Woodleigh Rest Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Woodleigh Rest Home is a residential care home providing personal care to up to 33 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 19 people using the service.

People's experience of using this service and what we found
People were not safe. Medicines were not managed safely. Routine checks were not in place and we were not assured people received their medicines as prescribed. Risks to people's health and safety and wellbeing had not been effectively assessed and reviewed. This included risk relating to moving and handling, skin integrity and the environment. People's nutritional needs were not always met.

The manager was unable to demonstrate effective leadership. This had not been effectively addressed by the provider and they were unable to demonstrate robust governance arrangements and evidence of lessons being learned. Specific issues we raised at the last inspection had not been addressed.

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.

Staffing levels had been increased and staff had received support, training and supervision to carry out their role. Recruitment was managed safely. Most people and relatives told us they felt safe and there were enough staff to meet people's needs. Staff were kind, respectful and caring.

The service had made some improvements since the last inspection. However, they were not consistent and some initial improvements had not been sustained. The provider was responsive to the inspection findings and provided assurances they would make the required changes to improve the quality and safety of care.

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

Rating at last inspection and update: The last rating for this service was inadequate (published 25 July 2022) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced inspection of the service on 14,16 and 27 June 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. The report only covers our findings in relation to the Key questions Safe, Effective and Well-Led.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Inadequate to Requires Improvement based on the findings of this inspection

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodleigh Rest Home on our website at www.cqc.org.uk..

Enforcement
We have identified breaches in relation to the management of risk and medicines, nutrition and hydration and good governance at this inspection.

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

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

Special Measures:
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures.' We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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?

Requires Improvement

The service was not always 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.

Woodleigh Rest Home Limited

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 first day of the was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was carried out by one inspector. A third inspector made telephone calls to staff.

Service and service type
Woodleigh Rest Home is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Woodleigh Rest 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the

quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post. There was a manager in post but they resigned during the inspection.

Notice of inspection
This inspection was unannounced on both days.

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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 8 people and 3 relatives about their experience of the care provided. We looked around the building and observed care and support in communal areas. We spoke with 8 staff including the nominated individual, manager, deputy manager and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment, training and supervision. We also looked at a variety of records relating to the management of the home including polices and audits.

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 inadequate. At this inspection the rating has changed to 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; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Risks to people's health and safety were not always managed safely.
● At the last inspection we reported where risks had been identified and action had not been taken to ensure people's safety. For example, we raised concerns about people being able to access an open staircase. At this inspection the provider had introduced a sensor mat which was positioned at the bottom of the staircase. On arrival we found this was not working. We pointed this out to the provider, but we stood on the sensor mat a further five times later in the day and found it did not alert staff. This meant people with limited mobility were vulnerable as they were able to access the staircase without staff being aware.
● People who required support with moving and handling did not always have clear assessments and we were not assured staff were following guidelines. On the first day of the inspection we saw a person who had been assessed to use a hoist being moved and handled without the use of the equipment. This exposed the person to the risk of injury and harm.
● Care records did not always evidence people were receiving safe care. Where checks and monitoring were required, they were not always in place. For example, we saw one person had been assessed to have additional night-time checks as they had recently had two unwitnessed falls. There was no evidence of routine and additional checks being in place.
● Accidents and incidents were recorded by staff but there was a lack of robust management review. We found multiple examples where there was no evidence reported accidents and incidents had been followed up by the manager. This meant we were not assured events were used to inform risk assessments or lessons were learned when things went wrong.

The lack of effective risk management processes meant people were not protected from harm. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Buildings and environmental checks were routinely completed.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe use of medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Medicines were not always managed safely.
● Robust systems were not in place to monitor and check the use of controlled drugs. Controlled drugs are medicines controlled under the misuse of drugs legislation due to being especially addictive or harmful. The provider told us controlled drugs should be checked weekly by two authorised staff. We found some checks had not taken place since November 2022 and checks were not always accurate. We found one instance where a controlled drug was thought to be missing. This had not been investigated or reported to the appropriate body.
● We checked medicine stocks and they did not always reflect what was recorded on the medication administration record. This meant we were not assured people were receiving their medicines as prescribed.

● There were protocols in place for 'as required' medicines but they were not always clear, and we found examples where staff were not following the guidance. For example, two people's protocols for the administration of laxatives stated staff should refer to their daily records to review if administration was required and seek medical advice. We found this had not been done. This exposed people to the risk of harm as their health and wellbeing was not monitored effectively and medication had not been given when required.

Medicines management systems were not always safe and placed people at risk of harm. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were improvements in how topical medicines were administered and recorded. The provider had installed lockable cupboards in people's bedrooms, so creams were easily accessible when required. Records were generally clear and well completed.
● Staff had received training and had their competency to administer medicines assessed.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to have effective systems in place to ensure people were protected from abuse, neglect and poor care. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13

● Systems were in place to safeguard people from abuse and poor care.
● People and relatives said they felt safe living at the home. One relative said, "Yes [person] is safe. [Person] would not be here if she wasn't in this home." One person said, "It's nice, clean, airy and comfortable. I'm not worried, it's safe."
● Staff had received safeguarding training and understood how to recognise and report signs of abuse and

poor care.
● Where needed the provider had made referrals to the relevant authorities.

Staffing and recruitment

At our last inspection the provider had failed to ensure robust systems were in place to recruit staff safely. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19

● Recruitment was managed safely. The required checks had been completed prior to staff starting work.
● The provider had introduced a dependency tool to assess the number of staff required. People, relatives and staff told us staffing numbers had increased since the last inspection, but we found staff did not always have the time to be flexible to meet people's needs.
● We continued to receive mixed feedback about staffing levels. Staff said there were usually enough staff on duty to keep people safe. They told us staffing levels had increased but confirmed they were often rushed. One staff member said, "We don't get the time to spend with residents. I think that could be improved."
● At the time of our inspection there were vacancies in the housekeeping and catering team. These were being covered by care staff and we found examples where this was not always clearly defined on the rota. We discussed this with provider who told us recruitment was ongoing and assured us any shortfalls in these departments would be reflected as extra hours on the rota.

Preventing and controlling infection

At our last inspection the provider had failed to properly protect people from the risk of infection as effective control systems were not in place. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to infection, prevention and control.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were somewhat assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Safe systems were in place to support people to maintain important relationships with their friends and relatives. Over the course of the inspection we saw people visiting flexibly and safely.

Requires Improvement

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

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

At our last inspection the provider had failed to ensure people's nutrition and hydration needs were met. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14

- People's nutritional needs were not always met.
- Where people had been assessed as requiring their weight monitoring weekly this was not always in place. This meant there was a risk people were losing weight without the appropriate action being taken.
- One person had been assessed by a professional to need a soft diet, but two staff told us they enjoyed eating 'finger goods' and another person at the home often offered them food which was not of the assessed consistency. This exposed the person to a serious risk of harm from choking. We discussed this with the provider, and they took immediate action.
- We raised concerns about staff' knowledge and understanding about people's nutritional and hydration needs at the last inspection, but they had not received any additional training in this area.

Systems were not robust enough to demonstrate people's nutrition and hydration was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People gave us positive feedback about the quality of the meals, although we observed on both days of the inspection people were not offered a second portion. One person said, "It's lovely. I enjoyed it."
- After the inspection the provider confirmed nutrition and hydration training had been scheduled for all staff.

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

At our last inspection people did not receive effective care and treatment as the provider had failed to carry out an effective assessment before they were admitted to the home. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 9

● There had been no new admissions to the home since the last inspection. We spoke with the deputy manager who explained what process they would follow if an admission was planned.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff had the right level of training, supervision and support to carry out their roles safely. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 18

● Staff had the training and support to carry out their roles.
● People and relatives spoke positively about staff. One person said, "The staff are smashing. They look after us 100%."
● Staff confirmed they had received a range of training to carry out their role. We reviewed the training matrix which indicated staff were up to date on mandatory training such as safeguarding, moving and handling and infection prevention and control. Where we had raised concerns about staff moving and handling practices on the first day of the inspection, we saw they had received face to face refresher training promptly.
● Since the last inspection support for staff had improved and they had received supervision. One staff member said, "Supervisions are supportive. You can talk when you need to."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare and support.
● The service supported people to access appropriate healthcare support.
● The provider had weekly calls with the GP.
● People's care records evidenced the involvement of professionals such as the GP, district nurses and mental health professionals. We saw one person being supported to attend a health care appointment by staff.

Adapting service, design, decoration to meet people's needs
● People's bedrooms were personalised and comfortable. People had access to a choice of communal areas and an attractive and safe outdoor garden.
● There was an ongoing refurbishment plan in place and since the last inspection the provider had made some improvements including replacing flooring and introducing dementia friendly signage around the home. The provider told us further improvements were scheduled including an accessible shower room and bedroom doors being personalised to support people with dementia to orientate themselves.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff asked for consent before offering care and support. One person said, "You do what you want here."
- Where people lacked capacity to make their own decisions and choices, best interest decision were completed.
- Systems were in place to monitor DoLS applications.

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 inadequate. At this inspection the rating for this key question has remained 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; 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; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems to assess, monitor and improve the service were in place This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Governance processes were not effective. This is the second inspection when the well-led key question has been rated Inadequate. The service remains in Special Measures.
● At this inspection we found the provider continued to be in breach of the same regulations including managing risks to people, medicines and good governance. This demonstrated the provider's oversight did not ensure safe, quality care and support.
● There was a lack of strong and effective leadership. There had been no registered manager at the service since October 2022. The manager had been in post for 4 months but they had not commenced their application to register with the Commission. On the first day of the inspection they were not able to provide a clear overview of the service and people's needs. The manager resigned after the first day of the inspection.
● There continued to be a lack of robust systems to manage risks to people. Record keeping was not reliable or consistent. This meant people were at a heightened risk of injury or their health and well-being deteriorating.
● Audits were in place, but they had not always been completed effectively and failed to identify the shortfalls we found. For example, medicines audits had been completed but they did not review stock checks and contained inaccurate information about controlled drugs checks. Care plan audits had been completed but they had ticked to indicate all records were clear and in place which contradicted our findings.

Systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider continued to update us after the inspection. They confirmed the deputy manager would be taking up the role of manager. They assured us the provider and a registered manager from another service would be providing a robust induction and support.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff felt listened to and involved in the service. Most staff said they had seen improvements since the last inspection and felt they could raise concerns with the provider.
● People and relatives spoke positively about staff. They said they felt listened to. One relative said, "When things get raised, they are dealt with."
● Over the course of the inspection we did not observe person-centred activities taking place. A range of activities were displayed on a board in communal areas, but they were not offered to people. There was no activity coordinator in place and staff were focused on daily care needs. One person said, "There is not much of anything to do." A relative commented, "The thing that bothers me is the they [people] are just sat; There is no stimuli." The provider responded and said there were plans to recruit to an activity coordinator.

Working in partnership with others
● The provider worked in partnership with health and social care professionals. They had worked closely with the local authority on their improvement plan since the last inspection.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the nutritional and hydration needs of people were met. Regulation 14 (1)(2)(b)

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 failed to monitor and review the risks to people's health and safety. The provider did not have safe systems in place to ensure the proper and safe use of medicines Regulation 12 (1)(a)(b)(g)

The enforcement action we took:

We served a warning notice

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 there were effective systems in place to assess, monitor and improve the quality of the service. Regulation 17 (1) (2)(a)(b) (c)

The enforcement action we took:

We served a warning notice.