care.

The provider had failed to ensure sufficient staff were available to support people's needs. This placed people at risk of harm. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They provided additional staff and additional management support.

- The provider had a robust recruitment process. We have not reviewed recruitment records at this inspection due to there being no concerns raised at previous inspections or in relation to the providers other locations.
- We saw staff responded to people in a kind and friendly manner and when time allowed, they engaged on

a personal level.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks to people were not always managed. We saw risk assessments had been completed, however some risks had not been mitigated. For example, two people were at risk of choking, there was conflicting information shared with staff which resulted in the people receiving an inconsistent approach to their support. This meant the people were more at risk of choking as the correct guidance was not always being followed.
- Some people required regular pressure relief to reduce the risk of sore skin. However, the records we reviewed were not clear in ensuring the planned support had been provided. Despite this we noted there were no newly acquired concerns in relation to skin.
- New admissions to the home did not have an initial care plan prior to arrival. This meant staff did not have information relating to these peoples care needs.
- Risk assessments had not been completed to reflect the needs of people isolating for the 14-day period as per the government guidance. This meant there was no plan to provide the required support if the person needed additional support when isolating or if they placed a risk to other people in the home.
- Medicines were not always managed to ensure people received their prescribed medicines. This meant people were at risk of not receiving medicines for pain, or any deteriorating health conditions.
- When peoples medicine had changed due to their deteriorating health condition this had not been clearly communicated with staff. This meant some people received inconsistent doses of their medicine.
- Protocols were not always in place to provide guidance for as required medicine for pain or anxiety. This meant staff were unclear when the medicine should be administered.
- The stock for some people did not tally with their administration records. This meant we could not be assured people had received their medicine as prescribed.
- Records for prescribed creams were not always consistently recorded. This meant we could not be assured they were being applied as prescribed to reduce dry or sore skin.

The provider had failed to mitigate risk and keep people safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They reviewed all the risk assessments and medicines and provided additional training and guidance to staff.

Preventing and controlling infection; Learning lessons when things go wrong

- Infection prevention and control was not consistently implemented to reduce the risk of infections.
- Staff did not always wear a face covering (mask) in line with the government guidelines. We saw staff touching their mask and not replacing it or wearing their mask below their chin during aspects of care.
- Cleaning items were not always accessible at the point of care. We identified several bedrooms where paper towels, pump soap and foot operated bins were not accessible. This meant staff were unable to ensure good hand hygiene practices before and during care.
- Government guidance states care staff should be bare below the elbow and not wear nail polish or jewellery. We observed staff not following this guidance and this meant they had not reduced the risk of infection.
- When people were admitted to the service, there was no clear signage to reflect the person was isolating or when that period had ended.
- We were not assured the provider was promoting safety through the hygiene practices of the premises. Equipment which was used to provide safety or personal care was not cleaned to reduce the risk of



transmission of any infection.

- Opportunities had been missed by the registered manager in not ensuring government guidance was consistently being followed to reduce the risk during COVID-19. Observations and competency checks had not been made to ensure compliance in these areas of risk against infections.

The provider had failed to mitigate risk in relation to infection, prevent and control. This placed people at risk of cross infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They reviewed the infection control practices in line with government guidance.

- Other areas of preventing and controlling infection were in place and we were assured in these areas.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding was not always identified. Staff had received training, however during our inspection one person had an unexplained bruise. At the end of the day this had not been body mapped or any action taken to raise concerns with the local safeguard team.
- Other areas of safeguarding were not regularly reported. One staff member said, "A couple of people often fall out (resulting in a service user on service user incident). I was not aware these should be raised as a safeguard and it happens a lot." This meant we could not be assured all safeguards were being recorded.
- The registered manager had an audit in respect of any safeguards which had been raised. Over the last two months no safeguards had been reported. This meant we could not be assured there was ongoing reflections on the incidents which had occurred in the home or actions taken to mitigate these reoccurring.

The provider had failed to ensure people were protected from 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.

# 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 Good. 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.

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

We made a recommendation at the last inspection around audits being more robust and used to drive improvement. We found these improvements had not been made and additional concerns were raised in this area.

- Although audits had been completed, these had not been effective in identifying issues. The audit for infection control had stated all areas were being followed and there were no concerns, we have detailed several areas in the safe section of this report which should have been identified and addressed.
- Other audits had not identified concerns in respect of the environment. We found peeling paint in the dining area and damaged equipment which was in use. For example, a wheelchair with one footplate missing, other equipment was dirty or not in good repair.
- When audits had identified shortfalls, actions had not been completed, for example a photographic identity cards for the medicines folder for three people had not been done. This meant important information about the persons allergies, a picture reference or guidance was not available. Actions within this audit had not been followed up to ensure they had been completed.
- Daily charts had not been audited to ensure all tasks had been completed in accordance with the care plans. Concerns were raised for people who required a limited fluid intake and how it was recorded and monitored. Other people required enhanced meals and snacks, the records often detailed the meal, however not the amount the person had eaten, therefore it was unclear if they had received the correct level of nutrition. Staff relied on the information shared, however this was not always in line with peoples needs which meant some aspects of care were not provided correctly.
- Staff had not been provided with clear guidance on their roles and there was no allocation system. This meant staff relied on the handover for information, one staff member said, "We only get the information from the handover, we don't have time to read the care plans." We found some details in this document where not up to date and this placed a risk that some areas of people's care could be missed.
- Notifications about areas of concern had not always been completed, for example one person had a notifiable pressure sore and the required paperwork had not been submitted to CQC in a timely manner. Other notifications had been received, however when CQC updated the notifications due to COVID 19 it took several reminders before the new paperwork was completed. Timely information is required by us to support the monitoring of the home.
- The lack of governance oversight by the provider meant people were placed at risk of harm.

The provider had not ensured their systems were reviewed with oversight to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They reviewed the management support and provided additional resources to address the concerns raised.

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

- The registered manager had not supported staff in meeting the needs of people using the service. Staff told us and we observed the registered manager and deputy manager spent a lot of time in the office and lacked the understanding of the needs of the people and how busy the home was.
- Staff had not been provided with up to date information. Although the care plans were audited, any new information had not been transferred to the handover detail. This meant people were at risk of not receiving the required care they needed.
- The service was mainly task led and people had to wait for their care needs or they were provided in a routine timed manner.

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

We made a recommendation at the last inspection the provider should review the activities, so they are more meaningful for people. We found at this inspection the improvements had not been made.

- We saw that people in the lounge had limited interaction or engagement in an activity with exception of care tasks. One staff member said, "We are too busy watching people and doing paperwork".
- People had not recently been given the opportunity to contribute to the running of the home or offered preferences for their day to day experiences.
- Staff we spoke with felt there was not enough communication. Information about people's needs was not always shared and there was pressure on staff. One staff member told us, "When it gets busy it's the little things which get missed, I worry we don't do the care in enough detail."
- Some staff had not received risk assessments in relation to their role when they may require reduced duties. This meant adjustments had not been made to their role or additional support provided to support other care staff.

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 manager was aware of compliance with duty of candour and this was noted when responding to people or their relatives in relation to any concerns or complaints.
- The provider acknowledged our concerns at the inspection and immediately took action to address these.

Working in partnership with others

- Partnership had been established with social and health care professionals. We saw the home had regular contact with the GP and district nursing services.
- A health care professional we spoke with told us, "Staff here are pretty good at calling us out and they work quite well with us. We have a good relationship."
- We saw referrals had been made to a range of other health care professionals to obtain detailed guidance. This information was recorded, however on some occasions this had not been shared to ensure consistency.

- After the inspection improvements were made in the communication of people's needs.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. People had been placed at risk from not receiving their medicines. Risk assessments were not always followed to reduce any ongoing risk of harm.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider had not always ensured people were protected from the risk of harm.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The providers systems and processes to ensure the safety of the services was not embedded. Risks had not been reviewed placing individuals and others at risk of harm. Good governance systems were not in place to ensure ongoing monitoring of the service.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There were not always sufficient levels of staff to respond to people's needs. Staffing levels had not been continuously reviewed to adapt</p>

to the changing needs of people.

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 12 HSCA RA Regulations 2014 Safe care and treatment  The provider had not ensured people and staff were protected from the risk of infection. Infection prevention and control measures were not in place.

### **The enforcement action we took:**

Served a WN in respect of IPC