Larchwood Care Homes (South) Limited

Wickwar

Inspection report

Castle House
Sodbury Road
Wickwar
Gloucestershire
GL12 8NR

Tel: 01454294426
Website: www.orchardcarehomes.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 and 15 September 2016 and was unannounced. This service was previously inspected in August 2015. At that time we found there were areas that required improvement and we made recommendations to the provider in order to achieve this. Wickwar Nursing Home provides accommodation and nursing care for up to 39 people. At the time of our visit there were 26 people living at the service.

The new manager had been in post since May 2016 and they had applied to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During 2015 there had been a lack of consistent management within the service. Because of this a significant number of improvements were required to ensure people were kept safe and received quality care. The arrangements in place to ensure the service was well led were unsatisfactory. The provider acknowledged the deterioration in the service provision earlier this year and contracted an independent company to oversee the operation and running of the service. Health Care Management Solutions joined the home in February 2016. It was evident at this inspection they had made significant improvements.

A comprehensive action plan had been developed highlighting areas for improvement. We were able to see where action had been completed and where other areas were being addressed. Work had been prioritised and realistic timescales had been put in place so that the quality of work and further development was not compromised. The service had been supported by various health and social care professionals and this had been embraced by the management and staff. They acknowledged shortfalls, learnt lessons and took action to resolve issues. It was evident that much had been achieved and working progress continued.

We did however find one area where the service was in breach of regulation. People were not protected from the risk of cross infection. This was because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment. On the second day of our inspection some concerns that required a quick fix had been addressed.

People and visitors told us they were happy and things were improving. Despite the areas for improvement, people said things were satisfactory and staff always did the best they could. Comments included, "There is a lot going on and they are doing their best", "I cannot fault the staff, they are a lovely" and "I am very happy living here, it was the right decision". Two relatives we spoke with shared their views about where they felt there was room for improvement and we fed this back to the area manager.

Staff were knowledgeable in safeguarding procedures and how to identify and report abuse. People were protected by the recruitment policy and practices to help ensure that staff were suitable. The manager and staff were able to demonstrate there were sufficient numbers of staff with a combined skill mix on each shift.

Despite staff vacancies, every effort was made to ensure continuity when using agency staff.

A training programme had been developed for all staff and good progress had been made rolling this out to staff. Staff acknowledged the training had been useful and effective. People were helped to exercise choices and control over their lives wherever possible. Where people lacked capacity to make decisions Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented to ensure that people who could not make decisions for themselves were protected.

People received a varied nutritious diet, suited to individual preferences and requirements. Mealtimes were flexible and taken in a setting people had chosen. Staff took prompt action when people required access to community services and expert treatment or advice if they were at risk of malnutrition or dehydration.

People enjoyed receiving visitors and had made "friends" with the people they lived with. They were relaxed in each other's company. Staff had a good awareness of individuals' needs and treated people kindly. People moved into the service only when a full assessment had been completed and the manager was sure they could fully meet a person's needs. People's needs were assessed, monitored and evaluated. This ensured information and care records were up to date and reflected the support people wanted and required.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People were not protected from the risk of cross infection because appropriate guidance had not been followed. Some areas of the home were not clean and hygienic.

Staff had received training in safeguarding so they would recognise abuse and know what to do if they had any concerns.

People received care from staff who took steps to protect them from unnecessary harm. Risks had been appropriately assessed and staff had been provided with clear guidance on the management of identified risks.

There were enough staff on duty to support people safely.

People were protected through the homes recruitment procedures. These procedures helped ensure staff were suitable to work with vulnerable people.

People were protected against the risks associated with unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were encouraged and keen to learn new skills and increase their knowledge and understanding

People were supported to make decisions and choices about their care. Staff supported those who were unable to make choices themselves and to make decisions in their best interests in line with the Mental Capacity Act 2005.

People had access to a healthy diet which promoted their health and well-being, taking into account their nutritional requirements and personal preferences.

The service recognised the importance of seeking advice from community health and social care professionals so that people's

health and wellbeing was promoted and protected.

Is the service caring?

Good

The service was caring.

Everyone was fully committed to providing people with the best possible care.

Staff were passionate about enhancing people's lives and promoting their well-being.

Staff treated people with dignity, respect and compassion.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

Staff identified how people wished to be supported so that it was personalised.

People were provided with activities. Activities and stimulation for people was being further explored so that they were more meaningful.

People were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Requires Improvement

The service was partially well led. Improvements required had been identified and plans were in place to rectify these.

Quality monitoring systems were in place and had influenced change and improvement.

The service needed to sustain improvements made to evidence they were effective.

People who used the service felt supported by the management team.

Procedures were in place for recording and managing complaints, safeguarding concerns, incidents and accidents.

Wickwar

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This service was previously inspected in August 2015. At that time we found there were areas that required improvement and we made recommendations to the provider in order to achieve this. One adult social care inspector carried out this inspection who was accompanied by an expert by experience. An expert by experience is a person who has used this type of service in the past.

Prior to the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

The service was being monitored and supported by various health and social care professionals following previous safeguarding concerns which were raised about people's well-being. We have referred to the intelligence reports we have received from those that visit the service and from multi-agency meetings we have attended.

During our visit we spoke with 10 people living in the home and six relatives. We spent time with the area manager, and spoke with 11 staff on duty. We received feedback from two visiting healthcare professionals who regularly visit the service. We looked at people's care records, together with other records relating to their care and the running of the service. This included staff employment records, policies and procedures, audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. On the first day of our inspection we looked at the environment. People were not protected from the risks associated with cross infection because appropriate guidance had not been followed. Although some areas of the home were clean and fresh, we saw evidence where parts of the home were not clean and smelt of urine. In some areas the interior fixtures, fittings and furnishings were not in good physical repair and could not be effectively cleaned.

Laminate had peeled off vanity sink units which revealed rough chipboard. Plastic coating on the frames of the commodes and toilet seat raisers had started to peel away to expose rust. Flooring in one toilet upstairs was particularly in poor repair and two toilets downstairs were dirty and smelt of urine. There was an unpleasant drain odour in some toilets. Effective cleaning was compromised in these areas and could harbour germs.

We noticed staining on several chairs and carpets both in communal areas and in people's rooms. Bedside table tops were sticky and not being wiped down after mealtimes. We saw crumbs and debris on carpets in bedrooms and corridors. A small amount of surface dust was noted on some bed heads. Two relatives thought the level of cleanliness was not consistent through the week and was usually 'worse at weekends'.

Staff were not always following infection control policy and procedure. Several toilets did not have hand towels and soap dispensers were empty. We saw a small pile of soiled clothes on the floor in a sluice room and they had not been placed in the appropriate laundry bag. Not all commodes had lids which meant staff would be carrying used pans to the sluice uncovered. Some bins were broken and could not be opened via their foot pedal.

Infection control audits were not satisfactory and had not identified the concerns we had during our visit. The provider and manager were not following the Department of Health, Code of Practice on the prevention and control of infections, or other relevant guidance.

We showed the area manager some of the areas we identified that would require immediate attention. On the second day of our visit some of these had been addressed and plans had been put in place to rectify the others.

This was a breach of Regulation 12 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

Staff were kind and protective, they wanted people to be happy and feel safe. People we spoke with told us they felt safe and staff looked after them. One relative told us, "I am very happy when I leave, I feel mum is in very good hands". Staff confirmed they had recently attended safeguarding training updates and this had helped refresh their knowledge and understanding.

The manager recognised their responsibilities and duty of care to raise safeguarding concerns when they

suspected an incident or event that may constitute abuse. Agencies they notified included the local authority and CQC. We had recently attended safeguarding meetings held by the South Gloucestershire safeguarding team. The manager had prepared well for these meetings and it was evident from the information they provided that they had completed thorough investigations, were open and transparent and completed comprehensive records to aid all professionals who attended.

Staff understood their roles for reporting accidents, incidents or concerns. Written accident and incident documentation contained a good level of detail including the lead up to events, what had happened and what action had been taken. Any injuries sustained were recorded on body maps and monitored for healing. There was evidence of learning from incidents that took place and appropriate changes were implemented. Monthly audits helped to identify any trends to help ensure further reoccurrences were prevented. Staff monitored for signs of infection as a possible cause and reviewed medication with the GP. If a person had fallen they reviewed the environment to see if risks could be eliminated for example moving furniture and reviewing walking aids and footwear.

Staff knew about specific risks relating to people's health and well-being and how to respond to these. This included risks associated with weight loss, maintaining skin integrity and difficulty with swallowing and potential choking risks. People's records provided staff with information about these risks and the action staff should take to reduce these.

During the inspection the atmosphere was calm and staff did not appear to be rushed, they responded to people's requests for support. People, visitors and staff confirmed there were enough staff on duty. The team made every effort to ensure vacant shifts with covered by permanent staff members but this was not always possible. Staff absence and vacant posts had meant an increase in agency use. The manager used the same agency which helped promote continuity and consistency of care. Staffing levels were determined by people's needs and the level of support and care they required. Levels did not alter if occupancy reduced. If people's needs increased in the short term due to illness or in the longer term due to end of life care, the levels were increased. The manager ensured there was a suitable skill mix on duty over each 24 hour period. Staff escorts were also provided for people when attending appointments for health check-ups and treatments if required. The manager and deputy were supernumerary and available to offer support, guidance and hands on help should carers need assistance. The regional manager, manager and deputy were on available after 5pm weekdays and every weekend.

Safe recruitment procedures were followed at all times. Appropriate pre-employment checks had been completed and written references were validated. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant has had any past convictions that may prevent them from working with vulnerable people.

Policies, procedures and records were in place to help ensure safe management of medicines. Records of medicines entering and leaving the home were maintained. Staff completed safe medicine administration training before they were able to support people with their medicines and this was confirmed by those staff members we spoke with. Staff were observed on medicine rounds until they felt confident and competent to do this alone. The area manager spoke with us about a new medicines system they were introducing over the coming months. The system was designed to be tailor made specifically for the service which promoted safer management of medicines.

We spent time with maintenance staff for the home. They had robust systems in place with regards to health and safety checks throughout the home. It was evident they considered their role an essential part of keeping everyone who used the service safe. They spoke about fire drills and how these were set up as real

life scenarios so that everyone got a more accurate experience as possible. The scenes were set up to help raise awareness about good practice, for example purposely blocking fire exits with equipment. There was a sense of team working with the fire drills and group feedback was always encouraged to discuss what went well, where improvements could be made and whether additional training may be required.

Good

Is the service effective?

Our findings

The service was effective. The manager listened to staff feedback about training they received which helped to ensure it had been useful and effective. Alternative training had recently been sourced on the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) because staff felt the previous training was too complicated. Staff had enjoyed attending recent training sessions and sharing what they had learnt with colleagues. Care staff had completed nationally recognised qualifications in health and social care and others were in the process of completing this. Nurses were supported to update their skills and knowledge for the roles they performed. This included wound care management, diabetes and syringe driver updates. Syringe drivers were used to administer medicines continuously through a needle just under the skin.

Frequency and quality of supervisions had improved since the last inspection. A formal process had been introduced where staff had private one to one time with the manager, or other senior supervisors. Supervisions supported staff to discuss what was going well and where things could improve, they discussed individuals they cared for and any professional development and training they would like to explore. Staff felt supported on a daily basis by the area manager, manager, deputy and other colleagues. Staff meetings were an additional support, where they shared their knowledge, ideas, views and experiences. The manager and deputy were in the process of introducing practical observation sessions to help staff develop their skills, for example, medicine rounds, wound and catheter care.

Communication systems were in place to help promote effective discussions between staff so they were aware of any changes for people in their care. This included daily handovers, head of department meetings and written daily records. Daily records provided a good level of detail for all staff to read, they told staff about what had been happening over a 24 hour day. This was particularly useful for those staff who had been absent during holiday leave or sickness absence.

Staff had received training on the MCA (2005) and the DoLS. The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so. Staff understood its principles and how to implement this should someone not have mental capacity and how to support best interest decisions. This included those decisions that would require a discussion with family, and possibly other significant people, for example health and social care professionals.

There were no restrictive practices and daily routines were flexible and centred around personal choices and preferences. People were moving freely around their home, socialising together and with staff. They chose to spend time in the lounges, various seating areas, the dining room and their own rooms.

People and staff told us there had been an improvement with the meals prepared and the choices available. People appeared to enjoy their meal and ate in a tranquil setting. They told us they were happy with the food and the variety. Comments included, "All meals are good", "I haven't turned anything down yet", "It's

tasty and traditional" and "The food has definitely improved, I have enjoyed many meals here when I visit my wife". Two people told us they were really enjoying the cooked breakfasts and that it 'set them up for the day'. In addition to morning coffee and afternoon tea, beverages and snacks were available to people throughout the day.

We met with the cook who was knowledgeable about the people living in the home, their likes dislikes and dietary requirements. Menus reflected seasonal trends and consisted of meals that people had chosen. If people were at risk of weight loss a screening tool provided guidelines to assist with developing a care plan and identifying any action required. Food and fluid intake was recorded if required, so that any poor intake would be identified and monitored. People were weighed monthly but this would increase if people were considered at risk. Referrals had been made to specialist advisors when required, including speech and language therapy when swallow was compromised and GP's and dieticians when there were concerns regarding people's food intake and their weight.

The manager and staff sought expert advice from community health and social care professionals so that people's health and wellbeing was promoted and protected. People were supported to register with GP's and dentists of their own choice. Referrals had been made to speech and language therapists and community dieticians. Opticians and dentists were accessed to provide regular check-ups and treatment where necessary. Two GP's were visiting at the time of our inspection and they spoke with us about their experience when visiting. One thing they felt could be improved was for the nurses and care staff to prepare in advance prior to their visits. They had found on occasions that communication had not always been effective and staff were not always expecting them. We fed this back to the area manager at the end of our inspection.

Good

Is the service caring?

Our findings

The service was caring. We were introduced to people throughout our visits and we spent time observing them in their home. The atmosphere was relaxed and people appeared comfortable and relaxed in their surroundings. We received positive comments about staff which included, "I am quite happy here thank you", "They don't try to boss you about", "They are a good bunch" The staff are wonderful they always have time for me" and "They are a smashing bunch, I am spoilt". Comments from relatives included, "The care is excellent, mum is very fond of them"

Although it had been an unsettling year for staff there was still a sense of determination and pride. We asked staff what they thought they did well and what they were proud of. Comments included, "The care we give is centred on the person, we treat people as individuals", "I enjoy working here and I think people are cared for well. I hope they feel happy" and "I wouldn't hesitate for my relative to live here". One new member of staff said, "I like how friendly all the staff are, I am enjoying working here".

During our visits we saw staff demonstrating acts of patience and kindness. Mealtimes were a good example where staff promoted an atmosphere that was calm and conducive to dining. We observed staff speak tentatively to people, they described the meal they served, repeatedly offered drinks and asked if everything was satisfactory. People who required help with eating and drinking were supported with dignity and respect. Staff were supporting people respectfully and at their own pace, sitting at the same level, with clothes protected where requested. Staff were attentive throughout lunch offering drinks, gently encouraging and cutting up food if required.

People were smartly dressed and looked well cared for. It was evident people were supported with personal grooming and staff had sustained those things that were important to them prior to moving into the home. This included preferred style of clothes that were clean and ironed, shaving, manicures, helping people to fasten their jewellery and weekly hairdressing.

Previously the service had promoted keyworker roles to further enhance a personalised approach. The keyworker role provides a link between the service, the person and their family and focuses on liaising with different professionals or disciplines in order to ensure the services work in a coordinated way. We discussed the role with staff and their views on the value of this system. They told us it had been a positive way to support people and helped promote personal preferences, and leant itself to ensure meaningful experiences for people. The area manager told us staff had expressed a wish for the role to be reinstated during their supervision sessions and as a company this was something they supported and promoted. We look forward to seeing the progress made at the next inspection and how this has impacted on people.

Staff told us about friends and family members who remained important to people and how this was encouraged and supported. People kept in contact through telephone conversations and staff helped them send cards when celebrating special occasions. Visitors were welcome any time and spent time in the privacy of their own rooms or in communal areas. Family and friends were also invited to join in any celebrations or events at the home.

Good

Is the service responsive?

Our findings

During our visits we saw people being cared for and supported in accordance with their individual wishes. One relative told us, "I feel the staff do everything to get to know my wife and I have been asked what she likes and how she would prefer things to be done".

The manager completed an assessment for those people who were considering moving in to the service. Every effort was made to ensure that significant people were part of the process including family, hospital staff, GP's and social workers. The information gathered supported the manager and prospective "resident" to make a decision as to whether the service was suitable and their needs could be met.

The assessments assisted staff to develop care plans based on individual needs and personal preferences. They were reviewed and further developed during the first four weeks of admission. The area manager told us they had completed audits on the existing care records. Staff felt the system used was hindering staff efforts to improve the documentation and making care plans 'more specific and personalised'. As a result of this a new system was going to be implemented alongside training to help support the quality of the work they would be embarking on. Even though there was room for improvement in the current system, plans captured a holistic approach to care and included the support people required for their physical, emotional and social well-being. Information on people's life experiences, significant people, interests and hobbies had also been sought.

One area that had been identified as requiring improvement was activities. There was a selection of activities people could join in and entertainers visited the home. Particular favourites for people included arts and crafts, games, reminiscence, quizzes and one to one interaction. People also had individual ways they liked to relax for example, knitting, sewing, completing crosswords and receiving daily newspapers. Some people were able to go out independently, families and friends also went out with their loved ones and staff supported as escorts where required.

A new activity coordinator had been in post for four weeks. During this time they had concentrated on getting to know people and their families. This had helped identify what people wanted to do as individuals and as a group. Initial outlines for the future included befriending schemes, more local trips and building relationships with local schools, churches and clubs. They also wanted to introduce a quarterly newsletter which would provide information about significant events, new staff and future plans for the coming months. Previously 'resident's' committee meetings had been received well and this was something the coordinator intended to re-established soon.

The manager encouraged people to express concerns or anxieties so they could be dealt with promptly. This approach helped prevent concerns escalating to formal complaints and relieved any anxiety people may be feeling. They also spent time around the home and saw people every day to see how they were. This approach had helped form relationships with people where they felt confident to express their views. Small concerns were documented in the daily records and provided information about how they had been dealt with. This information was also shared with staff in shift handovers.

Requires Improvement

Is the service well-led?

Our findings

The service was partially well led and things had greatly improved over the last six months. The new management team in place had worked hard to identify where improvements were required and plans to resolve these had been placed in order of priority. The whole staff team should be acknowledged for the improvements to date but will need to concentrate on strategies to ensure the standards reached were sustained.

The introduction of and quality of audits had helped ensure improvements within the service. However the infection control audits were not satisfactory and meant the service had not identified the risks we had, during our visits.

We recommend that the service seek advice and guidance from a reputable source such as the Department of Health, Code of Practice on the prevention and control of infections, or other relevant guidance.

Improved staffing structures had been put in place, with revised job specifications, roles and responsibilities. This structure was a new concept and as it was in its infancy we were unable to judge its effectiveness. However we did receive positive feedback from staff and there was an overall feeling that this had helped promote accountability, continuity of work flow and a smoother running of the service. In addition to the area manager and manager, there was a deputy, a team leader and senior staff roles.

There was a genuine sense of relief from staff with regards to recent changes and the new management structure in place. Although this was a relatively new whole staff team there was evidence of a cohesive group who were committed to moving the service forward. Relationships of trust and confidence were being promoted by the area manager in order to ensure the manager was respected and approachable. Since commencing their new post the manager displayed enthusiasm and passion about the service and those who used it. Both area manager and the manager promoted and encouraged open communication amongst everyone who used the service.

Good relationships were being established between people, relatives and staff and everyone agreed that improvements were being made. Comments from people, relatives and staff reflected this and that things would continue to improve with time. Comments included, "There is a definite improvement with the managers in place", "Managers are very supportive even on a personal matters", "There is a vast improvement, morale is much better and it feels more like an extended family" and "The manager is much more visible, walking around the home every day, making enquiries and making sure the residents and staff are ok".

Despite the shortfalls in the infection control audits for the home, other audits had proved that they were a valuable asset to the service and had led to many improvements. In addition they had enabled the service to formulate a longer term plan to drive further improvements and create new initiatives. The care documentation audits had provided nurses with very clear details of any omissions, out of date information and where more information was required. A new post for an activity coordinator had been filled and hours

for activities had been increased per week. Audits for the premises had resulted in a rolling programme for refurbishment and redecoration of the whole home. Plans for the future included, new documentation for care records in order to further evidence a person centred approach, staff recruitment initiatives in order to reduce agency cover and increased observation of practice for all staff. These were only some examples and we look forward to seeing the progress the service makes at our next inspection.

Additional systems were in place to monitor and evaluate services provided in the home. The manager reviewed complaints, incidents, accidents and notifications. This was so they could identify trends and risks to prevent re-occurrences and improve quality.

The service had not been assessing the quality of care and service by asking for the views of people, relatives and visiting health and social professionals. The new management company had addressed this by formulating surveys for people to complete. The closing date for return of these had meant they were not available at the time of this 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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with cross infection and appropriate guidance had not been sought or followed. Regulation 12 (2) (h)