

Woodcrofts Residential Homes Limited

Woodcrofts Residential Home

Inspection report

164 Warrington Road
Widnes
Cheshire
WA8 0AT

Tel: 01514245347

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Woodcrofts Residential Home is a care home providing accommodation and support for up to 19 people with mental health needs. The service was supporting 17 at the time of inspection. The building has two floors accessible via stairs and has on-site parking.

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

People were placed at risk from a lack of effective risk management systems. We found gaps in care plans, risk assessments and the management of infection control. We could not see any systems in place to monitor and record safeguarding concerns. People said they felt safe and well cared for. They were supported by experienced staff who knew people and their needs well.

The provider had not delivered recent training in essential areas such as medicines and infection and prevention control. We made recommendations about meeting people's dietary requirements and mental capacity assessments.

People were supported to be as independent as possible and several people visited places such as shops and pubs without staff support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

A lack of effective governance systems meant people were placed at risk of avoidable harm and improvements were not being made where required. The provider did not complete audits, meaning opportunities to improve care were missed. There was no system for recording and monitoring incidents, meaning we were not sure whether risks and concerns were identified and acted upon. We were unsure whether the provider understood their statutory responsibilities to report issues to relevant others.

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 good (published 9 July 2019).

Why we inspected

We received concerns in relation to governance of the service, training and IPC. As a result, we undertook a focused inspection to review the key questions of safe, effective and well led.

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.

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.

The overall rating for the service has changed from good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the relevant key question sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodcrofts Residential Home on our website at 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 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 keeping people safe from the risk of abuse, staff training, monitoring risk, infection prevention control, the safe management of medicine, and the overall governance of the service.

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

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 effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-Led findings below.

Woodcrofts Residential 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

This inspection was conducted by two inspectors.

Service and service type

Woodcrofts Residential 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. 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 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. 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 used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service including a relative about their experience of the care provided. We spoke with five members of staff including the deputy manager and care staff.

We reviewed a range of records. This included four people's care records and medication records. We looked at three 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 requested further information following the inspection however this was not received.

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.

Systems and processes to safeguard people from the risk of abuse

- The service did not have effective systems to safeguard people from the risk of abuse.
- There were no systems to record and monitor safeguarding concerns. This meant we could not be certain that the registered manager understood their responsibilities or would respond appropriately to concerns of abuse.
- There was a safeguarding policy in place however this had not been reviewed since March 2019.
- The registered manager had not notified CQC of any safeguarding concerns.
- Staff had not received recent safeguarding training, although staff could describe appropriate actions they would take if they had any concerns.

We found no evidence that people had been harmed, however systems were not in place to safeguard people from the abuse. This placed people at risk of avoidable harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives told us they felt safe and well cared for.

Assessing risk, safety monitoring and management

- Risks to people's health, safety and well-being had not always been effectively assessed, monitored or managed.
- There were gaps in people's care plans. Not all risks to people's health were documented and staff were not always recording how risks were managed. For example, one person's care plan stated their skin integrity required monitoring, however this was not being done. A second person required their fluid levels to be monitored, however this was not happening. For both people managers told us they were not monitoring because people were independent, however we were not assured this had been properly risk assessed and therefore being managed safely.
- Some information in people's care plans was out of date, and it was not clear whether issues relating to risk were current.
- Some aspects of the environment were observed to be unsafe or in poor condition. For example, a communal bathroom that required maintenance work, shower equipment that needed fixing and a fire door wedged open.
- A basic visual health and safety check of the environment had been completed on an annual basis for the past two years. However, the registered manager had failed to respond to several requests for additional health and safety monitoring records. This meant we could not be assured the registered manager was identifying or managing risks to the environment.

We found no evidence that people had been harmed, however systems were not in place to assess, monitor and manage risks to people's health and well-being; including those related to the environment. This placed people at risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not being managed safely.
- Policies in relation to the safe management of medicines were out of date. There was no policy in relation to covert medicines, however the registered manager said this was because no one required covert medicines.
- Staff had not received recent medicines training or checked the competencies of staff responsible for medicine administration. Therefore, there was a risk that staff were not supporting people in line with up to date guidance.
- The registered manager did not undertake a medicines audit, meaning safety issues and concerns may be missed or not acted upon, and potential mistakes repeated.
- The provider administered everyone's medicines; people were not assessed as to whether they could manage this themselves to promote independence.

We found no evidence that people had been harmed, however systems were not in place to manage medicines safely. This placed people at risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were locked away in the office, and there were no controlled drugs on the premises.
- One person had 'as required' medicines. We found an adequate care plan in this person's record to help guide staff to ensure these medicines were only being administered when needed.

Learning lessons when things go wrong

- The provider was unable to show they learned lessons when things went wrong.
- There was no system in place for identifying, recording, or monitoring incidents.
- We could not see how the provider would review or investigate any safety concerns or incidents.
- As a result, it was unclear whether the provider would take appropriate action following incidents and share any learning amongst the staff or with external agencies.

We found no evidence that people had been harmed, however there were no systems in place to identify issues of concern and make changes. This placed people at risk of avoidable harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- The provider did not always manage infection prevention and control effectively.
- We were not assured that the provider was preventing visitors from catching and spreading infections.
- We were not assured that the provider's infection prevention and control policy was up to date.

We found no evidence that people had been harmed, however systems were not in place to effectively manage infection prevention and control. This placed people at risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was using PPE effectively and safely.

- We were assured that the provider was accessing testing for people using the service and staff.
- People and their relatives told us they saw staff wearing PPE and thought the home was kept clean and tidy.

Staffing and recruitment

- The provider had safe staffing and recruitment.
- There were enough staff to meet people's needs and people told us staff knew them well.
- People said there was a good amount of staff within the home, and they did not have to wait long if they needed help.
- The provider did not use agency staff to cover sickness, they were able to manage within the permanent staff.
- Safe recruitment practices were followed by the provider to make sure newly recruited staff were safe to work at the service.

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider did not manage staff support, training and skills effectively.
- Staff had not received relevant training since 2017. This meant we could not be certain they were delivering care and support in line with current best practice guidance. The provider told us they were looking for a new training provider to address this, however we received no further assurances this would be imminent.

The provider failed to ensure staff received adequate training. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We did not see any evidence that staff received recent one to one supervision. However, staff told us they could access informal support as and when required.
- Many staff had worked at the service for several years and they had good knowledge about the needs of the people that lived there.
- People told us staff were experienced and were skilled at supporting them.

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

- The provider did not always support people with dietary needs effectively.
- It was not clear how staff made sure that meals met people's dietary needs. One person required a gluten free diet and there was nothing in place to show whether this was taken account when planning their meals.
- One person required their fluid intake to be monitored due to health issues, however a lack of records suggested this was not being completed

We recommend the provider consider current guidance and review their practice regarding supporting dietary needs.

- All food was prepared by a member of the care staff.
- We saw that people had choice with food and drink, and meals were healthy and balanced.
- People told us the food was good, and they enjoyed the meals.

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA

- The service was not always working within the principles of the MCA.
- We could not be certain that people's capacity to make specific decisions was being assessed or reviewed where appropriate. For example, one person had a diagnosis of dementia. We found no records to show that this person's capacity had been assessed or reviewed.

We recommend the provider reviews their processes for assessing people's capacity in line with MCA 2005.

- Staff supported people to be as independent as possible and understood principles such as using least restrictive options.
- People told us they regularly went out on their own, for example to local shops, cafes and pubs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices were assessed, and care was delivered aiming to produce good outcomes for people.
- We saw assessments and care plans in place, regarding both physical and mental health needs. People's choices were assessed and considered, and staff ensured people's preferences were adhered to. However, it was unclear how often care plans were reviewed.
- Staff had good knowledge about the needs of the people that lived at the home, and quickly identified if someone became unwell.

Staff working with other agencies to provide consistent, effective, timely care/ Supporting people to live healthier lives, access healthcare services and support

- Staff worked with other agencies to provide timely care, for example, dieticians, mental health teams and GP.
- Managers communicated with community mental health teams if someone's health deteriorated. People had regular contact with mental health professionals where required.
- People were supported to live healthy lives and access healthcare services and support.
- Referrals were made to healthcare services and support, for example, physiotherapy and district nurses, to make sure they were assessed and supported with their health needs.
- Relatives told us they thought people were well looked after.

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

- The design of the home met people's needs.
- The building had a homely feel and there were plenty of communal lounges and areas for people to access.
- There were gardens and outdoor areas for people to use at their leisure.
- The second floor was accessible by stairs only. The provider ensured that anyone who had mobility needs

moved into the ground floor level.

- People told us the home was comfortable and they enjoyed using the communal areas.

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

- We were not assured that managers understood quality performance, risk and regulatory requirements.
- We found a number of issues relating to risk management, medicines management, environmental concerns and staff training. These concerns had not been identified through the provider's own governance systems.
- The provider had failed to respond to repeated requests for additional information relating to the safety of the environment. This meant we could not be certain their own systems had identified the issues we found or whether other aspects of the environment were safe; such as up-to-date inspection certificates.
- The provider was not evaluating their practice or undertaking audits, for example, care plan audits, medicine audits or maintenance checks. This meant concerns and risks could be missed or improvements not made where needed.
- There was no system to identify, record, monitor and manage incidents. Therefore, opportunities to identify themes, learn lessons and make changes were missed.
- We could not be certain the provider understood their statutory obligations as they had failed to notify CQC of specific incidents as required by law.
- Following our feedback to the provider regarding the issues we identified, we received no assurances action would be taken to address the concerns.

The provider failed to implement robust and effective governance systems which had resulted widespread, significant shortfalls in the way the service was led. This was a breach of Regulation 17 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

- We were not assured the provider always acted on their duty of candour.
- There were no systems to identify and record incidents meaning opportunities to share issues of concern with people and their relatives could be missed.

Continuous learning and improving care

- We could not see whether the service was committed to continuous learning and improving care.
- As there was no system to analyse and monitor practice, opportunities to identify concerns and make improvements could be missed.

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

- We found that although effective management systems were lacking, there was a positive culture amongst staff.
- Staff told us they enjoyed working at the service and could seek informal support when required.
- Several staff including the deputy manager had worked there for many years. Both could clearly describe the needs of people and how their needs should be met. Staff were committed to empowering people and achieving good outcomes.
- People said they got on well with staff and staff were friendly and caring.

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

- It was not clear how the service engaged with the people using the service, public and staff.
- Managers told us they used questionnaires to check people's satisfaction levels, although we did not see any completed ones or examples of any changes made.
- The provider worked in partnership with others such as GPs and infection prevention and control teams.

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>People who use services and others were not protected against the risks associated with:</p> <ul style="list-style-type: none">- <input type="checkbox"/> A lack of undertaking risk assessments- <input type="checkbox"/> Out of date documentation- <input type="checkbox"/> A lack of effective medicines management- <input type="checkbox"/> A lack of effective management of infection prevention control- <input type="checkbox"/> A lack of up to date staff training
Regulated activity	Regulation
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>People who use services and others were not protected against the risks associated with:</p> <ul style="list-style-type: none">- <input type="checkbox"/> A lack of systems in place to safeguard people from the risk of abuse.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider did not deliver regular training to ensure staff worked in line with up to date guidance.</p>

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>How the regulation was not being met: People who use services and others were not protected against the risks associated with:</p> <ul style="list-style-type: none">- □ A lack of effective incident recording and monitoring system.- □ A lack of auditing- □ A lack of quality performance and risk management systems.

The enforcement action we took:

We served a warning notice against the Provider