Woodrow Retirement 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

Woodrow is a residential care home providing accommodation and personal care for up to 18 people. At the time of our inspection 15 people were using the service.

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

Quality assurance processes and checks were not always in place or effective and had not identified the concerns raised during the inspection.

People's medicines were not always managed in a safe way. Medicine recording systems did not demonstrate people received their medicines as prescribed.

People were not always protected by safe recruitment procedures.

People's capacity had not been assessed following the principles of the Mental Capacity Act 2005 (MCA).

People's care and risk assessment records were not always reflective of people's care and support requirements. However, staff demonstrated a good awareness and understanding of people's individual needs.

People, their relatives and staff spoke highly of the management team. Feedback was positive about staffs' approach and understanding of people's care and support needs.

The provider failed to notify us of incidents that happened in the service as is required by law.

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 3 February 2018).

Why we inspected

This inspection was prompted by a review of the information we held about this service.
Concerns were identified. As a result, we undertook a focussed inspection to review the key questions of safe and well-led. 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 requires improvement based on the findings of 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.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodrow Retirement 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 and will take further action if needed.

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 to discuss how they will make changes to ensure they improve their rating to at least good. We will also 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?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

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Detailed findings

Background to this 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 team was made up of one inspector and an assistant inspector.

Service and service type
Woodrow Retirement 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. Woodrow Retirement 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 there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information, we held about the service including notifications we had received. We used the information sent to 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 information gathered as part of monitoring activity that took place on 6 April 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with the provider who was also the registered manager, the head of care and six care staff. We spoke with four people who used the service and four relatives. We also spoke with one visiting healthcare professional.
We reviewed a range of records. This included eight care records and four medicine records. We looked at four staff files in relation to recruitment and management records.

After the inspection
We requested records in relation to governance such as audits and checks along with staff training. We continued to seek clarification from the provider to validate evidence found.

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 good. 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; Using medicines safely

- People were placed at risk of unsafe care as their care needs and associated risks had not been routinely assessed, updated and monitored. In some people's care records information was out of date and had not been updated as people's needs had changed. For example, one person did not have any risk assessments in place and was at risk because they had fragile skin and poor mobility.
- People at risk of losing weight were not always managed safely. Whilst there were systems in place to monitor people's weight, the provider had failed to ensure timely or appropriate action was taken to monitor weight. For example, one person required their weight to be monitored monthly, the results would inform any actions required in relation to their diet and ensure equipment they used was appropriate. Records showed the person's weight was not monitored monthly as required. By not ensuring this occurred, the provider placed the person at risk of harm.
- People's medicines were not always managed in a safe way.
- The process to carry over ongoing medicines at the beginning of a new recording month was not robust enough. For example, a medicine which was needed extra security should have been entered on a 'register', but this had not been logged. This meant we could not confirm the number of medicines in stock nor were we able to verify people always received their medicines as prescribed.

Whilst we found no evidence that people had been harmed. The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. 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.

- Audits of medicines management and administration was not carried out which put people at risk of harm. After the inspection, the provider arranged for an audit of medicines to be completed and a copy sent to CQC.
- Some people were prescribed medicines to be given 'as required' known as PRN. Protocols detailing when and how these medicines should be given were in place. Staff knew people well and administered these medicines in accordance with their protocols.
- The service had a fridge to store medicines which needed to be stored at a colder temperature. Systems were in place to monitor the temperature of the fridge to ensure these medicines were stored appropriately.
- Health and Safety checks of the environment and equipment had been completed. People had Personal Emergency Evacuation Plans (PEEPs) in place. However, some required updating to reflect people's changing needs.

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).

● The registered manager lacked knowledge of the MCA and there was a failure to understand when this needed to be applied. As a result of this, everyone living at the service had their mental capacity assessed prior to admission into the service regardless of whether they had the mental capacity to consent to their care, treatment and support.

Although, we identified no impact to people living at the service, the provider failed to follow the principles of the MCA. This was in breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection, no person was being deprived of their liberty.
● Staff were aware of their responsibilities in relation to the MCA. For example, staff asked for people's consent before commencing any personal care tasks.
● People told us they were given choices and made their own decisions. One person commented, "I choose what I want to do and when, staff respect my decision."

Systems and processes to safeguard people from the risk of abuse
● During this inspection, we found the provider had failed to ensure CQC was consistently notified of reportable events without delay such as allegations of abuse or serious incidents. This meant we could not check that appropriate action had been taken to ensure people were safe at that time.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

● People and their relatives told us the service was safe. One person told us, "I feel safe here." Another person said, "Staff are very kind to me, and I feel safe here."
● People were comfortable with staff and had no hesitation in asking for help from them if required. Where people were anxious, staff were seen to respond in a caring respectful way.
● Staff understood their responsibilities in relation to reporting any concerns about the safety of people using the service. One member of staff commented, "I would approach [manager name]," Another member of staff said, "In the first instance I would go to the manager, if I could not go to the manager, I would go to the CQC." Staff said they felt confident any concerns raised would be dealt with appropriately.

Staffing and recruitment
● People were not always protected from safe effective recruitment practices. We found information collected about applicants during the recruitment process had not always been robustly assessed. For example, we looked at four staff files and found employment history had not been completed or requested for all the files we looked at. Proof of ID was missing in one of the files and only two staff files had adequate reference checks.

The failure to establish and operate safe and effective recruitment processes is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) had been completed for all staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer.
● People and their relatives told us staff responded quickly to meet their needs. One relative said, "There are always plenty of staff." One member of staff commented, "I think there are enough staff here. I have never been concerned about staffing." Throughout the inspection we observed there was sufficient numbers of staff to support people safely.

Learning lessons when things go wrong
● Although incidents and accidents were recorded, and action was taken to ensure a person's safety. Information was not reviewed to assess if there were any trends or if actions could be taken to reduce the risk of reoccurrence.
● Processes had not been established to share learning from events with staff. For example, we saw some skin injuries had occurred, however, measures to reduce re-occurrence had not been shared.

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

● We were assured that the provider was meeting shielding and social distancing rules.

● 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 accessing testing for people using the service and staff.

● 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

● People were supported to maintain contact with their family and friends. Relatives, people and staff confirmed that visits were supported. Although visitors were welcomed at the service the provider had insisted visitors were vaccinated against COVID 19. This is not in line with the legal requirements. We brought this to the attention of the management team who told us they would address this matter.

We have signposted the provider to resources to develop their approach.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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

● Processes and systems were not in place to identify and monitor the quality of the service and drive forward improvement. Systems operated by the provider had failed to identify concerns and shortfalls we found during this inspection.
● The registered manager had a dual role and responsibility which impacted on their ability to have an effective oversight of the service. For example, the registered manager supported people to attend appointments as well as covering shifts when required. This meant their capacity to complete audits to monitor the quality of the service together with making, embedding and sustaining any improvements made were impacted which put people at risk of harm.
● Monitoring and auditing of medicines had not been established or completed. This put people at risk of harm from medicines errors and omissions. For example, we were not able to clarify how long recording errors had continued in relation to the supplies of medicines. As a result, we could not be assured people always received their medicines as prescribed.
● The provider did not have a quality and auditing system to ensure all people living at the service had an up to date and complete care record. This included a care plan that reflected a person's needs and risk assessments that identified how risks might be reduced. Where people's needs had changed, we saw some care records had not been updated to reflect a change of need. For example, in relation to skin integrity and mobility. Although staff were knowledgeable and understood people's needs, the provider had not ensured or identified the need for robust care records for staff to refer to.
● The provider's quality and monitoring systems had failed to ensure that legislation was complied with. For example, mental capacity assessments were not completed in line with of the requirements of the Mental Capacity Act 2005.
● The provider had not ensured incidents such as serious injuries were notified to CQC as is required by law. For example, an incident which affected a person's health and resulted in a hospital admission was not notified to CQC.
● Records were not analysed to identify any patterns or trends following any incidents, accidents or concerns being raised, in order for improvements to be made to the care people received.
● Although visitors were welcome at the service the provider had insisted visitors were vaccinated against

COVID 19. This is not in line with the legal requirements.

Robust systems and processes were not in place to demonstrate the provider had effective oversight of the service. This demonstrates a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The management team shared information with external agencies such as healthcare professional's when things had gone wrong as well as liaising with families.
● The management team and staff at the service were open and honest during the inspection. They told us they were committed to the people that lived at the service and aimed to provide the best possible care.
● There was a clear management structure within the service and the staff understood their roles and responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and their relatives were positive about the care and support people received and spoke highly of the staff and management team. One relative said, "It's very good here."
● Staff described the service as person-centred and said care and support revolved around the people living at the service, to ensure they received good care. One member of staff commented, "The management are very good. They actually do care; it is a nice place to be for both the residents and staff."
● The management team told us they often worked alongside care staff to ensure people's care needs were met in a timely manner particularly when there were staff shortages due to COVID-19 or annual leave. Staff said they felt very supported in their role.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although, people and their relatives told us management and care staff communicated with them regularly and kept them informed about any changes in the service or updated them about any changes in their relative's healthcare or care needs. We found systems were not used to gather and analyse feedback effectively from people and their relatives to improve the quality of care.
● People's communication needs were met. A relative told us, and we observed, staff used gestures and observed body language to understand what a person was communicating. People also told us staff took time to explain things to them in a way they understood so they could make choices and decisions about how they would like to receive their care.
● Staff told us they had a handover at the start of each shift to share information about people to ensure they received safe care and support.

Working in partnership with others
● People achieved positive outcomes and were supported effectively due to staff working well with external healthcare professionals involved in people's care and support.
● People and their relatives confirmed the management team made timely and appropriate referrals to health and care professionals such as their GP, dentist and enhanced care 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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to follow the principles of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks associated with their care. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service. The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Regulation 17 (1)(2)(a)(b)(c)(e)(f)

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 had failed to ensure that recruitment procedures are established and operated effectively.