Midland Health Care 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?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 18 February 2015 and was unannounced.

Woodlands Care and Nursing Home provides nursing and personal care for up to 50 older adults, including some people living with dementia. At our visit, 45 people were living in the home and 23 of them were receiving nursing care. There is 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 of this service in February 2014, we found that the provider did not have appropriate arrangements for cleanliness and hygiene. This was a

Summary of findings

breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider told us about the action they were taking to address this and at this inspection we found that not all of the required improvement had been made.

At this inspection, the provider's arrangements for the prevention and control of infection and the cleanliness and hygiene of the premises, did not fully protect people from the risks of cross contamination. This was because not all areas of the home were being kept clean and hygienic. Staff, were not provided with all of the information they needed and recognised guidance was not being followed for the prevention and control of infection at the service.

Staff had received training about and they were aware of the key principles of the Mental Capacity Act 2005 (MCA). However, staff did not always follow the principles of the MCA when required. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this. Some improvements were being made by the provider to address this. We have made a recommendation about further training for staff on The Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards based on current best practice.

People felt safe in the home and both they and their relatives and staff were confident and knew how to raise any concerns they may have about people's care. The provider's arrangements helped to protect people from the risk of harm and abuse. People received safe care and treatment and their medicines were safely managed.

Overall, people were supported to maintain and improve their health and staff understood people's health needs. People and their relatives were generally satisfied with the care and food provided and people's health needs were being met. This was done in consultation with external health professionals and their instructions were followed for people's care when required. However, a few people's treatment records did not always fully account for, or meet with recognised guidance associated with their wound care needs. This increased the risk of people receiving ineffective care and treatment.

Staff recruitment arrangements were robust and overall staff training, supervision and deployment arrangements were sufficient to meet people's needs.

Staff understood the provider's aims and values for people's care, which focused on promoting people's rights, but they did not always put them into practice. Improvements were being made to promote people's dignity when they received their care.

Staff supported people's known daily living preferences, choices and routines and often took time to engage socially with people. Staff supported people at their own pace when they provided care, which helped to promote their independence. People and their relatives were confident and knew how to raise any concern or complaints they may have about the care provided. They were also appropriately informed and involved in agreeing people's care before their admission to the home. This helped to make sure that people received personalised care that met with their needs, wishes and lifestyle preferences. However, some people felt they had not been fully involved in their care plans since their admission to the home and they were not provided with any information about relevant advocacy services that may assist them to do this.

The provider's checks of the quality and safety of people's care and their environment were not always effective. They did not always identify whether their arrangements were sufficient to protect people from the risks of receiving unsafe, ineffective care or inappropriate care and treatment. The provider had not always sent us written notifications about important events that happen in the service when required, until we asked them to.

People, relatives and staff were generally positive about the management of the home. However, the provider's arrangements for seeking people's views about the service were not consistently or proactively communicated or used to develop the service. Staff understood their roles and responsibilities for people's care and received the information and support they needed to report any changes or concerns about people's safety or health needs.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which

Summary of findings

corresponds to 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.

Summary of findings

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.

Arrangements for the prevention and control of infection and cleanliness and hygiene did not fully protect people from unsafe care.

Staffing and emergency arrangements were sufficient and staff recruitment procedures were robust. People felt safe in the home and they were protected from the risk of harm and abuse. People's medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

The Mental Capacity Act 2005 was not always followed. People were not always protected against the risk of care being provided without the consent or appropriate authorisation of a relevant person. Care plan records did not always fully account for, or meet with recognised guidance concerned with wound care needs. This increased the risk of people receiving ineffective care and treatment.

Staff received the training they needed to provide care effectively and people's health and nutritional needs were being met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were mostly but not always treated with respect by staff, who often but not always, maintained their dignity and privacy. Improvements were being made to promote people's dignity in their care.

People and their relatives were informed and involved in agreeing people's care before their admission to the home. Some had not been fully involved in their care plans since and were not provided with information about advocacy services that may assist them to do this.

Is the service responsive?

Good

The service was responsive.

Staff, were generally helpful and they promoted people's independence and preferred daily living routines and lifestyle preferences. People and their relatives knew how to raise concerns or make a complaint and they were confident to do so.

Summary of findings

Is the service well-led?

Arrangements to check the quality and safety of people's care did not always protected them from the risk of receiving unsafe, ineffective in inappropriate care and treatment. The provider had not always told us about important events that happened in the service when required.

People, their relatives and staff were generally positive about the management of the home and staff understood their roles and responsibilities for people's care. Arrangements for seeking people's views to improve the service were not effectively used.

Requires Improvement

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 regulator 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.

We visited the home on 18 February 2015. Our visit was unannounced and the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before this inspection, we looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law. We also spoke with local health and care commissioners responsible for contracting and monitoring people's care at the home.

During our inspection we spoke with 10 people who lived at the home and three relatives. We also spoke with five nursing and care staff, one catering assistant and the registered manager. We observed how staff provided people's care and support in communal areas and we looked at eight people's care records and other records relating to how the home was managed. This included staff training and recruitment records, medicines records, meeting minutes and checks of quality and safety.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2014, not all areas of the premises were kept clean or hygienic. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider told us about the action they were taking to address this.

During this inspection we found that sufficient improvements had not been made. The provider's arrangements for the prevention and control of infections, including the cleanliness and hygiene of the premises, did not fully protect people from the risk of unsafe care.

Some people we spoke with felt that parts of the home were not kept as clean as they should be. Particularly bathrooms and toilets. We observed that not all parts of the home and some of the equipment used for people's care were not always clean or hygienic. Communal toilets, bathrooms and sluice rooms were dirty, with old dust and debris accumulated around the floor edgings. Some equipment, such as hoists and toilet grab rails were rusting and encrusted with black dirt or had flaking coatings. Shelves in sluice areas that were used for cleaning and storing equipment, such as commode pots, did not provide smooth sealed surfaces. The shelves were damaged with edging strips that exposed porous surfaces. The surfaces were a potential harbour for germs as they could not be effectively cleaned. This increased the risk of cross contamination from the equipment being stored there that was used for people's care.

Recognised guidance concerned with the prevention and control of infection was not always being followed for the safe storage of waste and dirty laundry and also for clean continence products and personal protective equipment. Clean and unused products and equipment were stored in dirty areas such as toilets and sluices. Clinical and household waste storage bins did not provide a non-touch system for staff to operate them. Soiled and set linen was stored openly alongside clean linen on a clean linen trolley in use. We observed that one care staff carried a bundle of wet, soiled clothing in their arms from the first floor to the ground floor laundry. The staff member had not used the appropriate containers provided, that needed to be used for transporting dirty or soiled laundry. They were also not wearing any protective clothing that was available for their use when handling dirty or soiled items, such as disposable gloves or apron. These practices increased the risk of cross contamination.

Staff, were not provided with all of the recognised guidance they needed to follow to maintain cleanliness and for the prevention and control of infection at the service. Cleaning schedules did not provide staff with the information they needed. This included information about the areas and equipment to be cleaned, how often and the products to use. Staff that we spoke with did not show a consistent understanding of recognised measures and practice for the prevention and control of infection and their responsibilities for this.

The registered manager was not aware of recognised national guidance concerned with the prevention and control of infection and cleanliness in health and adult social care services, known as 'The Code of Practice.' The Code helps registered providers to understand what they need to do to comply with the requirement for cleanliness and infection control.

We found that the premises and equipment were not always clean and hygienic and the provider's arrangements for the prevention and control of infection did not fully protect people from the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People medicines were safely managed. People said they received their medicines when they needed them. Records kept of medicines received into the home and given to people showed that people received their medicines in a safe and consistent way. We observe a nursing giving people their medicines. At one point the nurse left the medicines trolley open and unattended in a communal area. This was unsafe practice because it increased the risk of medicines theft or misuse. However, the registered manager, who was passing through the area, took immediate and appropriate action to secure the trolley and spoke discreetly with the nurse responsible about this. At all other times we saw that nurses gave people their medicines safely and in a way that met with recognised practice. All staff responsible for people's medicines had received medicines training, which included an assessment of their individual competency.

Requires Improvement

Is the service safe?

People told us they felt safe in the home and their relatives also felt that people were safe there. All were confident to raise any concerns they may have about people's care or safety and knew how to do so. One person said, "I feel very safe here."

Staff knew how to recognise and report abuse and told us they were provided with guidance and training, which the provider's training records showed. Since our last inspection, the registered manager had notified us of any alleged or suspected abuse of a person suing the service and the action they were taking to protect people when required. This helped to protect people from the risk of harm and abuse.

Overall, staff, people using the service and their relatives felt that staffing levels were sufficient for people's care needs to be met. Managers regularly checked staffing levels and absences and staffing levels were determined against people's dependency, care and support needs. The registered manager and staff described robust arrangements for staff recruitment and deployment, which related records showed. This helped to make sure, as we observed at our visit, that staffing levels were sufficient to meet people's care needs.

People's care records showed that potential or known risks to their safety were identified before they received care. People's care plans showed how those risks were being managed and they were regularly reviewed. For example, risks form falls, pressure sores, poor nutrition and risks relating to people's mobility needs. Staff understood the risks identified to people's individual safety and the care actions required for their mitigation. This helped to make sure that people received safe care and treatment.

Arrangements were in place for staff to follow in the event of a foreseen emergency, such as a fire alarm. Emergency evacuation plans were in place for each person receiving care, which were accessible for staff to follow when needed. The most recent report from the local fire authority from their follow up visit in June 2014 showed that satisfactory arrangements had been achieved for fire safety. Appointed care staff, were trained as first aiders and regularly deployed to provide initial emergency support to people and staff in the home, in the event of any health emergency. First aid equipment was accessible and regularly checked to make sure it was fit for purpose.

Requires Improvement

Is the service effective?

Our findings

Before this inspection, the local authorities responsible for commissioning and safeguarding people's care in the home, told us about their investigation findings into concerns that some people's health care needs were not being met at the service. They found that people's health care needs were mostly being met. However, they found record keeping omissions in relation to people's health care needs and their capacity to consent to their care and treatment, which increased the risk of people receiving unsafe or ineffective care.

We found that staff had received training about and were aware of, the key principles of the Mental Capacity Act 2005 (MCA). However, people were not always protected against the risks of care being provided without their consent, or without following appropriate legislation when people were unable to give their consent. This was because staff did not always follow the principles of the MCA when required. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this.

Some people were not always able to consent to their care because of the health conditions, such as dementia. Three of those people's care plans had not mental capacity assessments or best interest discussions recorded. They did not show whether decisions about people's care and support were being made in their best interests. The registered manager provided us with their action plan to address this, which they had agreed with local care commissioners.

Staff told us about one person who freedom was being restricted in a way that was necessary to keep them safe, known as a Deprivation of Liberty Safeguard (DoLS). The person's care records showed that the local authority responsible for authorising DoLS had instructed the registered manager to submit a standard authorisation application for this restriction. A standard authorisation form had been partially completed but not submitted since the instruction given more than 28 days previously. This had placed the person at risk of receiving care by unlawful restrictions because a DoLS authorisation had not been sought in a timely manner. The registered manager was not able to explain why this had not been sent. However, following our inspection, they confirmed that this had since been submitted.

Two people's records showed that advanced decisions had been made in their best interests for their treatment, for them not to be resuscitated in the event of their sudden collapse. The records did not show the rationale for not consulting with them, or a valid reason for the decision. An external health professional concerned with people's care and treatment was responsible for their completion. However, the provider had not recognised their responsibilities to ensure that MCA processes were followed to protect people from the risks of inappropriate care and treatment. **We recommend the service finds out more about training for staff in The Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards based on current best practice.**

People we spoke with and people's relatives were happy with the care provided. All felt that people's health needs were being met. One person told us, "They know my condition and make sure that I see my doctor when I need to." Another person's relative was particularly pleased that the person's health had improved since their admission to the home.

Overall, people were supported to maintain and improve their health and staff understood people's health needs. This included the arrangements for people's on-going routine health screening such as chiropody and optical care. Staff consulted with external health professionals when needed and followed their instructions for people's care and treatment when required. For example, their nutritional needs. A few people required wound care because of their health conditions. The nurse advised that people's wound dressings were being changed when required and that people's wounds were either improving or not worsening. However, people's care plan records did not always show that staff had followed the instructions to change their wound dressings at the required intervals. Related wound assessment records did not fully meet with recognised guidance for wound car practice. They did not provide a clear or regular description and measure of each person's wound, to accurately determine whether the wound was healing or worsening. This increased the risk of people receiving ineffective care and treatment.

Requires Improvement

Is the service effective?

During our visit, we observed that the nurse supported people to speak with their GP who regularly visited the home. The nurse liaised with the GP and informed them about people's health conditions, including any changes, when people were not able to do this independently. Medical decisions that were made by the GP about people's care and treatment were recorded in their care plans following the visit.

Staff told us they received the training and supervision they needed to provide people's care. Records reflected this and showed that staff received regular training updates when required. This included advanced clinical skills training for the registered nurses employed. The registered manager told us that the home had recently been selected as a pilot site, via regional commissioning arrangements, for their staff to access competency based training relevant to people's health care needs, through the NHS.

People and their relatives told us that sufficient nutritious meals were provided and all were positive about their quality and choice. One person said, "The food is very good, they always offer me a choice of something else, if I don't like anything. Another person said, "The food is gorgeous."

Lunchtime was a relaxed and calm atmosphere. Tables were appropriately set and people received a nutritious diet. Staff knew people's food preferences and served different combinations of food to people to suit these. Food menus were displayed, which provided a choice at each meal, including at least one hot alternative. People were offered a choice of snacks and drinks at regular intervals.

Many people had difficulties eating and drinking because of their health conditions. This included some people who had swallowing difficulties, which meant they may be at risk of choking. We observed that staff gave people the support they needed to eat and drink. They served different types and consistencies of foods to people, that met with their dietary requirements and related instructions from relevant health professionals.

Requires Improvement

Is the service caring?

Our findings

During our inspection we observed that staff, were often, but now always, supportive, kind and caring. We also saw that people were mostly, but not always treated with respect and that staff often, but not always maintained people's dignity and privacy.

We sought either staff or the registered manager's assistance for three people during our inspection. This was because staff close by did not act when those people, who were not able to assert their needs verbally, needed their assistance. This resulted in their dignity or wellbeing compromised. For example, one person's care plan showed the type of non-verbal communication they used if they were in pain or distress. However, when they demonstrated this, staff close by did not show any compassion or concern for the person's wellbeing.

People and their relatives told us that staff, were often supportive, kind and caring. Most people and their relatives said that staff treated people with respect and promoted their rights to privacy and dignity. People were generally appreciative of the care they received and most felt that staff, were pre-emptive and mindful of their needs. We received many positive comments from people. This included, "Staff are respectful and thoughtful;" and "Staff are kind and caring and know what they are doing." However, we were told about a few occasions when people felt that staff had either not always been respectful towards them or they had not ensured their dignity and privacy.

At all other times we saw that staff supported people in a caring and timely manner when they needed assistance. For example, with their meals and drinks. Some people needed special equipment and staff support to help them with their mobility. We saw that staff needed to help one person to move in this way, by using a hoist. Staff understood this could sometimes be a distressing experience for the person, as they often struggled to understand what was happening to because of their dementia. Staff, were gentle and took time with the person, who became visibly more comfortable and relaxed, while staff completed the manoeuvre. Staff showed concern for the person's wellbeing and supported them in a caring and meaningful way.

Staff acted promptly and appropriately, when a person was in discomfort. The staff member understood the person's non-verbal communication, which they used because they were not able to verbalise their needs. The staff member showed concern and empathy towards the person and assisted them in the way they preferred. Care staff supported another person by accompanying them to attend their hospital outpatient appointment. The staff member explained that the person's mental health condition meant they did not always understand what was happening to them. They also confirmed that it was important to support the person in this way, as they easily became anxious in unfamiliar surroundings.

Most staff knew people well and they understood and supported their known daily living preferences, routines and choices, which were also recorded in people's care plans. We observed that staff took usually took time to socially engage with people. Staff also supported people at their own pace when the provided care. For example, helping people to mobilise or to take their medicines. This helped to promote people's independence, as staff encouraged them to do as much as they were able and wished to do for themselves.

People and their relatives said they were appropriately informed and involved in agreeing people's needs before they received care. However, six out of ten people that we spoke with felt that since then, they had not been fully involved in their care plans. People were also not provided with information about any relevant advocacy services that may assist them to do this.

Staff, were aware of the provider's aims and values for people's care, which focused on promoting people's rights. For example, their rights to dignity and choice in their care. However, we observed occasions when this was not always being put into practice. The registered manager told us that work had commenced to promote people's dignity when they received care, in response to the government's national challenge for this. Information about this, known as 'The Dignity Challenge,' was visibly displayed. Two care staff had been appointed to take the lead in promoting this via a local authority award initiative.

Good

Is the service responsive?

Our findings

Many people and their relatives made specific comments about the general helpfulness of staff. All said that staff promoted people's independence and choice when they provided care. Two people also told us about how their care was tailored to their individual disability needs and preferred daily living routines and preferences, which they felt staff understood well. One person told us, "They (staff) listen and follow my wishes; I like my own space and quiet time and they know that's important to me." Another person said, "Staff know I like my independence; they support me to do as much as I can for myself and to get out with family and friends, as I often do." Both told us that staff supported them to use their own specialist mobility equipment, which helped them to maintain their independence.

Staff we spoke with felt it was important to take time to get to know people, to understand their personal and lifestyle histories and interests and their preferred daily living routines. Information about this was sought from people and their relatives before people received care and recorded in their written care plans.

Three people told us that regular community meetings were held to discuss and agree general daily living arrangements. This included planning meals and menus, and choosing environmental décor, agreeing arrangements for spiritual worship and social, occupational and recreational pursuits and also seasonal celebrations. Information was also visibly displayed on a communal notice board, which showed that a wide range of opportunities were provided for people to engage in this way. This helped to make sure that people received personalised are that met with their needs, wishes and lifestyle preferences.

Staff told us about one person who was not able to communicate verbally because of their health condition. We observed that staff understood the person's hand gestures and eye movements, which they used to communicate their needs and wishes and responded promptly when they needed assistance.

People and their relatives knew who to speak with if they were unhappy or had any concerns about people's care. They were also confident to do so and felt that these would be listened to. Most said they had not had any cause to make a complaint or voice any concerns. One person told us about an occasion when they had raised a concern, which they felt was dealt with promptly and to their satisfaction.

An appropriate complaints procedure was openly displayed in the home, which could be made available in other formats to suit people's needs. Records showed that four complaints were received about the service during the previous 12 months. However, for three of the complaints, records did not show what action had been taken as a result or any improvements that may have been needed from this. The registered manager did not have this information to hand. However, they assured us that all of the complaints were investigated and resolved to people's satisfaction.

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. This included checks of people's health status and clinical needs, checks of medicines arrangements and checks of the environment and equipment. They also included checks of staffing arrangements and nursing staffs' professional registration status. However, we found that the provider's checks of the quality and safety of people's care were not always effective. They did not identify whether their arrangements were sufficient to protect people from the risks of receiving unsafe, ineffective or inappropriate care and treatment. This included their arrangements for cleanliness and infection prevention and control, obtaining appropriate consent or authorisation for people's care, observing care practices within the home and recording complaints.

The provider had not always sent us written notifications about important events that happened in the service when required, until we asked them to. Before our visit, we received information about a police incident in the home, which the registered manager had not told us about. We subsequently discussed this with the registered manager and following this, they submitted the required written notification. This showed they had taken appropriate action to deal with the incident.

People and their relatives were generally positive about the management of the home. They knew and understood the roles of staff that led and provided there are and a displayed staff photograph board helped them with this. People and their relatives told us that the registered manager and provider were accessible and approachable.

The registered manager told us that a survey type questionnaire was used to seek the view of people and their relatives about the service. Analysis of any completed questionnaires was not available to show when and how people's views had been sought or used to develop the service. The registered manager was not able to provide this information. They told us that the survey questionnaire was available in the office for people and their relatives to complete if they wished to. However, most people and their relatives that we spoke with were not aware of this and said they had not been invited to complete them at any time. This showed the provider was not always proactive in communicating with and seeking people's views to improve the service.

Staff understood their roles and responsibilities for people's care and senior management and nursing staff were visible and available to them. Staff received regular supervision and support through regular meetings that the registered manager or senior staff held with them.

Communication and reporting procedures were in place to help staff raise concerns or communicate any changes in people's needs. For example, procedures to be followed when accidents occurred or when there were any changes in people's health conditions or safety needs. The provider's procedures also included a whistle blowing procedures. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their responsibilities and rights to raise concerns about people's care if they needed to.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment.** **The registered person's arrangements for the prevention and control of infection in the home did not fully protect people from the associated risks of unsafe care. Regulation 12(1) (h).**