Millsted Care Ltd

Woodcroft

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 October 2018 and was unannounced. Woodcroft is a residential care home that provides accommodation and nursing care for up to six people with learning disabilities. At the time of our inspection six people were living and receiving support at the home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection of the service on 10 March 2016 the service was rated Good. At this inspection we found the service remained Good. The service demonstrated they continued to meet the regulations and fundamental standards.

People continued to be supported and protected from the risk of abuse or harm. Risks to people's safety and well-being were assessed and care plans were put into place to manage identified risks whilst ensuring individual's independence and rights were respected. Accidents and incidents were recorded, managed and monitored safely to assist in reducing the risk of reoccurrence. There were systems in place to deal with emergencies and protect people from the risk of infections. Medicines were stored, managed and administered safely. There were sufficient numbers of staff to ensure people were supported appropriately and promptly when required. Appropriate recruitment checks were conducted before staff started work to ensure they were suitable to be employed in a social care environment.

Staff received an induction when they started work and had on-going support, supervision and training. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to meet their nutrition and hydration needs and had access to health and social care professionals when required. People told us they were consulted about their care and staff treated them with kindness and respect. Care plans and assessments considered the support people required with regard to any protected characteristics they had under the Equality Act 2010. People were involved in day to day decisions about their care and treatment.

People indicated that staff were kind and caring and treated them with respect and dignity. People were involved in making decisions about their care. Staff we spoke with were knowledgeable about the contents of people's care plans and care plans contained clear guidance for staff on how best to support people to meet their needs and aims. People were supported to participate in activities that were meaningful to them and that met their need for social interaction and stimulation. The registered manager and staff were committed in ensuring people received appropriate support and care at the end of their lives. The provider

had a complaints policy and procedure in place which contained guidance for people and their relatives or visitors on what they could expect if they made a complaint.

Staff told us that the registered manager provided them with leadership, support and was always available to them day and night offering guidance when they needed it. The registered manager had notified us of important events that had happened at the service and understood the need to display the rating. There were systems in place that ensured the registered manager and provider took account of the views of people living at the home and their relatives where appropriate. The service worked well with external organisations including health and social care professionals to ensure people's needs were safely met and to help improve the quality of the service provided. The provider recognised the importance of regularly monitoring the quality of the service and there were systems in place to ensure audits and checks were conducted.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained safe.	**Good**
Is the service effective? The service remained effective.	**Good**
Is the service caring? The service remained caring.	**Good**
Is the service responsive? The service remained responsive.	**Good**
Is the service well-led? The service remained well-led.	**Good**

Woodcroft

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 12 October 2018 and was unannounced. The inspection was conducted by one inspector. Prior to the inspection we reviewed the information we held about the service. This included details of notifications received from the provider about injuries and safeguarding allegations. A notification is information about important events that the provider is required to send us by law.

The provider had also completed a Provider Information Return (PIR). This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help inform our inspection planning.

Some of the people living at Woodcroft were unable to communicate with us at length so we spent time during the inspection observing their interactions with staff. We met with all six-people living at Woodcroft and spoke with four of them. We also spoke with six members of staff including the providers regional manager, current registered manager, the new home manager who was in the process of registering with the CQC to become the registered manager for the service, the deputy manager and two support workers. We looked at three people's care plans and records, three staff files and records relating to the management of the service such as audits and policies and procedures.

Good

Is the service safe?

Our findings

People told and showed us they felt safe living at Woodcroft and with the staff that supported them. One person said, "Oh yes, I feel very safe. The staff are great." Another commented, "I love it here, everyone is lovely." A third person nodded and gave us a thumbs up sign when we asked them if they felt safe.

People continued to be supported and protected from the risk of abuse or harm. There were up to date safeguarding adults and whistleblowing policies and procedures in place to protect people from possible harm or abuse. The registered manager and staff we spoke with were knowledgeable about how to safeguard people and were aware of their responsibilities including the actions they would take if they had any concerns and how to report any issues of poor practice. One member of staff told us, "We all work together so well here and would know if someone or something wasn't right. We would report any concerns immediately to ensure everyone was safe." Staff training records confirmed that staff received up to date safeguarding training. We looked at the service's safeguarding file which contained local and regional safeguarding policies and procedures and information for staff on how to raise any concerns with an appropriate external body if they needed to. The registered manager told us there had been no safeguarding concerns since their last inspection. Appropriate pictorial and easy to read safeguarding information was displayed within the home for people's reference.

Risks to people's safety and well-being were assessed and care plans were put into place to manage identified risks whilst ensuring people's independence and rights were respected. Risk assessments documented identified risk factors to individuals and staff acted to manage them safely. Care plans included risk assessments covering areas such as travel, mobility, community support, mealtimes, road safety, personal hygiene, use of domestic appliance and managing and responding to epilepsy and choking amongst others. Where risks were identified, there was clear guidance available for staff in supporting people to manage and reduce the reoccurrence of risks. For example, where people were living with epilepsy, we saw risk management plans and guidance in place including information about the types of epilepsy, the frequency and duration of seizures and the action to take in the event of a seizure. Staff we spoke with were aware of the areas in which people were at risk and knew what actions to take to continue to manage them safely.

Accidents and incidents were recorded, managed and monitored safely to assist in reducing the risk of reoccurrence. Staff we spoke with told us they were aware of the provider's procedures for reporting accidents and incidents and we saw this was followed. The provider used an electronic care planning and auditing system which recorded and analysed all reported accidents and incidents. These records demonstrated that staff had identified concerns appropriately, took actions to address concerns and referred to health and social care professionals when required. There was an up to date accident and incident policy in place and notifications were sent to the CQC where appropriate.

The provider had systems in place to deal with emergencies and to protect people from the risk of infections. People had personal emergency evacuation plans in place which contained information for staff and the emergency services on the support they needed to evacuate from the service in the event of an

emergency. Regular checks had been conducted of emergency equipment and the service's fire alarm system to ensure it was fit for use. Staff were aware of the action to take in the event of a medical emergency or fire, and records showed that the service conducted fire drills to enable staff to practice the provider's fire procedures.

We observed the home environment was clean and free from odours. Liquid hand soaps and hand washing technique signage was visible in communal bathrooms to protect people from unnecessary infections and health and safety checks and audits were conducted on a regular basis to ensure this. Staff were provided with personal protective equipment such as gloves and aprons when required to minimise the risk of infection and had received training on health and safety, food hygiene and infection control. There were cleaning schedules in place which ensured the home was kept clean. Environmental and equipment checks were conducted to ensure the home environment was safe.

Medicines were stored, managed and administered safely. There were policies and procedures in place which provided staff with guidance on managing and administering medicines safely. Records showed that staff responsible for medicines administration had received medicines training which included an assessment of their competency to ensure they were safe to do so. Medicines were stored safely in a locked cupboard that only authorised staff had access to and records of medicines stock were completed accurately by staff. Temperature readings of medicines storage facilities were checked and recorded daily to ensure medicines were safe and fit for use. People had individual medicine administration records (MARs). We looked at the MARs for all the people living at the home and saw that these were completed accurately by staff. Medicines audits and checks were in place to ensure medicines continued to be managed and administered safely.

During our inspection we observed there were sufficient numbers of staff to ensure people were supported appropriately and promptly when required. Staffing rotas corresponded with the number of staff available on duty at each shift and there was an on-call member of staff available if required. The registered manager told us, and records confirmed that whilst they always planned to have a baseline of three staff on duty during the day and one staff at night, staffing levels were flexible to take into account any activities or appointments people had. For example, on the day of our inspection an additional member of staff was present supporting one person to attend a social event. There was an on-call manager system in operation providing out of office hours support to working staff if required.

There were safe recruitment practices in place and appropriate recruitment checks were conducted before staff started work to ensure they were suitable to be employed in a social care environment. The registered manager told us that all recruitment records were held at the provider's head office which were later sent to us following the inspection. We saw that criminal records checks were carried out before staff started work, staff pre-employment checks were completed and included application forms, proof of identification, references, right to work in the UK where applicable and history of experience or qualifications.

Good

Is the service effective?

Our findings

People were supported by staff with the right knowledge, skills and experience to provide them with safe and effective care. One person commented, "The staff are good."

Staff received an induction when they started work which included a period of orientation, reviewing people's care plans and records, becoming familiar with the provider's policies and procedures and time spent shadowing more experienced colleagues. Staff we spoke with told us they completed an induction when they started work and were provided with regular, appropriate training that met their needs and the needs of the people they supported. One member of staff commented, "I had a very good induction when I started. I had lots of support from everyone and did training which was good." The registered manager told us that all new staff were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. Staff records we looked at confirmed that staff had completed an induction programme when they started work and had received up to date, appropriate training.

Staff received training in a range of areas including safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, equality and diversity, first aid, end of life, moving and handling, health and safety and fluids and nutrition amongst others. They also received training relating to people's specific health and social care needs, for example, epilepsy, pressure care, diabetes awareness, depression and Makaton sign language amongst others. One member of staff told us, "The training we have is excellent. We are really supported well by the provider and I have completed all NVQ's and a train the trainer course." Throughout our inspection we observed staff supported people competently and demonstrated a good understanding of the areas in which they had been trained, for example, moving and handling and when supporting people with meeting their nutritional needs at meal times. Staff were also supported in their roles through receiving regular supervisions and an annual appraisal of their performance. One staff member told us, "The manager is so supportive. I have supervisions on a regular basis but I can speak freely at any time if I had any issues."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with told us they supported people to make decisions independently whenever possible and demonstrated a good understanding of the MCA and how it applied to their roles when supporting people. Care plans contained mental capacity assessments and best interest decision records relating to significant decisions, where people had been assessed as lacking the capacity to make the decision for themselves. The

registered manager demonstrated a good understanding of the MCA and DoLS and was aware of the process for making applications to seek lawful authorisation to deprive people of their liberty. Records showed that DoLS applications had been submitted to relevant local authorities where required, and where authorisations had been granted, we saw conditions were met by staff.

Assessments of people's needs, treatment and preferences were completed before they moved into the home in order to ensure the service's suitability and that their needs and preferences could be met. Assessments considered people's physical and mental health, social and emotional needs and formed the basis on which care plans were developed. People's care plans contained guidance for staff on the support people required which reflected nationally recognised standards. For example, positive behaviour support focused on strategies aimed at minimising the need for restrictive interventions.

People's individual needs were met by the design and decoration of the premises. We saw with permission, that people were supported to personalise their rooms how they chose with pictures, photographs, decorations and furniture which reflected their interests and hobbies. For example, we saw that one person liked coloured lights and had a disco light placed in their room.

People were supported to maintain a healthy balanced diet. One person said, "I love the food, we get to choose." Staff supported people to meet their nutritional needs and preferences and care plans documented the support individuals required with meal preparation and at meal times to ensure their needs were safely met. Staff told us they met with people on a regular basis and held meetings to discuss and plan menus together. They told us there were seasonal menus in place and these rotated on a six-weekly basis to ensure there were good menu options available. Staff used pictures to support people in decision making and picture menus were also used to support people's daily choice of foods. Care plans documented people's nutritional needs, support required, known allergies and any nutritional risks such as swallowing difficulties and weight loss or gain. Snacks and drinks were available to people throughout the day and we observed staff regularly offered and supported people with these when required.

People were supported to access a range of health and social care services when required in order to maintain good physical and mental health. People had individual health action plans in place which showed they received support from a wide range of health and social care professionals including GPs, community nurses, dentists and opticians. Records demonstrated that staff monitored people's mental and physical health and where any concerns were identified they referred to health and social care professionals as appropriate. Care records documented people's appointments with health and social care professionals and outcomes of meetings were recorded to ensure staff were aware of people's on-going needs. People had hospital passports in place which accompanied them on health care appointments. These provided important information to health care professionals regarding their health conditions, communication needs and any key support requirements they needed to be aware of.

Good

Is the service caring?

Our findings

People were treated with compassion, kindness, dignity and respect and praised the home and the staff that supported them. One person commented, "Its great here." Another person said, "The staff are kind." A third person nodded and gave us the thumbs up sign when we asked them if staff were kind.

Throughout our inspection we observed staff supported people in a kind and caring manner. For example, where people showed signs of anxiety or frustration, staff provided them with support and reassurance in a calming manner. The atmosphere in the home was relaxed and friendly and we noted that people were comfortable in the presence of staff and felt able to turn to them for support when they needed it.

Staff we spoke with knew the people they supported very well. They were aware of their family history and social networks, the activities they enjoyed and their preferred daily routines. We observed that staff had built strong trusting relationships with people and respected their individualities. People's diversity and cultural needs were respected, assessed and documented as part of their plan of care. They included information about people's cultural requirements and spiritual beliefs which we saw staff were aware of. Staff had received training on equality and diversity to ensure people were not discriminated against any protected characteristics they had in line with the Equality Act 2010.

Staff maintained people's privacy and dignity and described ways in which they worked to promote this. One member of staff said, "Our aim is to support people to be as independent as possible and to live well, so it's really important that we respect each other." We observed that staff sought permission before entering people's rooms and addressed people by their preferred names. We saw that people were supported and encouraged to maintain relationships that were important to them and were supported to make decisions about their daily chosen activities. For example, we one person wanted to go out for a walk and another person was supported to go out in the service's adapted car.

People were involved in day to day decisions about their care and treatment. Staff we spoke with told us they empowered people to direct their own care wherever possible by offering them choices; for example, in choosing what they wanted to wear or eat. Staff demonstrated their skills and knowledge, understanding people's communication needs and used tools such as pictures, body language, sign language (Makaton) and facial expressions. One member of staff told us, "I have worked here a long time and know people really well, they are like family. I know if someone is unwell or if they want something. We use set words or Makaton for some people." Care plans detailed individual communication needs clearly for staff and we noted that one person used set words to describe people and objects which staff had recorded to promote effective communication for that person.

Good

Is the service responsive?

Our findings

People received responsive care and support from staff which reflected their individual needs and wishes. People were supported and encouraged to be involved in discussions about their support and the planning and reviewing of their care. One person told us when we asked them about their care plan, "This is me and what I like to do." Another person gave us the thumbs up when we asked if staff involved them in their care.

We saw that care plans were signed by people when possible to show they were involved in their development and reviews and that they agreed with their content. We also saw that for people who were unable to directly contribute to their care plans, relatives or advocates where appropriate, had been involved in this process to act in individual's best interests. Care plans contained information regarding people's physical and mental health, life histories and choices, likes and dislikes and people and things that were important to them and recorded their preferred daily routines. Care plans were developed on the provider's electronic computer system but there were also paper pictorial care plans available to help promote and aid better understanding for people. Care plans were reviewed on a regular basis to ensure they remained up to date and reflective of people's current needs and conditions. This showed that the service complied with the Accessible Information Standard ensuring information met people's communication needs. From April 2016 all NHS care or adult social care services are legally required to meet the requirements of the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively.

Staff we spoke with were knowledgeable about the contents of people's care plans and we saw care plans contained clear guidance for staff on how best to support people to meet their needs and aims. For example, one care plan contained guidelines on how staff were to manage the person's behaviour. This included information on their speech, tone of voice and distraction techniques. Another care plan detailed that the person used echolalia as a way of communicating with staff. This meant that the person often used repetition of another person's spoken words as a way of communicating. Staff were very knowledgeable about the people they supported and were aware to be observant for any signs and changes in people's physical or mental health, and to report any changes in order that care plans and risk assessments could be reviewed and updated accordingly.

Care plans and assessments considered the support people may require with regard to any protected characteristics under the Equality Act 2010 they have. For example, in relation to age, race, religion, disability, sexual orientation and gender. We saw care plans documented guidance for staff on the support people required, for example, to practice their faith, maintain personal and intimate relationships and to meet cultural and dietary needs. One member of staff told us, "There are a couple of people who we support on a regular basis to maintain their personal relationships and to see their partners. Staff are very happy to drive one person quite some distance so they can see their girlfriend whenever possible."

People were supported to participate in activities that were meaningful to them and that met their need for social interaction and stimulation. Activities were provided inside and outside of the home and included

attending local day clubs, evening social clubs, music classes, aromatherapy and trips out to local places of interest and community amenities such as shopping centres, restaurants and theatres.

The registered manager and staff told us they were committed in ensuring people received appropriate support and care at the end of their lives. Care plans included advanced care plans which detailed people's wishes at the end of their lives. For example, one documented that the person wanted a Christian funeral with no flowers but for money to be donated to a charity of their choice. Advanced care plans were developed with people's full involvement where possible, and with support in place from relatives or advocates for people who required assistance. One member of staff told us, "This is people's home and most people chose to remain at home at the end of their life where possible. We work closely with palliative care nurses to ensure people's wishes are respected."

The provider had a complaints policy and procedure in place which contained guidance for people and their relatives or visitors on what they could expect if they made a complaint. We noted the procedure was on display within the service and in a pictorial format to help people to understand it better. The registered manager confirmed that the service had not received any complaints since our last inspection of the service and records we looked at confirmed this.

Good

Is the service well-led?

Our findings

People were positive about the staff that supported them and how the home was managed. One person said, "I love it. It's great." Another person commented, "They [staff] are very good." A third person gave us the thumbs up when we asked if they thought the home was managed well.

There was an experienced registered manager in post who was in the process of deregistering as the manager for the service. However, there was a long-standing member of staff who was in the process of registering with the CQC to become the registered manager for the 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. Both knew the service very well and were aware of their registration requirements with CQC. Both knew the different forms of statutory notifications they were required to send the CQC by law and had completed their CQC Provider Information Return as required. They were also aware of the legal requirement to display their CQC rating and told us they were in the process of updating their website to ensure this. Both demonstrated an in-depth knowledge of people's needs and the needs of the staffing team.

Staff told us that the registered manager provided them with leadership, support and was always available to them day and night offering guidance when they needed it. One member of staff said, "The manager is very supportive, we all support each other to do the best we can for people. I love my job and love working here." Another member of staff commented, "I love working here, it's like home. There is an open culture and we all communicate well. We have lots of meetings to ensure everything is running smoothly for people. The manager is really supportive and so too is the provider." Regular team meetings were held to discuss any service updates and to ensure staff were aware of their responsibilities and roles within the home. We looked at the minutes of the staff meeting held in August 2018 and noted items for discussion included, people's health and well-being, events, end of shift requirements, new staff and the implementation of the provider's new care planning system. Staff also shared information about the day to day running of the service at shift handover meetings which provided them with up to date information on people's conditions, planned appointments and daily service issues.

We observed there was a good supportive working culture within the home and the registered manager and staff, promoted the provider's ethos of, "Our core value is to develop each individual's potential, by providing homes which offer communal living, a vibrant social life and the encouragement of independence." Throughout our inspection, we saw that staff encouraged people's independence and involved them in all aspects of managing their daily lives to help them to develop and maintain their skills.

There were systems in place that ensured the registered manager and provider took account of the views of people living at the home and their relatives where appropriate. We saw that people were involved in the running of the home by way of house meetings that were held. Minutes of house meetings we looked at showed us that discussions included areas such as staffing, activities and planned holidays. Minutes also recorded that people communicated to staff that they were happy with the service. The provider also

conducted annual quality assurance surveys for family and friends. We looked at the results for the last one conducted in 2017 and noted all participants expressed that the staffing team at Woodcroft were friendly and welcoming and that Woodcroft appeared clean and in good decorative order. Participants were also asked what they felt Woodcroft did well and comments included, "Personalised care delivered with respect, thanks very much for all the care", and, "Kindness and community presence. Woodcroft is always welcoming, friendly atmosphere, it's obvious the residents are very happy there. The staff are wonderful."

The service worked well with external organisations including health and social care professionals to ensure people's needs were safely met and to help improve the quality of the service provided. The registered manager told us that they communicated and worked with local authorities who were commissioners of the service, GPs, district nurses, community mental health teams and other health and social care professionals when required.

The provider recognised the importance of regularly monitoring the quality of the service and there were systems in place to ensure audits and checks were conducted. The provider's electronic computer systems stored records for staff recruitment information, staff's working contracts and rota's, staff training, supervision and appraisals, care plan's and records reviews and incidents and accidents. The system also recorded and audited people's care needs and records and health and safety within the home. The regional manager told us the system allowed them to monitor the service thoroughly on a regular basis and to take appropriate prompt actions to address any issues when needed.