Charing Way Limited

Woodside Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodside Residential Care Home is providing regulated activity of accommodation and personal care to up to 40 people in one adapted building. The service is registered to provide support to people living with dementia, learning disabilities, older people, younger adults and autistic people. At the time of our inspection there were 31 people using the service.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support: The model of care did not meet the Right Support, Right Care, Right Culture guidance. People did not benefit from an interactive and stimulating environment such as listening to music or the use of therapy lighting both specified within their care plans. People were also not supported with daily exercise and assisted to leave their room as required within their care plan.

Where appropriate, legal safeguards had been put in place and the least restrictive measures were used. We found people did have a choice about their living environment and were able to personalise their rooms.

Right Care: Peoples' care plans were incomplete and entries were contradictory. Some clinical needs had not been identified and risks assessed. For example, people with diabetes did not have care plans in place to maintain foot care despite having poor skin integrity and sores on their feet. There were discrepancies over how foods should be pureed to mitigate the risks of choking. We found that all the food groups had been blended together into a liquid, as opposed to separately to the required consistency. Care plans lacked details of what pressure level people's mattress should be inflated to and had not been set correctly so that it had the most comfort and support to mitigate the risk of scores. Staff did not have access to communication aides specified within people's care plan to assist with their communication. However, we observed staff showing kindness to people and being polite and respectful whilst supporting them. Staff were able to tell us about the needs and individual preferences of people.

Right Culture: There was ineffective oversight of the service. Quality assurance processes were established and identified risks, but these were not followed up and mitigated in a consistent and timely manner. People were not always supported by staff who had been trained and assessed as competent. Staff had not completed mandatory training including in learning disabilities and autism. Whilst, people received consistent care from staff they did not always understand and support them with their basic care and specific health needs. Staff told us, "We have had a lot of agency (staff), but we tend to use the same agency,

they know as much as we do about people." Following our inspection staff told us, "Training (for staff) is ongoing" and changes had been made to how care was provided to people. A staff member told us, "We now have signs in the kitchen (to remind staff of how to puree food), we use moulds for the food, meat is separate from vegetables." We observed staff to be kind, patient and attentive to people. Staff told us they liked their job and cared about the people. Relatives told us they felt their relatives were safe and well cared for in a home described as, "Bright, welcoming, clean and comfortable with good food."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
The last rating for this service was requires improvement (the report was published on 14 June 2022). Consequently, we followed up on previous breaches of legal requirements from their last inspection.

At our last inspection we recommended that improvements were required to ensure people were safe, specifically; People were appropriately assessed, care plans contained details of individuals needs and how best to support them, people were responded to in a timely and appropriate manner when seeking assistance, incidents were recorded, investigated and actions taken to improve care and medicines were managed safely.

Improvements were also required to ensure the service was well managed, specifically; Managers and staff being clear about their roles, understanding quality performance, risks and regulatory requirements and continuous learning and improving care.

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

Why we inspected
The inspection was prompted in part due to concerns received about the safety of people and their dignity and care. A decision was made for us to inspect and examine those risks. As a result, we undertook an unannounced focused inspection to review the key questions of safe and well-led only.

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 the safe care and treatment of people, insufficient safeguarding systems and processes operating, the safe appointment of staff and overall governance systems at this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below.

Woodside 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 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 conducted by 2 inspectors. It was supported remotely by an Expert by Experience who spoke with relatives of people who use the service. 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
Woodside Residential Care Home 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. Woodside Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection a registered manager had not been in post since October 2022. In the interim, the Director of Care and Operations for the provider was overseeing the day to day running of the service together with her assistant.

Notice of inspection
This inspection was unannounced.

What we did before inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. However, we were able to review information we had received about the service such as information shared with us from health professionals who visit the service and people who use the service, including their friends, families. We used this information to plan our inspection.

During the inspection
We spoke to 5 people who used the service,7 staff including the Director of Care and Operations, 6 relatives and a professional and observed staff interacting with people. We looked at a range of documents, including; 6 peoples care plans, additional care planning documents for persons with specific dietary needs or support, medicine records, staff recruitment files and training records. We reviewed staff meeting minutes and governance documents.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating remains 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
At the last inspection the provider had failed to ensure risks to people were safely managed. This was a breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found further improvements were required in relation to the safe management of medicines, manging people care needs, assessing and mitigating environmental and fire risks. The provider remained in breach of regulation 12.

- There were not effective systems in place to ensure the timely and appropriate identification and management of people's individual needs. Staff were not always able to explain their role in respect of individual people without having to refer to documentation. Staff were unsure of people's clinical conditions and how this may affect their care and treatment. For example, how to care for people with type two diabetes or activities they were required to support people with.
- Care had not been planned to keep people's skin as healthy as possible. Some risk assessments and care plans did not include information on how to use equipment to best meet the individual's needs. For example, care plans did not include the correct setting for people's air mattresses and staff had not checked them. The use of such mattresses is intended to reduce pressure points for the person and the probabilities of bed sores and ulcers. The provider told us following the inspection people were weighed and their mattress adjusted to meet the persons individual needs.
- Fire evacuation procedures had not been rehearsed. Personal emergency evacuation plans had not been tested and not all staff had received fire safety training. Staff told us they had been shown the fire exit routes and assembly points as part of their induction. We have referred the provider to Kent Fire and Rescue Service for support and guidance.

The provider had failed to ensure risks to people were safely managed. This was a continued breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
- We were not assured that the provider was using PPE effectively and safely. Staff were not wearing face masks appropriately and not all staff had completed infection prevention control training.
- We were not assured that the provider was supporting people to minimise the spread of infection. Some people's rooms did not have soap and suitable hand drying facilities to enable good hand hygiene. We shared our findings with staff on the day of the inspection and they ensured soap dispensers were filled and hand towels were made available to people. A person's relative told us "Their (the persons relatives) hands

are always dirty."
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found some bedrooms smelt strongly of urine. We brought this to the attention of the Director of Care and Operations who confirmed our findings and arranged for deep cleaning of the rooms and/or the replacement of flooring to facilitate effective cleaning.
●Some people did not have enough bedding to cover the mattresses. Relatives told us, "The room is clean and tidy but no bottom sheet, it's missing bedding." The provider confirmed new bedding had been ordered and received by the service, but the staff had not made use of it.

The provider had failed to prevent, detect and control the spread of infections. This was a continued breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● 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.

People were supported and encouraged to have visitors in their rooms and communal areas of the home. Relatives told us when they visit the home, "I am always impressed…The staff are very welcoming."

Learning lessons when things go wrong
● Staff did not learn from safety alerts and incidents. We found inconsistencies remained in how injuries were recorded by staff despite this being raised with staff by the provider. There were no clear and auditable processes to identify patterns or trends in incidents and assure people they had mitigated the risk of them reoccurring.

The provider did not assess the risks to the health and safety of people. This was a continued 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
● Staff were not able to identify and respond to different types of potential abuse. We found people had not had basic care needs met for consecutive days. We checked one person's care record and found they had not been shaved or received oral care for three consecutive days. This was contrary to their care plan stipulating they required twice daily oral care. Staff told us, "Unless the electronic system is programmed correctly uncompleted tasked are not flagged for the attention of management." This meant that some peoples care records did not show they required support to have a shave and/or receive oral health care. This resulted in staff not being aware and delivering appropriate daily care.

The provider failed to establish and operate effective systems and processes to prevent the abuse of people. 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) 2014.

● People and those who matter to them had safeguarding information in a form they could use. Staff told us if they were concerned for a person they would, "Let the senior or management know straight away so they

can check it out" and they "Can ring safeguarding. The number is in the office." However, they did not always know how to recognise abuse such as neglect of a person's basic care needs.
● Staff worked well with other agencies where potential safeguarding incidents were raised to support investigations in a timely manner.

Staffing and recruitment
● People were not always supported by staff who had been safely recruited. We reviewed two staff files. Neither file evidenced a record of a full employment history. There were no explanations for the gaps in employment. References had not been sought from previous social care employers to evidence the staff's previous conduct. Consequently, the provider could not be assured the staff were suitable to be employed to care for people.

The provider failed to operate effective recruitment processes and ensure information specified in Schedule 3 of the Health and Social Care Act was available for each member of staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff had not completed the core training they needed to undertake prior to working independently. We found only 2 out of 20 care staff had completed fire safety training, first aid, diabetes and mental health and learning disabilities including autism and Asperger's.
● Staff were not trained to meet the needs of individuals. Staff had not received specialist training to meet people's individual needs, only 4 care staff had completed training in stoma care and 8 out of 20 care staff had completed training in dementia care.
● Staff did not ensure peoples basic care needs were consistently met. Records reviewed showed staff had not met peoples individualised care needs as detailed within their care plans such as supporting them with daily exercises and therapeutic activities.
● Staff were observed engaging with people in a polite and gentle manner when they requested support, or they identified a need. Staff told us, "I think there is enough staff, it is about everyone doing their fair bit and working together as a team…There is always time to make a cuppa and sit with people for a bit."
● People's right to work in the UK and Disclosure and Barring Service (DBS) checks had been completed before new staff began working at the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
● Management provided on-call cover so staff could obtain advice and guidance outside office hours when needed. Staff told us this system worked well as, "We are very well supported. All we ever have to do is say what we need and why and it is never a problem."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA. Appropriate legal authorisations were in place to restrict a person of their liberty. For example, staff would support people to access to outdoor space where people were unable to ensure their own personal safety.

Using medicines safely

At the last inspection the provider had failed to ensure risks to people from medicines were safely managed. This was a breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements had been made and the provider was no longer in breach of the regulation.

● People were supported to manage and take the medicines they needed in a safe way. Medicines were stored at the correct temperatures. Temperatures of the medicines room and medicines fridge were checked twice daily to make sure medicines were stored at a safe temperature.

● Some people were prescribed some medicines, such as pain relief, on an 'as and when' basis. There were protocols in place about when to give the medicine, how often and what to do if it was not effective. Staff noted the outcome of administering the medicines, such as 'pain eased'.

● All medicines were dated when they were opened to help make sure the medicines remained effective. When people needed prescribed creams to help keep their skin healthy, there was information for staff about where the creams should be applied and how often. Staff completed topical body maps. Whilst medicines were managed safely there were some shortfalls in the records relating to medicines that we have reported under the well led section of this report.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating has changed 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

At our last inspection we found the provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that insufficient improvements had not been made and the provider remains in breach of Regulation 17.

● The provider had not given staff the guidance they needed to provide safe care to people. Care plans for some people lacked information about their needs, their life before moving to the service, their wishes and how their basic care needs were being met. There was a lack of guidance for staff about how to manage risks to people from skin damage or using equipment.
● Some medicines records were found to be inaccurate. We found discrepancies in the records of the number of medicines stored and night staff had not consistently completed their records.

Accurate records about people's care had not been maintained. This is a continuing breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Continuous learning and improving care
At our last inspection we found the provider had not ensured that there were effective systems to assess and quality assure the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that insufficient improvements had been made and the provider remains in breach of Regulation 17.

● The provider did not have effective systems in place to learn and improve care. Audits had been conducted on peoples care plans and organisational processes such as staff training but many of the same failings were found when the audits had been repeated and during our inspection. For example, we found risk assessments had not been conducted for people, there were inconsistencies within peoples care plans and staff had not received core training. This was despite, the provider having written to staff with a deadline to complete outstanding training.
●Care was not provided to people in a coordinated manner. We found people did not consistently have all their identified care needs met. For example, ensuring daily personal care needs were met and people were supported to access therapeutic activities. The provider had not had effective oversight of the care provided

to people and had not identified where this had not occurred. For example, daily care records showed a person failed to be supported with their required daily exercise over three consecutive days contrary to their care plan.
● The provider had failed to successfully address areas for improvement identified at their last inspection in May 2022. During the previous inspection we reported observing call bells constantly ringing. We found this remained a concern as no system had been effectively implemented to assist staff to prioritise responses to call bells. We saw staff did not attend all call bell activations. People continued to be placed at risk of being ignored even when activating a call bell requesting assistance from staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
●The provider did not always ensure a person-centred culture. Staff did not always place people's needs and wishes at the heart of everything they did. Some peoples care plans did not include information on people's lives before living at the home, information on their future wishes or any records of discussions with their key worker regarding their care.
● People did not always receive the right care or support. They were unable to access activities that were important to them such as listening to music or light therapy.
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not supported to be involved in the development of the service. Sixteen people had participated in a survey of their experiences in October 2022. The staff had responded to some of the feedback from people requesting smaller meals in the evening and speaking with people on how they wished their clothes to be put away. One person said they (the staff) "Would like to talk to people one to one more." We found engagement with people remained an area for improvement. The last residents meeting had been held in May 2022.
● Staff were not regularly consulted regarding the management and development of the service. The most recent staff meeting was held in May 2022. The provider had invited visiting health professionals to feedback on their experience of the service but had received no responses.

The provider had failed to ensure there were effective systems in operation for monitoring and improving the quality and safety of the service. This is a continuing breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff told us they felt confident and able to raise concerns with managers.
● Staff were acknowledged and rewarded for good practice. The provider had a staff reward scheme to value and encourage staff retention.
● We observe staff kindly supporting people who took comfort from the presence of a doll, which they stroked gently and spoke to. Staff also told us how they were learning different languages and about other cultures to support people. They said, "The family have been giving us tips and hints."

Working in partnership with others
● Staff did not consistently implement the recommendations of specialists. For example, we observed some people's meals not presented appropriately to enable them to eat. Staff told us they were working with the Speech and Language specialist where people had experienced difficulties swallowing.
● Partner services reported difficulties contacting the service. Community health services had experienced difficulties contacting the service. They were now working with the provider to improve communication between parties.
● The service worked with relatives to help give people using the service a voice. Relatives told us, staff had

spoken to them and their relative to understand their needs. For example, "They (the staff) moved (person) to our GP surgery. We were given a choice," and "They (the staff) liaised properly with medical practitioners and her medications were substantially modified as a result."

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 service apologised to people, and those important to them, when things went wrong. We found the provider had notified relevant parties where standards of care had not been met and where the service needed to make improvements including how they were addressing the issue.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of people, they had failed to ensure risks to people were safely managed, including the prevention, detection and control of the spread of infections.

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 The provider did not establish and operate effective systems and processes to prevent the abuse of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure accurate, complete and contemporaneous records were maintained. The provider failed to there were effective systems to assess and quality assure the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate effective recruitment processes and ensure information specified in Schedule 3 of the Health and Social

Care Act was available for each member of staff.