Woodleigh Rest Home Limited

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Inspection report

Brewery Lane
Queensbury
Bradford
West Yorkshire
BD13 2SR

Tel: 01274880649

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16 June 2022
27 June 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Woodleigh Rest Home is a care home providing personal care and support for older people, people living with dementia and people with physical disabilities. The service is registered to accommodate up to 33 people, at the start of our inspection there were 23 people using the service. A further person moved into the home before the last day of inspection, increasing the capacity to 24. and by the last day there were 24 people using the service.

People's experience of using this service and what we found
Medicines were not managed safely which put people at risk of harm. There were no protocols in place to guide staff on how to administer as and when required medication. Stock checks were completed but did not capture accurate amounts of medication received into the care home? and there were gaps in the medication administration records with no explanations as to why.

People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs, as well as environmental risks. Infection control procedures were not always followed by staff as personal protective equipment (PPE) was not always worn correctly and social distancing was not maintained. Parts of the premises were not clean.

People were at risk of malnutrition and dehydration due to lack of monitoring of food and fluid intake. Daily records were not robust, and the provider did not have safe systems in place for monitoring the documentation. People who lost weight were not in receipt of support from external professionals as the service failed to monitor and respond to weight loss efficiently.

People did not always receive person centred care and care records did not fully reflect their current needs. Some staff were caring and kind to people, other staff were task focused and did not respond appropriately to people's needs. There were activities taking place and despite this many people were not engaged or included in activities and they did not have their interests occupied.

Staff did not receive induction, training and support they needed for their roles. Staffing levels were not sufficient to meet the needs of the people in the home. We have made a recommendation to the provider about increasing the staffing levels.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible an in their best interests. The policies and systems in the service did not support this practice.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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 10 June 2019)

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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 incident.

We received concerns in relation to the management of medicines, staffing and people's care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well led only.

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 good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has not taken appropriate action to mitigate these risks.

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

Enforcement and Recommendations
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 and will take further action if needed.

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

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.

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?

Inadequate

The service was not 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 inspection was carried out by one inspector, a medicines inspector 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 inspection was carried out by one inspector, and the third day was carried out by two inspectors and a medicines inspector.

Service and service type
Woodleigh Rest 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. 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 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.

On day one and two of our inspection there was a registered manager in post. However, the registered manager resigned with immediate effect on 23 June 2022. When we returned on the last day of inspection on 27 June 2022 the nominated individual had enlisted support of a registered manager at the sister home to oversee and lead the service part time. The nominated individual was overseeing the leadership and management for the remainder of the time.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 14 June 2022 and ended on 27 June 2022. We visited the location's service on 14, 16 and 27 June 2022.

What we did before the inspection
We used information gathered as part of a monitoring activity that took place on 27 April 2022 to help plan the inspection and inform our judgements. We also sought feedback from the local authority and other professionals who use 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
We spoke with nine people who used the service and seven relatives about their experience of the care provided. We looked around the building and observed people being supported in communal areas, inclusive of observing mealtimes. We spoke with 10 staff members including the nominated individual, registered manager, deputy manager, senior care workers, care workers and cook.
The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
- Medicines were not safely managed.
- Some people missed doses of their medicines on the first day of the inspection because the registered manager had forgotten to administer them.
- Stock checks for some medicines together with records about these medicines showed they had not been given as prescribed.
- There was no system for checking the medicines people were prescribed when they came to live at the service which meant they were not always administered? their medicines safely.
- Medicines which must be administered at specific times were not always given at those times. This meant the medicines may not work properly.
- People did not always have written guidance in place for staff to follow when medicines were prescribed to be given "when required" or with a choice of dose. This meant staff did not have the information to tell them when someone may need the medicine or how much to give.
- Medicines records were not always appropriately completed. There were gaps on the medication administration records and the quantity of medicines in stock was not always accurately recorded so it was not always possible to tell if medicines had been given. Topical cream records were inaccurate because they were signed for by staff who had not applied them.
- Medicines to be disposed of were not stored safely..

We found no evidence that people had been harmed. However, the provider did not ensure the proper and safe management of medicines demonstrates a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management, Learning lessons when things go wrong
- People were at risk of harm because risks had not been adequately assessed and monitored.
- Accident and incident reports for one person showed they had nine falls since January 2022. There was no falls risks assessment and no reference in their care plan of them being at risk of falls. Their mobility care plan reviewed in May 2022 stated there were 'no known risk of falls in the past 12 months'. We found people were at risk of harm from falls as there was no mitigation for the future risk of falls. There was no evidence of lessons learnt and action had not been taken.
- Two people had bed guards bought for them privately but there was no risk assessment completed for the use of these, and no referral to the district nurse team for an assessment for suitable bed rails. Other people in the service had bed rails in use with no risk assessment or best interest decision for the use of these. This placed the people at risk of harm from potentially falling or being trapped in bed unable to get out

independently.
● Daily progress notes for people who required additional and regular safety checks due to being cared for in bed were Reviewed on inspection. Safety checks were not being documented, and on occasions people had gaps of over three hours with no documentation of safety checks or personal cares being performed. This put vulnerable people at risk if they were unable to use the call bell system.
● Peoples weights were not being adequately monitored. Some people had been identified as being high risk in nutritional care plans and had lost significant amounts of weight. One person had lost 4.2kg from 3 May 2022 to 31 May 2022. There was no mention of this weight loss in their care plan, no risk assessments or action plan to support and guide staff on measures to take to reduce future weight loss. We did not see referrals to specialists such as Speech and Language Therapist, GP's or dieticians for support. This put people at risk of potential ill health from malnutrition.
● We reviewed 12 peoples care plans and risk assessments and found shortfalls in them all. Risks relating to people's skin integrity, mobility, falls, nutrition and hydration and choking risks were not assessed or monitored effectively. One person's skin integrity care plan had been reviewed on 24 June 2022 stating they were at high risk of developing pressure sores, and they needed regular repositioning. The care plan made no reference to how often this should be done. We reviewed the daily notes for this person and found no pressure care or personal cares had occurred between 05:40 and 11:37 on 13 June 2022, and then on 14 June 2022 between 13:53 and 18:43. This placed the person at higher risk of skin damage.
● The environment was not always clean, carpets in some bedrooms were dirty and stained and some bedrooms appeared unclean. We observed the gas fires were lit in the two communal lounges, both had naked flames. There was no risk assessment for these or the free-standing metal fire guards in front of the fires. There was a metal chain placed across the bottom of the stairs to deter people from going upstairs unaided. There were multiple periods throughout the inspection where this was not on and it failed to deter people. The service did not have an adequate risk assessment for this.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service 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 nominated individual was responsive to the environmental risk following inspection and has taken measures to remove the fires from use.

● Personal Emergency Evacuation Plans (PEEPs) were in place for people and contained relevant information for staff to follow.

Preventing and controlling infection
● We were not assured the provider was using PPE effectively and safely. We saw staff in the home without masks on, masks below their nose, and masks crossed behind the ears.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some parts of the building were not clean despite cleaning schedules being completed. Hand sanitiser was not always readily available through the home.
● We were not assured that the provider was meeting shielding and social distancing rules. Social distancing was not always implemented. Staff were congregating in the dining room whilst on their breaks. We saw people sitting very close together in the lounges.
● We were not assured that the provider was admitting people safely to the service. We saw no evidence of testing of people before they were admitted to the service.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a 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 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.

Visiting in care homes

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● Systems were not in place to protect people from the risk of harm or abuse.
● We found an example of a specific incident that had not been reported to CQC or the local safeguarding authority despite an accident form being completed. This person had also received emergency care in hospital and requires ongoing treatment. This meant there was no monitoring or oversight from external bodies. We have made the relevant referrals to the local safeguarding authority.
● Staff told us they had not received safeguarding, mental capacity or deprivation of liberty training. They were not aware of the correct safeguarding procedures and were unaware how to protect people in line with the policies.

Systems were either not in place or robust enough to demonstrate people were safeguarded from abuse and neglect. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe in the service.

Staffing and recruitment
● There were not always enough staff on duty to meet people's needs and keep them safe.
● We did not see evidence of a dependency tool being used to calculate staffing levels. Staff told us they felt staffing levels were too low and they needed more staff.
● We found staff recruitment processes were not robust or fully completed
●There were gaps in the recruitment files for some staff members, such as gaps in employment history not explored, no evidence of relevant qualifications provided, lack of verification for leaving previous roles.

Systems were not in place to ensure staff were recruited safely. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received a disclosure and barring service check prior to commencing employment. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- Daily notes showed amounts of food and fluid provided to people was not being recorded accurately, robustly or consistently. Some people's daily records showed a maximum of 500mls of fluids being given in a 24-hour period, and no detail on amount of food provided. We were not assured people were receiving enough food and fluid due to the shortfalls in the documentation.
- We did not see staff members monitoring the amount of food and fluids people in the dining room had consumed. There was no process for this monitoring and limited presence of staff in the dining room at mealtimes. Staff told us "It's too rushed, you're trying to serve tea, trying to get it out. I'd love to be able to spend time with residents".
- Some staff told us they felt the food portions were small and some people in the service had bigger appetites. We did not observe second portions being offered during the onsite inspection days. We also observed portions of food were small and served on small plates.
- Some people had lost significant amounts of weights but only one person's meal was being fortified. The staff and cook were not aware of their weight loss or the need for fortification.
- Drinks and snacks were not always readily available for people to help themselves to between meals.
- Feedback in relation to food was mixed. Some people told us the food was good, one person told us "The food is alright, you don't really get a choice, but its ok".

People did not have their nutritional and hydration needs met. This was a breach of Regulation 14 (Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- We did not see evidence of people's needs being assessed before they were admitted into the service on respite care. Pre-admission assessments for people new to the home were not completed. The staff did not have access to up to date and accurate information about the person's support needs. Care plans could not be formulated due to the lack of this information.

People did not have care or treatment that was specific to them due to a lack of an assessment of their needs. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff support: induction, training, skills and experience

● Staff did not always receive the induction, training and support they required to fulfil their roles.
● We found evidence that a new staff member who had been employed for over two months had not received induction training.
●Some staff members told us they had not received moving and handling or infection control training which is needed in their day to day care tasks.
● Some staff told us they had received a supervision in the past 12 months, but others were unable to recall. On reviewing the staff training matrix it shows 50% of staff were out of date and the other 50% had no previous supervision dates detailed. We could not be assured that these staff members had received a supervision.
● The staff training matrix was not up to date and failed to contain all the relevant information and dates to be able to monitor training required accurately and effectively.

Staff had not received the support, training and supervision necessary for them to carry out their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Peoples online care records did not always contain the relevant and most up to date information relating to the involvement of other professionals. For example, we identified one person who had a Speech and Language Therapist (SALT) referral and assessment done in May 2021, however this was not on the online care doc system. This letter was in a folder in the senior's office.
● People's care records did not accurately capture the involvement of other health professionals such as GPs, district nurses, SALTS or dieticians.

Adapting service, design, decoration to meet people's needs
● The environment was not adapted to meet the needs of people living with dementia. This did not promote their independence. For example, there were no pictorial signs on bathrooms or toilet doors. People's bedroom doors were not painted different colours and there was no pictorial aid to help identify individuals' bedrooms.
● We observed that some bedrooms were personalised, but others lacked comfortable furnishings. One person told us they felt cold in their room and had a thin duvet cover on their bed.
● The service required updating and refurbishment.

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 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 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.

● Systems were in place to monitor DoLs applications and authorisations and to make sure conditions were

met.

● Where people lacked the capacity to make their own choices and decisions, capacity assessments and best interest decisions were completed.

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. At this inspection 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Significant shortfalls were identified at this inspection that had not been addressed through the providers own governance systems. There were breaches in relation to medicine managements, risk management, infection prevent and control, safeguarding, nutrition and hydration, person centred care and safe staffing.
- There had been a change in leadership and management in the service. At the start of the inspection on day one and two, the registered manager was present. However, they resigned with immediate effect on 23 June 2022. When we returned on the last day of inspection on 27 June 2022 the nominated individual had enlisted support of a registered manager at the sister home to oversee and lead the service part time. The nominated individual was overseeing the leadership and management for the remainder of the time. The nominated individual is taking appropriate steps to actively recruit a new manager.
- Quality audits despite being completed were not effective in identifying issues and securing improvements.
- The reporting and management of risks to people including accidents and falls was inconsistent. Falls analysis for 1 March 2022 stated increased observations were to be done every 2 hours during night, and regular checks during the day for those at risk of falls. All to be detailed in the daily notes on care doc. On reviewing the care doc these daily notes and checks were not being done.
- Provider oversight and monitoring was not effective in identifying and managing organisational risks.
- People did not always receive person-centred care that led to good outcomes for them. Care records were not always accurate, or person centred.

Working in partnership with others

- The service was not working well with other agencies. Care records had little evidence of partnership working with district nurses, GP's, pharmacists or speech and language therapists, despite the registered manager at the time informing us of the involvement of all these agencies in people's care.
- The manager and staff did not appear to understand the importance and benefits of working alongside these professionals or the importance of effective communication and clear documentation to evidence effective partnership working.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood the requirements of the regulations to make notifications and to comply with the duty of candour responsibilities when things had gone wrong.

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

● Most people and relatives expressed satisfaction with the care provided. There had been two complaints received from a relative but the registered manager at the time had not detailed the outcome of these despite making initial investigations.

● Most staff said there hadn't been many meetings in the past twelve months and they felt they should have them more frequently.

● Satisfaction surveys were completed by some people in November 2021. All feedback was positive with no areas to follow up. Staff surveys took place with five responses noted. The general feedback was good however, areas for improvement on all five had the same themes; a need for more staff, more activities and better snacks and food for people.

● Relative meeting minutes were held for May 2022 again with no areas of concern identified and no actions to be taken forward. One person told us, " It's really nice and friendly here".

● The last resident meeting detailed was December 2021, where there were no concerns detailed. This did not include the full service, there was a limited amount of people included in this due to some people being unable to participate.