Regal Care Trading Ltd

Woodlands Nursing Home

Inspection report

38 Smitham Bottom Lane
Purley
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Tel: 02086459339

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Woodlands Nursing Home on 27 June 2016. The inspection was unannounced. Woodlands Nursing Home is registered to provide nursing and personal care for a maximum of 18 adults. At the time of our visit there were 16 people living in the home.

At our last inspection in September 2015, we found the provider was meeting all the requirements and regulations we inspected.

The service had a manager who had submitted an application to be registered with the Care Quality Commission (CQC) to become the registered manager of the service. Like registered providers, registered managers 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. The manager's application is in the process of being considered.

On entering the home there was an unpleasant odour. The home was in need of maintenance and re-decorating. We found that there were poor standards of hygiene and parts of the home were not clean. This meant that people were not protected from the risk and spread of infection.

People felt safe. Staff had a good understanding of how to protect people from abuse. Care was planned and delivered to ensure people were protected against identified risks.

People received their medicines in accordance with their care plan but the arrangements in place to ensure people's medicines were stored safely were not always followed by staff. We have made a recommendation that the service consider current guidance on storing and managing medicines in care homes and take action to update their practice accordingly.

The provider did not adequately support staff to deliver care effectively through an annual appraisal. Staff had received training in the mandatory areas required for their role such as, safeguarding people from abuse, moving and handling people and infection control.

The manager and staff did not have a good understanding of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. Care was not always delivered in accordance with people's care plans. This meant the care people received was not always as effective as it could be.

People were as involved in their care planning as they were able. Where appropriate, their relatives were also involved. Care plans provided information to staff about how to meet people's individual needs.

People were satisfied with the quality of their meals and told us they had a sufficient amount to eat and drink.

Staff were recruited using an effective procedure which was consistently applied. People told us the staff were kind and caring. People were treated with respect and their dignity was maintained. People were supported to express their views and give feedback on the care they received.

There were systems in place to assess and monitor the quality of care people received. However, these systems were not always effective. Where these systems identified areas for improvement, action was not always taken.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to there being a lack of effective systems to prevent the risk and spread of infection, the lack of staff appraisal and the failure to follow the requirements of the Mental Capacity Act 2005 and associated code of practice. We also found breaches in relation to how staff supported people to maintain good health and the lack of effective systems to assess and monitor the quality of care people received.

You can see what action we told the provider to take at the back of the full version of the 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

Some aspects of the service were not safe.

People were not protected from the risk and spread of infection.

Staff were recruited using an appropriate recruitment process which was consistently applied.

People were protected from abuse.

Is the service effective?

Inadequate

Some aspects of the service were not effective.

Staff received supervision and training but not an annual appraisal. People's rights were not always protected because staff were not following the principles of the Mental Capacity Act 2005.

People were not appropriately supported to maintain good health. People received a healthy, balanced diet.

Is the service caring?

Good

The service was caring.

Staff were caring and treated people with kindness and respect. People received care in a way that maintained their privacy and dignity.

People felt able to express their views and were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People felt in control of the care they received and were satisfied with the quality of care.

People and their relatives felt able to make suggestions and comments about the quality of care and their comments were taken into account.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led

There were systems in place to regularly monitor and assess the quality of care people received but these were not always effective. Where areas for improvement were identified these were not always remedied.

People using the service, their relatives and staff felt able to approach the manager with comments and concerns.

There was a clear management structure in place which people living in the home, their relatives and staff understood.

Woodlands 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.

This inspection took place on 27 June 2016 and was unannounced. The inspection was carried out by an inspector 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 care service. The expert-by-experience's area of expertise was dementia care.

Before the inspection we looked at all the information we held about the service. This included routine notifications received from the provider, information about the provider and the last inspection report.

We spoke with seven people living in the home, two relatives, three staff and the manager. We also spoke with a member of the commissioning team from a local authority that commissions the service.

We looked at five people's care files and four staff files which included their recruitment records. We reviewed a variety of other records relating to staff and maintenance of the home. We looked at the service's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

The provider did not have appropriate arrangements in place to minimise the risk and spread of infection. People told us, "It's not as clean as it should be", "I don't think anyone comes to clean" and "It's quite clean". A relative commented, "The cleanliness of the home could be improved."

There was a strong, unpleasant odour when we entered the home and this was also present in some people's rooms. The carpets in the hallway and communal lounge were dirty with multiple stains. There were food and liquid stains on the walls in the communal lounge and liquid stains on the chairs in the communal lounge. Staff had attached a plastic supermarket bag on to the side of the medicine trolley and this was overflowing with empty medicine packaging. We saw used incontinence pads on the cistern of a communal toilet.

People's rooms were not clean and tidy. In one person's room there were two dustbins which were both full and the rubbish had overflowed on to the floor. There was a pile of empty boxes in the corner of this person's room. In another person's room we saw food underneath the bed and rubbish on the floor behind a chest of drawers.

The manager told us that the provider was in the process of employing a cleaner and that in the meantime care staff were meant to ensure the home was cleaned daily. A review of the cleaning rota showed that the home was last cleaned three days before our inspection and that in total the home had been cleaned three times in the two weeks before our inspection. There was not a system in place to help ensure that equipment used to support people was regularly cleaned.

The lack of appropriate arrangements in place to ensure the home and equipment was clean and hygienic meant that people were not properly protected from the risk and spread of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines at the right time and in the correct dosage. People told us, "So far so good, I have tablets", "Yes, I do get my medication"
and "I get my medication on time". A registered nurse was responsible for giving people their medicines. Staff were required to complete medicine administration record charts. The records we reviewed were fully completed which indicated that people received their medicines as prescribed. However, staff did not consistently follow the provider's procedures in relation to checking that medicines were stored at the correct temperature as we saw gaps in the temperature records.

Records showed that risks to people had been assessed when they first moved in to the home and were regularly assessed thereafter. Risk assessments gave staff information on how to manage the risks identified. People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People told us, "I think I am safe here, "I feel safe" and "I am safe. I have no problem with the staff here". A relative told us, "She has definitely been safe here." The provider had policies and procedures in place to guide staff on how to protect people from abuse

which staff were familiar with. Staff had been trained in safeguarding adults and knew how to recognise abuse and report any concerns.

We saw evidence that appropriate checks were undertaken before staff began to work with people. These included criminal record checks, obtaining proof of their identity and their right to work in the United Kingdom. Professional references were obtained from applicant's previous employers which commented on their character and suitability for the role. This minimised the risk of people being cared for by staff who were unsuitable for the role. There was a sufficient number of staff to help keep people safe.

We recommend that the service consider current guidance on storing and managing medicines in care homes.

Inadequate

Is the service effective?

Our findings

At our last inspection we found that staff were not receiving an annual appraisal. We raised this with the deputy manager at the time who told us they had fallen behind with some of the staff appraisals but senior management were aware of the issue and would be supporting her to carry out the remaining staff appraisals. However, during this inspection we found that staff had still not had an annual appraisal. We asked the manager for records of staff appraisals. The manager told us that staff appraisals had not been conducted. This meant there was not a system in place to ensure staff performance was evaluated and performance objectives set.

The provider did not ensure staff received an appraisal to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received an induction when they began to work at the service during which they were introduced to the main policies and procedures in the home and received basic training. Staff received training in the areas relevant to their work such as safeguarding, moving and handling and infection control, although they were not putting their training in relation to infection control in to practice. Staff told us the provider would support them to obtain further qualifications relevant to their roles. People felt staff had the knowledge and experience to carry out their roles effectively. One person told us, "They treat me with professionalism." Another person commented, "I think they are well trained."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. 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 such as Woodlands Nursing Home are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general or the specific requirements of the DoLS.

Records demonstrated that when a person was found to lack capacity there were no decision specific mental capacity assessments in place. Some people's capacity assessments had not been fully completed but a decision had been made that the person lacked capacity. We looked at a capacity assessment which had been conducted three weeks before out visit. The provider's standard form which staff needed to complete when undertaking a capacity assessment asked whether the person can understand the information relevant to the decision, retain that information and communicate their decision. These were all relevant and necessary questions for staff to ask people when conducting a capacity assessment. None of

these questions had been answered but the form stated, "We have assessed [the person]" and the person was found to lack capacity.

There was either none or very little recorded rationale in place explaining why decisions had been made in people's best interests and little recorded evidence of best interest meetings being held or reviewed. This meant there was a risk of people having a decision made for them when they were capable of making the decision themselves. We saw an example of this during our visit. One person wanted to go outside and sit in the garden but the staff refused to let the person out because they feared the person would go outside of the garden and go for a walk. The person tried to go into the garden several times and on each occasion staff stopped the person and led the person back to their chair in the lounge. The person was said to have the capacity to make this decision and there was not a deprivation of liberty safeguard in place. The person told us, "I can't go out. I haven't been out since I came in here." A staff member told us, "We keep the door locked for their safety."

People's care and treatment was not always provided with their consent. This is a breach under Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff did not consistently carry out the necessary checks and follow people's care plans in order to maintain people's health or stop it from deteriorating. We looked at the turning charts of five people who were at high risk of pressure sores and whose care plans stated they needed to be moved regularly. There were gaps in all five charts which indicated that staff were not moving people as often as they needed to. This was particularly the case at weekends. We looked at one person's turning charts whose care plan stated that they shouldn't be seated for too many hours because they had the early signs of a pressure sore. The chart showed that between 20 and 26 June 2016, there were three days when the person was not moved at all and one day when they were moved once. Another person who already had a pressure sore and whose care plan stated staff needed to move them regularly was moved once on one day and twice on two days between 20 June and 26 June 2016. Another person who had suffered a fall and sustained severe bruising was meant to checked on an hourly basis by staff to minimise the risk of this happening again. The manager could not provide any evidence that these checks were taking place. These people were therefore not receiving appropriate care and treatment which met their needs.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of poor nutrition and dehydration. People's dietary needs were identified when they first moved into the home and this was recorded in their care plans. A cook was employed by the provider and people's meals were freshly prepared. The cook knew what constituted a balanced diet and the menus we looked at were designed to offer healthy, nutritious meals. People were given sufficient amounts to eat and drink and were satisfied with the quality of food available. People commented, "I'm fussy but I don't mind the food", "The food is good" and "The food is fine. Lovely party food."

Good

Is the service caring?

Our findings

People were supported by a caring staff team. People living in the home made positive comments about the staff such as, "I think they do a good job", :"The staff seem okay, friendly and kind", "[Staff] are very polite" and "The nurse is nice". Relatives commented, "[Staff] are so loving" and " "We were confident she was well looked after when we went away".

There was a relaxed, calm atmosphere in the home. Staff spoke to people in a kind and respectful manner and respected people's dignity and privacy. We observed, and people confirmed that staff knocked on the door and asked for permission before entering people's rooms. Staff were able to describe how they ensured people were not unnecessarily exposed while they were supported with their personal care. One person told us, The staff do give me privacy when dealing with me." A relative told us, "The staff do definitely treat the residents with dignity and privacy."

People were supported at a pace that suited them. People told us that when they were in pain or feeling unwell and asked for assistance, staff usually responded quickly and displayed empathy. Staff were patient and assisted people to communicate their needs and understand the care options available to them. People using the service and relatives told us they felt able to express their views and give feedback to staff and the manager.

Care plans gave staff information about people's diverse needs, life histories, dislikes and preferences. Staff knew the people they were caring for well. People were involved in making decisions about their care as far as they were able to be. Where appropriate relatives also contributed to the care planning process. A relative told us, "We were involved with the making up of her care plan when she came."

People's values and diversity were understood and respected by staff. People from other cultures were able to eat the food they preferred. People's religious and spiritual needs were taken into account. The home had links with a local place of worship. Clergy attended the home to conduct religious services.

Good

Is the service responsive?

Our findings

People were satisfied that the care they received met their needs. People commented, "I do get the care I need" and "I think they do a good job. I'm happy here". Relatives told us, "She gets the care she needs." and "The staff are very responsive to their needs".

People who were able to were in control of their care planning. One person told us, "I make my own decisions about how I want things done and they respect that." Relatives who chose to, were in regular contact with home and kept updated on their loved ones health and welfare. A relative told us, "I feel that I know exactly what is going on with [the person] They are very good at keeping me informed"

People were supported by a consistent staff team. Staff knew the content of people's care plans and how they preferred their care to be delivered. Staff worked sufficiently flexibly so that where there was a change in a person's circumstances, they were able to meet their needs without delay. Where specialist treatment was required, referrals were made to external healthcare professionals. People received co-ordinated care when they used or moved between different healthcare services.

People's social needs were taken into account. People were supported to maintain relationships with their friends and relatives. People told us there were no restrictions on the time or how often their friends and family were able to visit. Visitors told us they were made to feel welcome. The provider employed a part-time activities co-ordinator who organised group activities for people living in the home. People told us there were not many activities but they were satisfied with the frequency and variety of activities offered. and told us they enjoyed the organised activities. People's preferences were respected in relation to how they spent their time day-to-day. One person told us, "I like to stay in my room and read and they leave me alone to do that."

The provider sought people's views on how they wanted their care to be delivered. Although no meetings had been held recently, we saw the minutes of residents meetings which had been held in the first three months of 2016. People were given the opportunity to give their views on the quality of food and activities and discuss whether they were happy with the care provided.

People and their relatives knew who to talk to if they wanted to make a complaint and were confident it would be dealt with appropriately. One person told us, "I've never had to make a proper complaint but when I've had anything to say they do take notice."

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were disorganised and not well managed. There were arrangements in place for checking the quality of the care people received. Audits were conducted at manager and provider level in areas such as staff training and supervision, infection control and medication. However, where the audits identified areas which required improvement these were not always made or followed up. For example, there was a system in place to check that staff supervision and appraisal were up to date. The system identified that some staff had not had an appraisal but this remained unchanged month after month.

Provider level audits conducted in March and May 2016 identified that the carpets in the home were not clean and had an odour. No effective action had been taken to remedy this and we found that the carpets were not clean on the day of our visit. The provider had recently moved to an IT based recording system, one of the benefits of which was supposed to be that the manager could easily identify if staff had not provided care in accordance with people's care plans. People's care records, including their medical records were not fully completed and up to date such as those relating to people's mental capacity as described earlier. We found many instances where care was not provided as it should be and where staff were not following the provider's procedures. However, this had not been identified by the manager.

This meant the provider did not establish and operate effective systems or processes to assess, monitor and improve the quality and safety of the service provided. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested a variety of records relating to the people using the service, staff, maintenance and management of the home. People's confidentiality was protected because the records were securely stored and only accessible by staff. The staff files and records relating to maintenance and management of the home were promptly located.

There was a clear staff and management structure at the home which people living in the home and staff understood. Staff knew their roles and responsibilities within the structure and what was expected of them by the management and people living in the home. The manager was newly appointed and was still in the process of becoming familiar with the provider's systems. People and their relatives told us the manager was approachable. Comments we received included, "We love the manager", "She is dead open and approachable" and "She would do her best to sort a problem out". The manager made people aware of plans to develop the service and staff changes during residents meetings. People knew who to speak to if they needed to escalate any concerns.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment people received was not appropriate and did not meet their needs. This is a breach of Regulation 9 (1) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not provide care and treatment to people with their consent. Where people were unable to give their consent because they lacked capacity to do so, the provider did not act in accordance with the Mental Capacity Act 2005. This is a breach of Regulation 11 (1) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not provide care and treatment to people in a safe way by.assessing the risk of, and preventing, detecting and controlling the spread of infections including those that are health care associated This is a breach of Regulation 12 (1) and (2) h.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not establish or operate effective systems or processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity or maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided This is a breach of Regulation 17 (1) and (2) (a) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff employed by the provider did not receive appropriate support through an appraisal as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 (2) a.