Midland Healthcare Limited

Woodlands Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Woodlands Care and Nursing Home is registered to provide personal care for up to 50 adults, which may include some people living with dementia. This inspection was unannounced and took place on November and 12 December 2016. At the time of our inspection there were 43 people living there.

There was a registered manager at this service. 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. At our last inspection in February 2015 the provider was in breach of Regulation 12 Safe care and treatment. At this inspection we found they had met this breach. However this took the intervention of a senior manager from the provider to recognise and meet this breach.

During our inspection visit we observed that staff were friendly and approachable. However they did not spend time with people other than to meet their basic needs. At times staff walked through the communal areas without speaking or acknowledging people.

People's physical and mental health was promoted. Some staff were trained to care for people living with dementia. Medicines were stored appropriately and were administered and recorded as prescribed. However the process of administering medicines took too long and this delay could impact on time sensitive medicines.

There was a process in the service to ensure the Mental Capacity Act and the Deprivation of Liberty was used to protect people. However we found that the registered manager did not fully understand this and made some unnecessary referrals to the Local Authority.

We saw staff ensured people were comfortable. However people's dignity was not always promoted when they were been assisted to move using a hoist. Some people's clothing had risen up and this left them in an undignified position they could not control themselves.

People were offered choices at meal times and were seen to enjoy their food. Although some people who struggled with eating they were not offered support. When people were offered a snack staff made the choice for them rather than taking time and allowing people the choice. There were two dining rooms and there was a marked difference between both. In one the dining experience was promoted and the other lunch was served in a haphazard manner.

Most staff were caring and communicated well with people, however some staff focused on the task they were carrying out rather than on people. Some staff spoke over people's heads. Most staff spoke in a positive manner about the people they cared for and had taken the time to get to know people's preferences and wishes.

Staff understood how to keep people safe, however if they had concerns they were not always aware of who to contact outside the service to address this. Assisting people to move using a hoist was not always carried out in a safe manner as people did not have individual slings bases on their weight and size. This put them at risk of an accident or injury as the sling needs to fit people correctly to keep them safe.

People were supported to maintain relationships with family and friends. Visitors were welcomed at any time.

Records we looked at were not always easy to follow and although they contained good information they were not always personalised. They did not always included decisions people had made about their care including their likes, dislikes and personal preferences.

Staff were well supported and had regular meeting with their line manager to ensure they had the training and information to care for people.

The service was not always well managed. The management of the service lacked structure. The registered manager was not always able to recognise areas of the service that required input to ensure good outcomes for people and staff. There was no clear leadership and the deployment of staff and responsibilities was not always clear. There were sufficient staff on duty however they were not effectively deployed and this meant people were left unattended at times and had to wait for their needs and wishes to be met.

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.

The service was clean.

Staff knew how to keep people safe but were not always aware of how to report any concerns they may have. Risks were identified but not always managed effectively to keep people safe. There were systems in place for the storage and administration of medicines. Staff understood these and administered medicines as prescribed. However the administration of medicines took too long to administer and could have impacted on time sensitive medicines

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to meet the varied and specialised needs of people using the service. Staff mostly knew people and their individual care needs.
People's nutritional needs were understood and met. Some people struggled unassisted to eat. The registered manager did not fully understand the MCA and DoLS. People were supported to ensure their physical and mental health was promoted.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always respected. Staff did not always offer people choice. Staff did not always have time to spend with people.

Lunch was not always an enjoyable experience. There was a marked difference between two dining rooms.

Most staff were caring and respectful. However some staff did not acknowledge people and show respect to them. Some spoke about people and spoke over their heads to colleagues.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did contain good information, however they were not always easy to follow and did not contain personalised information about people and how they wished to live.

People were not offered the opportunity to participate in their interests. They appeared to be bored and unstimulated

Is the service well-led?

Requires Improvement

The service was always well led.
The registered manager was not always aware of the areas of the service that needed to improve and therefore did not have plans in place to achieve this. The deployment of staff and their responsibility was not clear.

People and their needs and wishes were not put at the centre of the service.

Staff felt supported by the assistant manager who was available to staff for support and guidance.

There were quality assurance systems in place however they did not identify and plan a resolution to the issues raised.

Woodlands Care and Nursing Home

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 November and 8 December 2016 and was unannounced. It was carried out on both days by one inspector and one specialist advisor whose speciality was the care of older people. Before the inspection we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Also before the inspection visit we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As some people were living with dementia at Woodlands we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with six people and four relatives. We spoke with four staff members, the registered manager, the deputy manager and a senior manager. We observed how care was delivered and reviewed the care records and risk assessments. We checked medicines administration records and reviewed how complaints were managed. We looked at four staff recruitment records and staff training records. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

At the last inspection carried out 18 February 2015 we found a breach of regulation 12 in relation to infection control in the service.

On the first day of our inspection we found areas of the service that were not clean. This included the floors and skirting boards in the main corridor and areas of the kitchen floor and some equipment such as the deep fat fryer. We pointed this out to the manager who refuted this. The registered manager told us the service had been inspected by the local authority who found the service to be clean. Paperwork showed they visited in January 2016. Later a senior manager arrived, agreed the service was not the standard the provider expected and told us it would be dealt with straight away. On the second day of our inspection visit this had been address and the areas we were concerned about were clean.

People told us they felt safe. One person said, "I feel safe as houses." Another said, "Yes I feel safe and it's a lovely feeling."

Staff knew how to recognise signs of abuse and they were able to tell us what they were. However they were not sure what to do and who to contact outside the service should they be concerned about the welfare of someone using the service. They told us they had confidence in the management team to report incidents of abuse.

People had risk assessments carried out to identify areas of risk in their lives, identify this risk and have actions in place to reduce the risk where possible. Risk assessments were not easy to find in the care plans. However they contained good information and gave clear directions to staff on how to keep the person safe. For example it was clearly highlighted if a person was at risk of falling out of bed. Actions such as, putting on bed rails and bumpers to avoid injury on the rails was identified. However, we saw staff use the same slings to assist people to move. This was not safe as all people should have individual slings to accommodate their different size. Using individual slings is important measure to keep people safe while assisting them to move safely while using a hoist. People were also assisted to move using wheelchairs. Some of these did not have foot plates, this put people at risk of injury as their feet could have been caught under the chair and caused an injury.

People's falls were monitored and where appropriate action was taken. For example staff ensured footwear was appropriate.

People's medicines were administered safely and as prescribed by their GP. Staff had been trained to administer medicines safely. Medicines were stored appropriately within a locked cabinet. We looked at the medicines administration record (MAR) for two people and found these had been completed correctly. There was a system to return unused medicines to the pharmacy. Protocols (medicine plans) were in place for people to receive medicines that had been prescribed on an 'as when needed' basis (PRN).

Medicines were administered by two staff members. A qualified nurse administered medication to people with nursing needs and a senior carer administered medication to people who were having their needs met through residential care. This took a long time as staff were subjected to constant interruption. This delay in administration could have a negative impact on medication due to be administered in a timely manner such as paracetamol where four hours is needed between doses.
We noted the medicines trolleys were left unattended on the first day of our inspection visit. This left medicines unprotected and within reach of many people. This could have put people at risk.

The registered manager used a recognised tool to assess staffing levels. We found this was effective and there was enough staff around to call on should people need assistance. However staff were not effectively deployed and there were times when people were left unattended in the communal areas. This meant people were left at risk, for example risk of falling should they decide to move unassisted.

We found thorough recruitment procedures in place. These ensured staff had the right skills and attitude, and were suitable to support people who lived at the home. The provider checked whether the Disclosure and Barring Service (DBS) had any information which might mean a person was not suitable to work in the home; and checked staff references. The DBS is a national agency that keeps records of criminal convictions. We saw from staff records that they did not commence employment until all the necessary checks were completed.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the way staff cared for them. One person said, "You know I have my favourites, but they are all great, they would do anything for you." Another person said, "The girls are the best." A relative said, "[Relative] has [named condition] and there is nothing they can do to make [relative] better. The staff are wonderful and look after them really well."

The 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 Act 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.

Staff we spoke with mostly understood in principle the requirements of the Mental Capacity Act 2005 (MCA) and the importance of acting in people's best interests. The registered manager told us how they put the principles of the MCA into practice when providing care for people. However, the registered manager and some staff we spoke with did not fully understand the circumstances which may require them to make an application to deprive a person of their liberty and were not familiar with the processes involved. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Consequently a referral had been made on behalf of all people who used the service. This was unnecessary as some people clearly had the mental capacity to make decisions for themselves and showed the registered manager did not have a full understanding of how the Act protected people. However, this did protect people who needed to have a DoLS in place for their own protection.

People's capacity was established. People who were considered as not having mental capacity had their rights protected because the service involved the appropriate professionals and representatives to ensure decisions made were in people's best interest. We saw information for people on how to access independent advice through advocacy and those people without family or representatives had access to advocates who acted in their best interest.

Records showed and we saw received training which the provider considered necessary to care for people effectively. This was up to date and included how to assist people to move safely, care of people living with dementia and how to care for people at the end of their life. All staff we spoke with said they enjoyed training and that it helped them to understand people's needs better and offer more effective care. Some staff had training in end of life care and dementia and they were able to tell us the difference it made in assisting them to care for people.

People's nutrition was supported. People who were at risk of poor nutrition had their daily input of food and fluid monitored. People who had difficulty swallowing were offered a soft diet or pureed food. The service referred people with swallowing difficulties for an assessment to the appropriate health care professionals and then followed their advice and guidance. However people were not always encouraged to eat. This was

particularly true at breakfast. We saw people were served food and left to eat alone. One person was on their own and was facing the wall we saw they were not eating. Staff did not interact with them or encourage them to eat their breakfast. We saw two other people have their food taken away after a time and they had not eaten it. Staff did not make enquiries as to whether it was to their taste and they were not offered an alternative. Another person was heard say, "I asked for a cup of tea 20 minutes ago and I'm still waiting." A member of staff eventually brought a cup of tea to them.

People had their physical and mental health supported. Referrals were made to appropriate health care professions such as GP's and nurses, chiropodist, dietician and dentist. We saw that appointments were made and kept in a timely manner.

A visiting professional said they were happy with the care of people. They said staff do their best and staff were good at keeping them informed on how people were progressing. They also said they were lots of staff around and that communication between them and the service was good or very good. They also said pain control was well managed and the staff worked well to ensure people had optimum pain relief and commented on the progress of one person.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always promoted. For example we saw two occasions where people were assisted to move using a hoist. On both occasions their dignity was not promoted as they were wearing very short clothing and their underwear was exposed. Staff were unaware of this and the manoeuvre was carried out without maintaining people's dignity.

Lunch was not made an enjoyable experience in the larger dining room and seemed to be a haphazard event. People at the same table were served their meal at significantly different times. This resulted in some people helping themselves to the food off others plates. People were not offered the opportunity to wash their hands prior to eating. They had protective clothing put on them without their consent.

However, the people who used the smaller dining room had a very different experience as their tables were set with freshly laundered table cloths and cutlery. Service was done by table and this enabled people to eat together and enjoy their lunch.

People's dignity was not always promoted through appropriate clothing. Some people wore clothes that were very short and creased and looked unclean other people did not have footwear. This detracted from their dignity.

Some staff spoke about people in a disrespectful manner. Staff in dining room were, overheard using language that was lacking in care. We heard people been referred to as 'needing feeding' others as 'wandering' and another staff member said staff to 'push fluids.'

Confidentiality was compromised as the staff handovers were carried out in the dining room and could be overheard. Other staff were heard discussing who had been to the 'loo' and who 'needed to go'.

Staff did not always acknowledge people or speak to them when attempts had been clearly made to attract staffs' attention. Some staff passed through the sitting room without acknowledging the people there or saying hello. Other staff were seen to be very caring and made sure they spoke to people and smiled and made eye contact with them. We saw that this made a difference to people who we saw smiled after the staff contact.

We saw that during morning 'coffee/tea' people were not offered a snack of their choice. Staff put a biscuit on their saucer and did not check if it was the one they wanted.

People's independence was not always promoted. For example one staff member asked a person if they wanted to go to the toilet and other staff member answered that 'they had just been.' The person was not given a further opportunity to answer.

However we saw most staff showed kindness and caring when they were in direct conversation with people. They showed signs of good communication skills. For example, they gave people enough time to consider

the questions put to them and to answer.

Staff had arranged a party for one person and their family to celebrate a personal occasion. We were told this had gone very well and a good time was had by all.

Requires Improvement

Is the service responsive?

Our findings

All people had their care need documented in a care plan. The service was part way in the process of converting from a paper records system to an online system. This meant the information contained in care plans was difficult to identify and locate. Once located information was presented in a 'tick box' manner where boxes were not ticked if people did not have a given condition. For example if a person lived with dementia, this box was ticked in a long list of other conditions. This was confusing and time consuming for staff. A senior manager told us the system was on trial and staff had been invited to and were welcome to comment on the format. Staff were unaware of this and were frustrated with the care plans. Most care staff had not read the care plans and relied on hand over notes and information sheets for their information on people.

There were some person centred elements in the care planning. For example, detail on how people wanted to be cared for rather than the tasks to be carried out. Where the tick boxes were used needs and wishes were not explored, nor was how the care should be delivered. Some of the language used was not always dignified or appropriate. For example we saw written about a person, 'Is just transported from bed to lounge and back' and 'sometimes feel worried/nervous at night' and 'known to be physically aggressive during care intervals.' These were staffs' opinions and offered no professional explanation or advice on how to respond to people's individual needs and wishes.

Most care plans we reviewed did not have people or their relative's signatures to show they had taken part in the drawing of their plan of care. One relative said they were not involved in care planning and had not been offered the opportunity to review their relative's care plan. However two other people told us they were involved in care planning but some were unable to tell us if they had read their care plans or knew what they contained. Two people were able to tell us how they were involved in their care planning. For example one person said, "My pain can be difficult, staff assist me to live as pain free as possible. Staff know what to do."

There were elements of the care planning that gave good information to staff. This included direction on swallowing difficulties and we saw this was reviewed by health care professionals on a regular basis.

Staff told us they kept up to date with people's changing needs and preferences through handovers which took place at the beginning of each shift. Records we saw supported this. This meant that staff were made aware of any changes in people and were able to respond appropriately.

All people had a shortened care plan with necessary basic details. This included special needs, allergies, blood sugar levels, blood pressure, first language and next of kin details. This was a hard copy and was readily available to staff, this coupled with hand over notes was given to agency nurses on duty to ensure people needs were recognised and met.

Although not always documented, staff were aware of people's interests and hobbies. Staff knew what was significant to people in assisting them to live well. There were specialised activity staff who ensured people were supported to pursue their hobbies and interests. For example staff and people like to watch the Grand

National, Remembrance services and other items of interest people chose. Some people were also supported with quieter activities such as reading. However we noted most people appeared bored and they were left un-stimulated for long periods.

Families and friends were welcomed to the home at all times. This approach to care helped to ensure people had the opportunity to continue relationships that were important to them.

There was a complaints process in place. The provider was proactive in receiving feedback and open to listening and making changes, before they became a problem. Details on how to make a complaint were freely available. At the time of the inspection there were no outstanding complaints. People we spoke with said they knew how to complain. Most people said they would speak to [deputy manager.]

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who told us that regular checks were carried out of the quality and safety of people's care. Systems and process were in place to identify these. However the service lacked clear concise management to enforce these. The registered manager was unable to give us some basic information on how the service was run and their responsibilities for keeping people safe. For example on the first day of our inspection areas of the service were visibly dirty. The registered manager was unable to agree this and referred us to an inspection report carried out in January 2016 as evidence the service was hygienically clean. It wasn't until a senior manager intervened and gave us an assurance that are concerns would be dealt with as a matter of urgency were assured this would happen. Our second visit showed the service had been cleaned to an acceptable level.

The quality assurance checks in place were not fit for purpose as it did not identify the issues raised during this inspection. For example the registered manager had not ensured the safety of people by putting systems in place to ensure staff who administer medication were not subjected to interruptions. The present method meant staff were interrupted, causing delays in giving people their medicines. This had not been highlighted as a concern and therefore not addressed as a concern by the registered manager.

The registered manager did not ensure care was delivered in an inclusive and person centred manner. People and care staff were not involved in the drawing up of care plans and this resulted in staff administered care that was task focused rather than person centred.

The registered manager did not ensure people's dignity was always promoted as we saw staff spoke over people and did not always listen to them. This had not been identified and addressed as an issue. There were enough staff on duty however, they were not effectively deployed and there were periods when people were left unattended. For example this lack of direction to staff meant that staff struggled to assist people in a timely manner. We heard senior staff organise staffs' breaks on the spot. Allowing half the staff to take a break without checking if there was enough staff to attend to people

The registered manager had not recognise the risk caused by not ensuring people had their own personalised sling to ensure their safety while being assisted to move using a hoist.

The care planning system in use was not easy to follow and to extract information from. It contained some good information however, most of the information was difficult to access. Some staff told us about areas of this they found difficult. The assistant manager told us this was the system they had to use. The area manager was clear the system was on trial and could be adjusted to meet the individual requirements of each service. Staff had not been told this and therefore had not fed back to the provider with the information they needed to individualise the system. Had this been done the system would have been easier to access and easier to extract the information needed to care for people. For example the staff had to eliminate the conditions people did not have rather than one they had. This was time consuming and confusing.

Areas of the environment were in need of repair and on the first day of the inspection the manger was unable to give us a timetable to address these issues. On the second day a senior manager was provided us with these details.

Staff were patchy in explaining how they were supported to do their work. There was a supervisions system in place and staff received regular supervision. However, senior staff were not offered definitive time when they were off duty. They were often called on their off duty time and therefore did not have time to fully relax away from the pressures of work this included staff calling them for support and guidance.

Most people and their relatives knew who the registered manager was. However, all the people we spoke with said they would approach the deputy manager if they had a problem as 'she was always there'.

The deputy manager told us they monitored incidents and accidents to identify any themes or patterns which may indicate a change in people's needs, circumstances or medical condition. They said this helped reduce the potential risk of such accidents or incidents happening again and we saw documentary evidence to support this.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications to us, regarding any significant events or incidents, in a timely manner, as they are legally required to do.