Arolygiaeth Gofal Cymru
Care Inspectorate Wales

# Inspection Report on

**Woffington House**

**Forestgate Healthcare Ltd**
**Rear Earl Street**
**Tredegar**
**NP22 3QW**

## Date Inspection Completed

01/09/2023

# About Woffington House

| | |
|---|---|
| Type of care provided | Care Home Service<br>Adults Without Nursing |
| Registered Provider | Forest Gate Healthcare Ltd |
| Registered places | 36 |
| Language of the service | English |
| Previous Care Inspectorate Wales inspection | 07 September 2021 |
| Does this service promote Welsh language and culture? | This service does not provide an 'Active Offer' of the Welsh language and does not demonstrate a significant effort to promoting the use of the Welsh language and culture. |


## Summary

Most people are happy with the care and support they receive at Woffington House. Opportunities to participate in activities are available; however, levels of social interaction and stimulation are variable. Each person has a personal plan of care which is person centred, directs staff to deliver care and support and is regularly reviewed and updated. Individualised risk assessments should be in place to accompany plans of care. The management of medicines requires improvement. Care staff enjoy their work and are generally happy in their role. Staff are knowledgeable about the people they support. Governance arrangements are in place to support service delivery. There is oversight of the service on a day-to-day basis from the manager and deputy manager. Policies and procedures require review and updating. The environment is clean, safe and comfortable.

## Well-being

People are encouraged and assisted by care staff to be as healthy as they can be. People have developed good relationships with care staff and this helps to support people's well-being and emotional health. People have access to GP services, are referred to other healthcare professionals, for example district nurses, as and when needed. Medication administration requires improvement. Care staff demonstrated they knew the people they support and notice any changes in a person's health and wellbeing quickly. The service had been inspected by the Food Standards Agency and had been given a rating of 5 demonstrating the service was rated as very good. People's likes and dislikes, allergies and specialist diets are known.

Opportunities to participate in activities are available to people; however, levels of engagement in these are often low in number. Limited evidence was available to show if people enjoyed the activities or not. We noted differences in the level of social interactions and general stimulation being provided for people. Interactions were often task orientated, resulting in people spending long periods of time with limited or no interaction from staff. In contrast to this, we saw examples of staff actively engaging people, motivating and supporting them. We heard laughter and humour being used appropriately.

There are measures in place to safeguard people from the risk of harm. Records of incidents and accidents are maintained, and safeguarding referrals are completed when necessary. Risk assessments are available; however, they need to be individualised to the person. Character and suitability checks of staff to undertake their roles are in place. Staff files and training records show care staff receive training to ensure people's safety; this includes training in safeguarding, medication, moving and handling. The provider has a safeguarding policy and guidelines for staff to follow, this requires review to reflect Welsh procedures.

## Care and Support

Each person receiving a service has a personal plan which covers core areas of an individual's care and support to be provided. Personal plans are person-centred and contain people's likes, dislikes, preferences and social histories. Plans are reviewed and updated on a regular basis. Plans do not always consider or record aspirations or identify personal goals each individual would like to achieve; this needs to be fully embedded. Some plans evidence representative's involvement in their development and review; this also needs to be fully embedded. Current risk assessments are not sufficiently detailed. Individualised risk assessments are required to maintain people's safety, for example in relation to skin care and falls. The review of risk assessment is not sufficiently robust, for example we saw risks that were no longer relevant remained in place and continued to be reviewed on a monthly basis. This is an area for improvement, and we expect the provider to take action.
People can access the necessary health services to maintain their health and wellbeing. Appointments with health and social care professionals are arranged for regular checks or if individual needs change. Deprivation of Liberty Safeguard (DoLS) authorisations are sought where people lack mental capacity to make decisions about their care and accommodation and need to be deprived of their liberty to keep them safe. People are supported to maintain a healthy weight and diets are reviewed when required and referrals to specialist services are made. Safety equipment is in place where people are at risk of falling. Staff respond to the sounding of safety equipment, for example sensor mats in a timely manner to check on the well-being of people.

The level of social interaction and general stimulation being provided for people differed across the two floors. On the ground floor we observed care staff taking time to sit with people and have meaningful conversations. Similarly, we saw care staff playfully interacting with people in group settings. In contrast to this we saw engagement being predominantly task led and not focussed on peoples' wellbeing on the first floor. Resulting in people looking bored, spending long periods of time with limited or no interaction from staff. This is an area for improvement, and we expect the provider to take action and we will follow this up at our next inspection.

The management and administration of medication requires improvement. Staff receive appropriate training and competency checking in relation to the safe administration of medication. Internal medication audits completed by the manager identified deficits and remedial action required. A sample of medication administration record (MAR) sheets were examined and gaps in recording were seen. Protocols for the administration of "when required" (PRN) medication were missing. This is an area for improvement and we expect the provider to take action. We will follow this up at our next inspection.

## Environment

The premises, facilities and equipment are suitable for the provision of the service. The location, design and size of the premises are as described in the statement of purpose (SoP).

The environment is clean, safe and comfortable. Rooms are a good size, communal lounges and dining areas are available. There are sufficient toilets and bathing facilities. Bedrooms are individualised to people's tastes and contain photos, decorations, and keepsakes, which promote a feeling of belonging. Family trees have been compiled and adorned bedroom doors to help with orientation and a sense of belonging.

The service has good systems in place to identify and mitigate risks to health and safety. People live in a safe environment, with safety checks and maintenance of equipment being completed on a regular basis. Records demonstrate routine completion of utilities testing. Fire safety tests and drills are completed regularly. Personal emergency evacuation plans are in place and provide guidance on how people can be safely evacuated in the event of an emergency. We saw fire exits were clear of clutter and obstructions, with no obvious trip hazards more generally. Substances hazardous to health are stored safely. Daily cleaning and laundry duties are being maintained. The provider has a system in place to record and monitor maintenance requests.

## Leadership and Management

Governance arrangements are in place to support the operation of the service. The manager and deputy manager oversee the day-to-day running of the service, with support from senior staff. Care staff told us the management team are approachable and supportive. Systems are in place which inform the Responsible Individual (RI) of issues that occur. The RI conducts regular visits to the service. Policies and procedures require review and update. The safeguarding and complaints policies reference out of date legislation and guidance and did not align with Welsh best practice. The policies and procedures did not provide clear guidance and expectations on care staff. For example, the safeguarding policy did not reference Welsh legislation and agreed safeguarding procedures. This is an area for improvement and we expect the provider to take action.

There are suitable selection and vetting arrangements in place to enable the service provider to decide upon the appointment of staff. We viewed staff files and found the necessary pre-employment checks have taken place. Employment histories are provided for applicants. Identification and references further support the individual fitness of staff to work at the service.

There are systems in place to support staff and develop their skills. Newly appointed care staff complete an induction programme which includes training and shadow shifts. Staff training records indicate care staff have access to training opportunities, and most have completed a good level of training. Staff can attend team meetings to discuss the operation of the service. Formal supervision with line managers have improved, however the frequency of these needs to be at least every three months. This provides opportunity for care staff to discuss any concerns or training needs they may have and for management to provide feedback on their work performance. Care staff are supported to register with the workforce regulator, Social Care Wales (SCW).

Staffing levels were sufficient on the day of our inspection to meet peoples care needs. However, the deployment of staff should remain under review to ensure that people's emotional wellbeing is consistently met. For example, ensuring everyone receiving a service experiences the same level of stimulation and engagement throughout the day. Staff we spoke with said *"we need more activities, things for people to do to make sure they are not bored".* Staff also told us they are happy in their role and spoke positively about their employment.

| Summary of Non-Compliance | |
|---|---|
| **Status** | **What each means** |
| **New** | This non-compliance was identified at this inspection. |
| **Reviewed** | Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection. |
| **Not Achieved** | Compliance was tested at this inspection and was not achieved. |
| **Achieved** | Compliance was tested at this inspection and was achieved. |

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

| Priority Action Notice(s) | | |
|---|---|---|
| Regulation | Summary | Status |
| N/A | No non-compliance of this type was identified at this inspection | N/A |

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

| Area(s) for Improvement | | |
|---|---|---|
| Regulation | Summary | Status |

| | | |
|---|---|---|
| 15 | Risk assessments are not specific to individual people. | New |
| 58 | Medication administration is not sufficiently robust. | New |
| 79 | Policies and procedures require updating to reflect current legislation and best practice. | New |
| 21 | Levels of engagement and meaningful interactions are not sufficient. | New |
| 57 | The service provider had not ensured that any risks to the health and safety of individuals are identified and reduced as far as reasonably practicable. This includes complying with current legislation and national guidance in relation to fire safety, regular fire evacuation and recorded fire drills. | Achieved |
| 36 | The service provider had not ensured all staff receive appropriate refresher core training to the work they are to perform. | Achieved |
| 16 | The service provider had not ensured that personal plans are revised as necessary. | Achieved |
| 67 | The service provider had not ensured the service manager is registered with Social Care Wales | Achieved |
| 73 | The Responsible Individual must ensure they meet with / talk with individuals and or their representatives using the service at least every three months and document this. | Achieved |
| 64 | Ensure the complaints policy is up to date and incudes all the correct information and the service is operated in accordance with the policy. | Achieved |
| 16 | Ensure the personal plan is revised as necessary. | Achieved |
| 16 | Ensure when personal plans are reviewed on a three monthly basis the service provider involves the individual and any representative. | Achieved |
| 35 | Ensure full and satisfactory information and documentation in the respect of each of the matters specified in Part 1 of Schedule 1 is available at the service for people working in the service. | Achieved |

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